Review of Women's Health during the COVID-19 Pandemic: Impact on Sexual and Reproductive Healthcare

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The COVID-19 pandemic has caused unmeasurable loss and dramatically changed the lives of many people across America. Many of its harmful effects have had an especially large impact on women's health. This literature review discusses the impact COVID-19 has had on women's sexual and reproductive healthcare (SRH) in the United States, with a focus on disparities. SRH is defined holistically, including mental health and fertility preferences. Before the pandemic, there were many reasons access to preventative care was limited in the United States, including financial, geographical, and logistical barriers. When the healthcare system shifted its focus to COVID-19, preventative SRH care often fell through the cracks, further restricting access to high-quality care. Additionally, the recession caused by the pandemic worsened the financial burden of healthcare, and massive job loss left many people uninsured. The increased barriers to healthcare also applied to abortion access, which is already severely restricted due to restrictive legislation. Likewise, the COVID-19 had a unique effect on the physical and mental health of pregnant women and mothers. Not only are pregnant women at elevated risk for severe symptoms when infected with COVID-19, but stay-at-home orders impacted maternity care. Stress due to the pandemic also had specific effects on pregnant women and mothers. Like most aspects of the pandemic, women of color and low-income women were especially at risk for gender-specific barriers and negative health outcomes. Future policy must acknowledge these disparities and focus on expanding access through insurance policy and low-cost clinics.

Keywords

women's health • COVID-19 • preventative care • access to care • sexual and reproductive health • cancer screening • motherhood • telehealth • racial disparities in health • prenatal care • childbirth • mental health

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Introduction

Sexual and reproductive healthcare (SRH) is central to individual health and public health (Keller & Sonfield, 2019). The COVID-19 pandemic has introduced new barriers to obtaining SRH. This has impacted people of all ages and genders, especially women, people of color, youth, and sexual and gender minorities.

Preventative Care

Since March 2020, many people in the United States have been facing additional difficulty accessing healthcare, especially SRH. In a national study of cisgender women who have engaged in penile–vaginal sex administered from April to May 2020, one in three participants reported that they had to delay or cancel a reproductive care visit or had trouble accessing birth control. Black, Latina, and queer women reported even more difficulty getting access to sexual and reproductive health education, abortion, and contraception care than the general population (Lindberg, VandeVusse, Mueller, & Kirstein, 2020b).

People living in poverty, immigrants and undocumented people, and residents of rural areas also had increased barriers to care (Ott et al., 2020). The economic recession caused by the COVID-19 pandemic has made the cost of healthcare an even more significant barrier than it was before. Lindberg et al. (2020b) also found that one in four women were worried about affording contraception. Concerns about affording contraception were even more common for Latina women, queer women, and low-income women (Lindberg et al., 2020b). Additionally, federally qualified health centers and community-based clinics were especially hard-hit by budget, personal protective equipment, and staff shortages, forcing them to prioritize other urgent patient concerns during the pandemic. A decrease in resources spent on reproductive health by community clinics primarily impacts those who rely on lower-cost care, especially youth and underserved populations. Additionally, people living in rural areas have limited access to healthcare clinics due to physical distance, so if one clinic focuses its resources on COVID-19, local patients may not have other options (Ott et al., 2020). Low-income immigrant women face additional barriers because they may not be able to access federally funded clinics and are more likely to be uninsured (Desai & Samari, 2020). While COVID-19 impacted everyone, those who were already underserved by the healthcare system faced the most additional barriers to SRH due to the pandemic.

Telehealth

During the pandemic, there has been a shift toward telehealth services, which are an effective and safe alternative for many forms of healthcare. Like all forms of healthcare, telehealth is not accessible to all people, and there are disparities drawn by many different social identities, including race, age, geography, class, and ability. Among Medicare beneficiaries, women are less likely than men to have digital access (Roberts & Mehrotra, 2020). Racial disparities in access to healthcare and access to technology are also displayed in telehealth. Black and Hispanic people had lower usage of telehealth, and Black patients were more likely to use audio-only telehealth (Pierce & Stevermer, 2020). Black and Hispanic people are also less likely than the population overall to have either a computer or smartphone that would give them digital access (Roberts & Mehrotra, 2020).

At the August 2020 LA County Women and Girls Initiative Town Hall, Andrea Garcia, director of Community-Centered Initiatives at the LA County Department of Public Health, represented the LA City/County Native American Indian Commission. She shared that Native Americans lack digital access, especially those experiencing homelessness. Black and Native American people make up a disproportionate percentage of people experiencing homelessness (US Department of Housing and Urban Development, 2020).

Access to physical technology is not the only barrier to telehealth. Even though telehealth removes the requirement of physical proximity, people living in rural areas have reduced use of telehealth and are more likely to use audio only, likely because people living in rural areas and on tribal lands are less likely to have high-speed digital access (Pierce & Stevermer, 2020; Jaffe, Lee, & Huynh, 2020). Additional challenges in healthcare utilization often affect adults older than 65, including technology literacy and lack of technology support; the desire to utilize telehealth and trust of the internet; and ability, including mental acuity, hand–eye coordination, visual acuity, and auditory acuity (Kruse et al., 2020). Overall, women are more likely to utilize telehealth than men (Coleman et al., 2020). However, it is important to consider these intersecting factors when discussing women's health, as women's experiences are not solely based on their gender.

Even when used to its full potential, telehealth has inherent limitations for sexual and reproductive health. For example, the shift toward telehealth has caused a decrease in the use of long-acting, reversible contraceptive methods (LARC) because they must be inserted by a provider (Ott et al., 2020). LARCs are the most effective form of nonpermanent birth control. Winner et al. (2012) found that those using oral contraceptive pills, a transdermal patch, or a vaginal ring had a risk of contraceptive failure that was 20 times higher than the risk among those using LARCs, including the intrauterine device (IUD) and implant, although the risk is relatively low for all methods.

Fewer in-person routine appointments have prevented screening for sexually transmitted infections (STI) and contraceptive needs (Ott et al., 2020). Additionally, women, especially adolescents, may lack the privacy to discuss sexual and reproductive care with their provider in a telehealth visit during stay-at-home orders (Ott et al., 2020; Lindberg, Bell, & Kantor, 2020a).

Sexually Transmitted Infections

Early in 2020, national infection rates of chlamydia, gonorrhea, and syphilis were higher than in 2019, following the trend of the last five years. In the spring, infection rates dropped due to a decrease in testing, not an actual decrease in cases ("2020 STD Prevention Conference," 2020). Bonett, Petsis, Dowshen, Bauermeister, & Wood (2021) found that from February 2019 to November 2020, STI testing rates decreased, but test positivity rates for chlamydia and gonorrhea increased (Napoleon et al., 2020). Chlamydia positivity rates increased by 10% in women and 18% in men between 2019 and 2020 (Pinto et al., 2021). Testing for chlamydia and gonorrhea decreased by approximately 59% for female patients (versus 63% for men) at its low point but gradually rebounded to about 15% below baseline by June 2020 (Pinto et al., 2021). The pandemic caused clinic closures and fears of going to see a healthcare provider, resulting in fewer tests. When testing is delayed, infected people have more time to pass the STI to others before receiving a diagnosis (Napoleon et al., 2020).

A rise in STIs should be thought of as a women's issue because untreated STIs in people with uteruses may lead to pelvic inflammatory disease, ectopic pregnancy, chronic pelvic pain, and adverse fetal and neonatal outcomes (Cohen et al., 2020). It is essential that testing centers continue to operate following COVID-19 precautions while expanding telehealth pretest screenings

and self-administered at-home tests ("2020 STD Prevention Conference," 2020; Napoleon et al., 2020). Though in-person activity has returned because of vaccine availability, STI testing may still be restricted due to medical supply chain disruptions. STI testing should be regarded as critical healthcare, and the test supplies needed should be prioritized (Bonett et al., 2021).

Sexual Health Education

COVID-19 has also impacted sexual and reproductive health education for adolescents. Sexual health education is primarily done in schools, but in many districts it was not transferred into the online curriculum. What has been missed may not be made up, especially with budget limitations due to the recession (Lindberg et al., 2020a). Maryjane Puffer, executive director of the LA Trust for Children's Health, stated, "With schools being closed, much of the informal communication about navigating the world for youth is very limited. Health education, while being provided, is not the same virtually as it would be in class." She went on to explain that youth who are sexually active or have experienced nonconsensual sexual activity now have limited access to the services provided at schools. Additionally, they may lack the privacy to discuss sexual health with trusted adults at school while learning at home. The transition to online learning was difficult for schools with tight budgets, and sexual health education and services were not often prioritized.

HPV Vaccinations

Cervical cancer is one of the most common causes of death for women worldwide. In the United States, over 4,000 people die of cervical cancer every year, with disproportionately high rates in low-income, Black, and Latinx women (Montealegre et al., 2020). The human papillomavirus (HPV) vaccine can prevent 90% of HPV-related cancers if given as recommended, between the ages of 9 and 12. During the pandemic, HPV vaccination has dropped by 73%, and while wellness visits for younger children have recovered, visits for preteens and teenagers remained low as of October 2020. Telehealth visits should be combined with in-person vaccinations, possibly through community partnerships, to increase accessibility to address historic disparities in underserved communities (American Cancer Society, 2020).

Cancer Screenings

As the COVID-19 response was prioritized by healthcare systems, care for patients using preventive services was limited. This includes cancer screenings, which can help doctors find and treat several types of cancer before they cause symptoms, when the disease is often easier to treat and less likely to be deadly ("Cancer Screening Overview," 2021). However, cancer screenings were deemed nonessential and put on hold at the beginning of the pandemic to reduce transmission of COVID-19 and decrease the burden on the medical system, which led to a sharp decrease in screening (Cavallo, 2020).

Between March and May 2020, an estimated 285,000 women in the United States missed their breast cancer screening, and 40,000 missed cervical cancer screening (Mast & Munoz, 2021). After the stay-at-home order was lifted on June 12, cervical cancer screening rates at Kaiser Permanente in Southern California were still 24–29% lower for the next three months, as compared to the same

period in 2019. As rates recover, it is unclear if those who missed their routine screenings are now receiving care or if those screened are primarily people who were due for screening after reopening (Miller et al., 2021). Because of the second COVID-19 wave in the winter of 2020, another delay in screenings was recommended for low-risk patients as of December 2020. As of October 2021, screening recommendations are dependent on local COVID-19 prevalence and vaccination status, but screenings are still treated as a low-priority, non-urgent procedure (French, 2021). The drop in breast and colorectal cancer screenings and treatment due to COVID-19 could result in nearly 10,000 additional deaths in the next 10 years because detection and treatment are delayed. These effects will likely have a greater impact on historically underserved populations, who already had higher rates of death due to cancer and are most affected by COVID-19 (Sharpless, 2020; Singh & Jemal, 2017).

Abortion Access

Abortions can be performed via a surgical procedure or by mifepristone, an oral medication that induces abortion. Typically, people who are prescribed mifepristone must receive it from their healthcare provider in person. In order to prevent the spread of COVID-19, a federal court temporarily blocked the requirement for in-person visits to receive mifepristone ("Federal Court Blocks," 2020). From July 2020 through January 12, 2021, doctors (and in some states, advanced practice clinicians) could prescribe the abortion pill via telehealth visits and deliver it to patients by mail. This allowed pregnant people to receive abortions without the risk of COVID-19 exposure ("Federal Court Blocks," 2020; Reproductive Access Project, 2021). Additionally, "No-touch abortions" eliminated the requirement for people to have a blood test or ultrasound before a medication abortion, further protecting patients from COVID-19 exposure and allowing clinics to save personal protective equipment (Jones et al., 2020).

However, on January 12, 2021, the Supreme Court upheld the U.S. Food and Drug Administration's (FDA) regulation requiring in-person visits to receive mifepristone. Patients now must pick up abortion pills at a medical facility, although they generally will take the pill at home (Barnes, 2021). This ruling increases the risk of patients being infected with COVID-19 while accessing abortion care and adds unnecessary barriers to care as they will need to coordinate transportation, make more time in their schedule, and possibly find childcare.

Abortion is not always covered by insurance, and even with insurance there are often out-of-pocket costs. Low-income people and people of color are most impacted by the recession and more likely to not be able to access abortion services (National Institute for Reproductive Health, 2020). However, in some states, there are programs to address this barrier. In California, Medi-Cal does cover abortion services, and pregnant people can enroll in coverage the same day they have their appointment, with a process called "presumptive eligibility" (National Health Law Program, 2020; Department of Health Care Services, 2021).

Pregnancy and Motherhood During COVID-19

Pregnant people are more susceptible to viral infection, and data on coronavirus are consistent with this vulnerability (Sharma et al., 2020; Zambrano et al., 2020). Pregnant women with COVID-19 are also more likely to have symptoms and require more intensive healthcare, including ICU

admission, invasive ventilation, and extracorporeal membrane oxygenation (Zambrano et al., 2020). Though the risk of death remains low, there is an increased risk for death associated with pregnancy in patients with COVID-19. Zambrano et al. (2020) reported 1.5 deaths per 1,000 cases in pregnant women, and 1.2 deaths per 1,000 cases in nonpregnant women, with an adjusted risk ratio of 1.7. Hispanic women had an adjusted risk ratio of 2.4, meaning pregnancy put them at an even greater risk of dying due to COVID-19. Pregnant and nonpregnant Black women had higher rates of death due to COVID-19 than the corresponding general populations (Zambrano et al., 2020).

Vertical transmission of COVID-19 needs to be studied further, but some evidence suggests vaginal delivery and cesarean birth do not cause transmission of COVID-19 from the birthing parent to the infant (Sharma et al., 2020; Weigel, 2020; Martinez-Perez, 2020). Cesarean deliveries in people with COVID-19 were associated with maternal health complications in a study of 82 pregnant people, likely due to the stress of surgery (Martinez-Perez, 2020). Birthing parents with confirmed or suspected COVID-19 may stay in the same hospital room as their newborn after birth with safety precautions if they feel well enough to provide care (Wycoff, 2021).

Though their increased risk means pregnant people should protect themselves from COVID-19 and follow safety guidelines to the best of their ability, this was especially challenging for essential workers, single mothers, people experiencing homelessness, and others who were unable to stay at home during the peak of the pandemic (Zambrano et al., 2020).

Fertility Preferences

People's decisions about having children are impacted by their social and economic contexts. COVID-19 has caused economic instability and a general unease about the future, and studies predict a large decrease in births during and following the pandemic. One study by economists predicted 300,000 fewer births in 2021 in the United States (Kearney & Levine, 2020). A national survey in May 2020 found that 34% of women decided to delay having children or wanted fewer children because of the pandemic. Black women, Latina women, queer women, and low-income women were more likely to report this change (Lindberg et al., 2020). While it is too soon to fully evaluate the connection between birth rate and the COVID-19 pandemic, in January 2021, the birth rate in the United States had decreased by 9.41% from January 2020, following the prediction by Kearney and Levine (2020). However, since March 2021, the decline had slowed to below 1% (Morse, 2021). The misalignment with the prediction may have been because Kearney and Levine (2020) did not predict the vaccine would become widely available as quickly as it did.

Prenatal Care

Telehealth is a viable method to provide safe care to pregnant women. When some prenatal appointments are moved to telemedicine, women seem to have comparable outcomes and feel a slightly higher level of satisfaction with their care. However, the home monitoring tools used in virtual care can also be expensive and are not always covered by health insurance. These tools may include blood pressure cuffs, scales, and a fetal Doppler, and together cost around $100 (Freyer et al., 2020; Butler et al, 2019; Weigel et al., 2020). Before COVID-19 vaccines became available, allowing for

in-person prenatal care, the high out-of-pocket price of home monitoring tools may have been a barrier to adequate care, especially for low-income mothers.

Disparities in Pregnancy Care

Even before the pandemic, pregnant Black and Native people faced disproportionately high rates of maternal morbidity and mortality due to systemic racism. The pandemic is expected to increase rates of complications and poor outcomes as access to care is limited, which will only further decrease Black and Native women's trust in the healthcare system and deter them from seeking help (Connor et al., 2020). Pregnant immigrants may also experience more negative health outcomes because the pandemic has especially impacted low-income immigrant communities. Immigrants, especially undocumented people, also face an additional layer of stress navigating misinformation about health and fear of immigration enforcement while accessing prenatal care, and before the pandemic already had less access to prenatal care than other U.S. residents (Fabi & Ludmir, 2021; Wycoff, 2021).

Giving Birth During a Pandemic

COVID-19 also presented challenges for people during birth. Family members who had planned to travel for the birth were unable to because of COVID-19, especially before the vaccine was available. Hospitals also limited the number of support people attending the birth. Changes in birth plans can be very stressful for pregnant people (Weigel, 2020; Fakari & Simbar, 2020). At the August 2020 LA County Women and Girls Initiative Town Hall, Nourbese Flint, program manager for Black Women for Wellness, an advocacy and community health nonprofit, stated, "A lot of folks are rethinking their whole birthing plan . . . there is just a lot of confusion and fear about going to the hospital. . . . Tied with the already disproportionately high maternal mortality and morbidity and infant mortality and morbidity in the black community, that only exacerbates what we've already been seeing." As Flint stated, Black and Indigenous women are significantly more likely to die of pregnancy-related causes. Hospital restrictions on the number of support people who can be present during childbirth may leave women of color without adequate support or advocacy from family, friends, and/or doulas (Ott et al., 2020).

Breastfeeding and COVID-19

With proper hygiene, there is no evidence of COVID-19 transmission through breastfeeding, and breastfeeding boosts the immune system of infants, protecting them from infectious disease (Lubbe, Botha, Niela-Vilen, & Reimers, 2020). Breastfeeding parents with COVID-19 should take precautions by wearing a mask when within 6 feet of their infant and washing their hands for 20 seconds with soap and water before caring for their child. Parents with COVID-19 may also express breast milk and have a healthy caregiver, who is vaccinated and not at increased risk for severe illness from COVID-19, feed the milk to the baby. After the isolation period, breastfeeding and skin-on-skin contact should be encouraged when possible (Lubbe et al., 2020; "Breastfeeding and caring," 2021).

Due to COVID-19, it may be challenging for new parents to receive lactation support, which can make breastfeeding difficult. Whenever possible, newborn follow-up visits should be held in

person, where providers can evaluate feeding and weight gain. If additional services were needed before the COVID-19 vaccine was available, lactation support should have been done virtually whenever possible ("Breastfeeding people," 2021). Not only was virtual lactation support (telelactation) safer during the peak of the pandemic, it was often more affordable and more accessible for busy parents and those who do not live near lactation resources (Dhillon & Dhillon, 2020; Grubesic & Durbin, 2020; Schindler-Ruwisch & Phillips, 2020). However, there are logistical and technical difficulties with telelactation, and it may be challenging to collect accurate information on the infant's weight or diagnose oral issues (Demirci et al., 2019). The necessity of virtual lactation consultations may have decreased the standard of care for new mothers during the height of the pandemic. If the lactation consultant and parents are fully vaccinated and not at risk for serious illness from COVID-19, lactation support can now be performed in-person following CDC guidelines ("Breastfeeding people," 2021).

Maternal Mental Health

There has been a well-studied link between poor mental health during pregnancy and unfavorable maternal and infant outcomes (Alder et al., 2007; Field et al., 2010). Fear and stress due to COVID-19 caused increased symptoms of anxiety and depression during pregnancy (Masjoudi et al., 2020; Salehi et al., 2020; Berthelot et al., 2020). Women who felt the most threatened by COVID and the least confident about their safety precautions had higher rates of mental health issues and birth complications (Qi et al., 2020). This stress may have stemmed from fear of the virus itself, financial stress associated with the recession, and/or the stress of drastic changes to their lives and birth plans (Salehi et al., 2020; Qi et al., 2020; Rashidi & Simbar, 2020). Previous mental health diagnoses, financial strain, and low household income were correlated with poor mental health, including depression and anxiety (Cameron et al., 2020).

In April 2020, prenatal and postpartum depression and anxiety had increased to about 33–36%, from the non-pandemic population comparison of 13–25% (Cameron et al., 2020). Due to isolation and social distancing measures, pregnant people were less able to rely on the support of friends and relatives (Rashidi & Simbar, 2020). Because social support is an important defense against mental health concerns during and after pregnancy, new parents may have experienced additional stress leading to poor mental health (Qi et al., 2020; Etiebet, 2020).

The stress of COVID-19 and isolation also affected mothers of older children. In a national survey of self-reported stress due to the COVID-19 pandemic in late March 2020, there was a striking gender gap in respondents who stated, "worry or stress related to the coronavirus has had a negative impact on their mental health." Fifty three percent of women overall reported that stress had impacted their mental health, while only 37% of men claimed the same. The gap was even wider among parents of children under 18. Stress in mothers increased to 57% compared to women overall, while stress in fathers decreased to 32% (Hammel & Salanicoff, 2020).

Though multiple factors contribute to this disparity, women's higher rates of anxiety during the pandemic align with gender roles in the home and the unequal distribution of family caregiving responsibilities (Hammel & Salanicoff, 2020). During the pandemic, as children spend more time at home, women have taken on even more work as caregivers for children and other family members. Among married heterosexual couples, before the pandemic, women spent 10.9 hours per day on childcare, compared to 7.2 hours spent by men. During the pandemic, women increased their

childcare time by 6.1 hours per day, compared to 4.7 hours by men (Alon et al., 2020). Furthermore, there has been a significant increase in depression and anxiety in mothers, with symptoms that interfere with their daily activities, including job performance, schoolwork, and relationships. This especially affected mothers who have low household incomes, low social support, and low marriage quality and who experienced employment loss and financial strain (Cameron et al., 2020).

Conclusion

As the U.S. healthcare system prioritizes COVID-19, resources have been diverted from the sexual and reproductive health programs that many people rely on (Desai & Samari, 2020). Rapid change was necessary to avoid the spread of COVID-19, but some preventative measures unintentionally decreased the quality of sexual and reproductive care. For example, the shift to telehealth, while effective in maintaining stay-at-home orders, is not accessible to all and restricts the health services that can be available. Additionally, hospitals and clinics were forced to delay non-urgent services in order to keep up with the demands of COVID-19, but many of these services are necessary to prevent future disease. While COVID-19 needed to be prioritized, reproductive care is still essential. Many people are facing additional barriers to accessing contraception, STI testing and treatment, abortion, and obstetric care. Due to high unemployment and the recession, the cost of healthcare may hinder people from accessing care more often than before the pandemic.

Like all aspects of COVID-19's effects, the impact on reproductive care has followed existing social inequities, disproportionately affecting Latinx and Black, LGBTQ+, and low-income women.

Recommendations

Women need accurate, up-to-date information so that they can make informed choices and community support to help them through these challenges (Etiebet, 2020). Policy makers must realize that access to SRH is necessary for people to maintain wellness and autonomy, and the healthcare system must be reformed to support this need (Lindberg et al., 2020b; Ahmed, Dawson, Donovan, Keller, & Sonfield, 2020). It is also important to center those who have been the most marginalized to ensure our approach to sexual and reproductive health is equitable and accounts for diverse needs (Connor et al., 2020; Ahmed et al., 2020). A community-based approach, where those who the program seeks to benefit are involved in decision-making, best ensures that real needs will be met (Lindberg et al., 2020b; Desai & Samari, 2020; Etiebet, 2020). Options to improve access to SRH during and after the COVID-19 pandemic include:

- Lifting the FDA's restrictions on medication abortion
- *The requirement for an in-person visit to access mifepristone, the abortion pill, a change by the Trump administration, described in Abortion Access. The Biden administration could immediately suspend the enforcement of this requirement and review the other FDA restrictions on mifepristone ("Tell the Biden Administration," 2021).*
- Creating reliable platforms online where pregnant people can learn from each other and healthcare professionals while staying safe in their homes
- *During the pandemic, there are additional barriers to forming communities among pregnant people and creating relationships with providers. Online forums where women and professionals*

could talk would make up-to-date information accessible and make pregnant people feel more supported (Etiebet, 2020).

- Developing telehealth
- *With telehealth, many SRH services, including contraceptive prescription, medication abortion, preexposure prophylaxis to prevent HIV, and some prenatal and postpartum care, can be provided without risk of exposure to COVID-19. Even as in-person activity returns after the development of the vaccine, telehealth can be used to expand access to care by removing geographic, transportation, and childcare barriers. The federal and state agencies must eliminate unnecessary restrictions on telehealth and its insurance coverage (Ott et al., 2020; Ahmed et al., 2020).*
- Expanding of access to comprehensive insurance coverage
- *The recession during the pandemic has caused many people to lose their jobs, and therefore their health insurance. Ensuring coverage removes a large financial barrier from many essential health services, including sexual and reproductive health (Lindberg et al., 2020b). This includes expanding the Affordable Care Act and Medicaid, specifically including SRH expenses, such as contraceptives and HIV medication. It also includes repealing the Hyde Amendment, which prevents federal funds from covering most abortions (Ahmed et al., 2020).*
- Continuing local programs to support sexual and reproductive health
- *For example, LA County has created important policies to improve access to* SRH, *such as offering free STI/HIV testing (Division of HIV and STD Programs, n.d.). The state of California has also created programs to support sexual and reproductive health, including the Black Infant Health program which provides free group support sessions, life planning services, and case management ("Black Infant Health," 2021). Local programs that provide basic, necessary services at a low cost have a huge effect on community health and should be expanded to locations that do not have these resources.*

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