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A qualitative exploration of experiences accessing community and social services among pregnant low-income people of color during the COVID-19 pandemic

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Abstract

Background: The COVID-19 pandemic has been associated with increased social and economic stressors among pregnant individuals. While community and social services have been available to mitigate stressors in pregnancy (e.g. food insecurity and financial hardship) and reduce the risk of adverse maternal outcomes, it is unclear how the pandemic impacted access to these resources, particularly in communities of color with lower incomes.

Objective: To examine the experiences accessing community and social service resources during the COVID-19 pandemic among pregnant people of color with low incomes.

Design: Participants for this COVID-related qualitative study were recruited from two sources—a prospective comparative effectiveness study of two models of enhanced prenatal care and the California Black Infant Health Program between August and November of 2020.

Methods: We conducted 62 interviews with Medicaid-eligible participants in California's Central Valley. During their interviews, study participants were asked to share their pregnancy-related experiences, including how they felt the pandemic had affected those experiences.

Results: We identified two broad themes: challenges with accessing community and social service resources during the pandemic and opportunities for improving access to these resources. Sub-themes related to challenges experienced included difficulty with remote access, convoluted enrollment processes for community and social services, and problems specific to accessing COVID-19 resources (e.g. testing). Sub-themes related to opportunities to improve access included leveraging instrumental support from perinatal staff and informational (e.g. practical) support from other community programs and pregnant peers. Participant recommendations included leveraging opportunities to improve client experiences through increased transparency and better patient–provider communication.

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Conclusion: This study highlights some important trends that emerged with the rollout of remote service delivery for social services among a vulnerable population. Many participants were able to leverage support through other programs and perinatal staff. These individuals identified additional opportunities to improve client experiences that can inform the future implementation of support services for pregnant people.

Keywords

COVID-19 pandemic, implementation, pregnancy, social stressors, support resources

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Introduction

The health and social consequences of the coronavirus disease 2019 (COVID-19) pandemic have been felt nationally, particularly among groups with low incomes in the United States. Several studies have identified adverse impacts of the COVID-19 pandemic on pregnant individuals, including increases in material hardship, food insecurity, and depressive symptoms.¹⁻⁷ These socioeconomic stressors are associated with an increased risk of adverse birth and maternal outcomes through important downstream factors, such as stress and limited access to quality care.⁸⁻¹¹ Studies show that receipt of community and social services in pregnancy can reduce risk of adverse outcomes by mitigating the impacts of socioeconomic stressors among Medicaid-eligible populations (i.e. households at or below 133% of the federal poverty level) with complex needs.¹² For instance, a study on the receipt of the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) benefits during pregnancy showed that WIC reduced the risk of adverse birth outcomes.¹³ Soneji et al.¹⁴ found that mothers with low incomes who received WIC benefits during pregnancy had a lower risk of preterm birth and infant mortality compared to mothers who did not. While the COVID-19 pandemic has shaped social and economic stressors among families with low incomes, additional research is needed to understand how the COVID-19 pandemic impacted access to resources that mitigate these stressors.

There are several ways in which the COVID-19 pandemic may have influenced access to community and social service resources. For example, federal, and state-wide expansions of community and social services during the pandemic may have increased access to supportive resources for pregnant people during the pandemic by providing more financial and social benefits and opening eligibility to those who may not have otherwise qualified. The federal Coronavirus Aid, Relief, and Economic Security (CARES) Act provided individuals with increased tax benefits and unemployment benefits, expanded Medicare telehealth services, and provided protective provisions for foreclosure and evictions.¹⁵ In addition, the statewide COVID-19 response in California included unemployment assistance, tax relief stimulus payment, housing aid, and expansion of nutrition assistance

programs.¹⁶ In the early phases of the pandemic, California was one of 14 remaining states to transition from paper vouchers to implementation of electronic benefit transfer and complete remote delivery of WIC services increasing access to WIC services.^{17,18} But while the transition to remote service delivery for WIC and other programs may have increased access to resources overall, some individuals with technology limitations may have experienced lower access through remote delivery. Furthermore, individuals may have preferences for in-person access to resources that include personal connections and social support from staff and other community members. To date, few studies examining the impacts of the COVID-19 pandemic have explored these experiences of accessing resources explicitly, especially among pregnant people.

Differences in the experience of social and economic stressors and differential access to resources to mitigate stress are rooted in social hierarchies upheld by the legacy of slavery in the United States, contemporary structural racism, and discrimination.¹⁹⁻²¹ Marginalized groups, such as pregnant people of color with low incomes, may experience challenges receiving resources during pregnancy that can be exacerbated during a global crisis, such as the COVID-19 pandemic. The purpose of this study is to describe the experiences of Black, Latinx, and multi-racial pregnant people with low incomes in accessing community and social resources, which we define broadly as services to address social and economic stressors as well as COVID-related resources (e.g. COVID-19 testing) in Fresno, California, during the COVID-19 pandemic.

Methods

Study sample

This convenience sample was drawn from an ongoing comparative effectiveness study entitled, Engaging Mothers & Babies-Reimagining Antenatal Care for Everyone (EMBRACE) and the Fresno Black Infant Health Program, a statewide support service for Black families during the perinatal period.²² EMBRACE compares the effectiveness of individual care and an adapted group prenatal care program (Glow!) developed in partnership with the local community on preterm birth, mental health, and the experience of care among Medicaid-eligible pregnant people in

the Central Valley, California. EMBRACE study recruitment was paused in March 2020 due to the COVID-19 pandemic, while a telehealth adaptation of the group prenatal care model was being created. The original group prenatal care model had been developed through several community engagement activities; the adaptation process expanded on these activities by soliciting community feedback from additional stakeholders, including people with low income who had been pregnant during the pandemic.²³ We recruited from the Black Infant Health Program to increase the representation of Black/African American participants in the qualitative study. Participants in this qualitative study consisted of Medicaid-eligible individuals, who self-identified as Black, Latinx, or multi-racial, and were either pregnant or gave birth in Fresno, California, during the COVID-19 pandemic. The EMBRACE study, which included a protocol for recruiting and interviewing participants for the qualitative research, received human subjects approvals from the Institutional Review Boards of the University of California, San Francisco (IRB#: 19-28319) and California State University, Fresno (IRB #: 922).

Data collection

Forty EMBRACE study participants and 22 Black Infant Health Program participants enrolled in this qualitative study. We conducted semi-structured interviews with these individuals between August 2020 and November 2020 to explore their pregnancy-related experiences during the COVID-19 pandemic as well as their perceptions of telehealth during pregnancy. Participants were asked to reflect on the period of March–November 2020. The interviews included questions related to COVID-19 experiences and challenges (e.g. accessing COVID-19 testing in community settings) and a subset of questions to explore experiences with accessing resources both before and during the pandemic. For instance, we asked participants to describe the resources and social services they were able to access before the pandemic, such as health navigators, case workers, WIC, Supplemental Nutrition Assistance Program (SNAP), transportation, mental health services, or childcare. We also asked participants to describe resource and social service access during the pandemic, using the following prompts:

- What resources/programs have you been able to access since the beginning of the COVID-19 pandemic?
- What resources/programs have been the most challenging to access?
- What were the top barriers to accessing these resources?

Finally, we asked participants to share how the community or social service agencies could improve the delivery of resources during the pandemic. To limit exposure during

the pandemic, all participants provided verbal consent via a verbal consent form completed by recruitment and retention specialists. EMBRACE study participants also provided verbal consent prior to enrolling in the study. An EMBRACE study recruitment and retention specialist conducted interviews virtually via Zoom (56 in English and six in Spanish). The interview durations ranged from 23 to 96 min and participants received US\$50 as remuneration. Interviewers received training from two co-authors on qualitative interviewing, and after each interview, they completed field notes to summarize responses.

Data analysis

Audio recordings from each interview were professionally transcribed and analyzed using qualitative software (Dedoose and Atlas.ti 9). Transcripts were initially coded deductively by a research team of community and academic researchers using a codebook developed based on the interview guide. Then, using thematic analysis,²⁴ the lead author (BEB) inductively coded all transcripts that included quotations coded with the codebook related to COVID-19 social and economic stressors and resources accessed during the pandemic. The new codes were then categorized into salient groups or themes. All authors reviewed subsequent themes and exemplary quotes and confirmed saturation of the themes identified. We defined saturation as the lack of new codes/ideas emerging in transcripts.²⁵

Results

The average age of the study participants was 27 (SD=5.8) years (Table 1). About 42% of participants identified as Black/African American, and 40% identified as Latinx, with the remaining 18% identifying as biracial or multiracial. Most participants had completed their education with high school graduation (34%) or had attended some college (34%). Most participants were married or lived with a partner (66%), US-born (76%), had a US-born mother (86%) or father (74%). Twenty-four percent of participants had a monthly household income of less than US\$1000, 31% of participants had a monthly household income between US\$1001 and US\$2000, and 36% and 5% of participants had a monthly household income between US\$2001 and US\$4000, and greater than US\$4000, respectively.

Overall, participants reported several community and social service resources that were accessed during the perinatal period and improved coping with COVID-19-related stressors. These resources included CalFresh (California's SNAP, referred to as food stamps), CalWORKs (California Work Opportunities and Responsibility to Kids, referred to as welfare), the CARES Act unemployment and stimulus payments, food giveaways, and school lunch programs. WIC was also cited as a resource that participants and their families utilized during the pandemic. Participants were

Table 1. Sample characteristics (N=62).

Sociodemographic characteristics	n (%)
Age, mean (SD), years	27.2 (5.8)
Race or ethnic group	
Black/African American	26 (41.9)
Latina/Latinx	25 (40.3)
Bi- or multi-racial ^a	11 (17.7)
Highest level of education	
Eighth grade or less	6 (9.7)
Some high school	9 (14.5)
High school graduate, GED, or equivalent	21 (33.9)
Some college, junior college, or vocational school	21 (33.9)
College or graduate degree	5 (8.0)
Relationship status	
Married or living with partner	41 (66.1)
Significantly involved with a partner, but not living together	9 (14.5)
Single/not significantly involved	12 (19.4)
Country of birth	
United States	47 (75.8)
Mexico	14 (22.6)
El Salvador	1 (1.6)
Monthly household income	
Less than US\$1000	15 (24.2)
US \$1001–US \$2000	19 (30.7)
US\$2001–US\$4000	22 (35.5)
Over US\$4001	3 (4.8)
Don't know	3 (4.8)

SD: standard deviation; GED: General Educational Diploma.

^aBi-racial includes individuals who identified as some combination of two races/ethnicities (e.g. Black and Latinx) and multi-racial includes individuals who identified as a combination of two or more races/ethnicities (e.g. Black, Latinx, American Indian).

engaging multiple services or community programs simultaneously, and agencies were implementing remote service delivery to varying degrees which became burdensome.

Challenges accessing community and social service resources

Sub-themes that emerged around challenges with accessing community and social services included (1) difficulty with remote access to services, (2) poor communication during service enrollment processes, and (3) challenges accessing COVID-19-related resources (Table 2). Participants also shared experiences of longer wait times for accessing services due to busy phone lines, delays in telephone appointments, and application processing for services that would typically take about a week to approve took 4–6 weeks during the pandemic.

Remote access to services. Participants who had experience with both in-person services before the pandemic and

remote services during the pandemic indicated a preference for in-person services because of the ability to interact with service agencies and other clients (Table 2). One participant described how the increased use of technology may present barriers for people who “don’t have the patience or don’t have the time or don’t know how to use the phone.” Another participant noted that remote service delivery posed challenges for those with fewer payment options:

[When] you don’t have credit cards and stuff for those sorts. It’s like, you have to go back to the old modern days. You can’t even go inside certain places and pay your bills. To me, it’s very hard when you’re trying to multitask and keep everything going and trying to do what you need to do to survive.

Some participants reflected on how the transition to online servicing and tools like WIC electronic benefit transfer made accessing services more efficient. For instance, a participant described how WIC services improved overall “because they give you a card and on that card is everything you have to take. If you want, take everything, and leave some values.” In another scenario, a participant described how the provision of remote services for WIC offices was preferred for mitigating risk of exposure to COVID-19 compared to other services that still required in-person enrollment. However, the transition to WIC electronic benefit transfer did not come without challenges for some, due to the steeper learning curve for interacting with the new WIC electronic benefit transfer system (Table 2).

Poor communication during social service enrollment processes. Participants also expressed challenges with enrolling in services during the pandemic that stemmed from a lack of transparency and, in some cases, harmful communication with staff. For example, a participant described how enrolling in WIC services as a pregnant person was more accessible than enrolling in other services and described a rude encounter where a worker questioned her pregnancy and made no effort to acknowledge her need during the pandemic (Table 3). Others reported experiencing a lack of transparency about enrollment processes. As this participant described, their inquiries were met with an impersonal exchange: “I had questions, I don’t really know how that worked. For them, I was just another person calling trying to use their system.” A lack of transparency in enrollment processes was also highlighted by another participant, which ultimately hindered their ability to receive much needed support and negatively impacted their mental health (Table 2).

Challenges accessing COVID-19-related resources. Access to COVID-19-related resources challenges, such as testing, were related to concerns about exposure and social and economic stressors experienced by participants. Participants expressed awareness of COVID-19 testing resources throughout the community and in healthcare settings.

Table 2. Themes and quotes: challenges accessing community and social service resources.

Sub-theme 1. Remote access to services

- “It was more convenient [before the pandemic]. I went to a lot of programs. I went to Black Infant Health, and we had a lot of sessions leading up to the pandemic, face-to-face interaction, and getting other people’s opinions on things. It was just easier to relate while being around people that can relate as well. I didn’t have to worry about, “Oh, would I get through this call, or would I even get a callback?” I never had to worry too much because there was always a way to get a hold of someone.”—Black/African American participant
- “I felt I got to actually connect with people that had kids, people that work there. It feels so different over the phone. It’s just like, most of that is gone.”—Latinx participant
- “I filed for maternity leave [disability] at the end of June and something happened to where they read my Social Security number wrong, so they had to redo it. Because of COVID, it’s taking four to six weeks in order to reevaluate it, whereas, if it weren’t COVID they’re saying it would have been a week thing.”—Latinx participant
- “I like the efforts everybody’s making, but I feel like this COVID situation all happened at a bad time, especially with WIC because they transitioned to the WIC card, and right where you’re supposed to be trained on it, that’s when the stay-at-home order happened. I had no idea what I was doing. I had to download this app and their instructions on it were extremely horrible. I pretty much had to figure it out on my own.”—Black/African American participant

Sub-theme 2. Poor communication during service enrollment processes

- “WIC asked, ‘Are you pregnant? What’s the date of you being pregnant?’ And then ‘okay, we’ll get you started on WIC’. With the CalFresh, they didn’t care. They’re like, ‘no, we’re not going to expedite anything. We’re not going to hurry this process. It doesn’t matter if you’re pregnant.’ Then the lady straight up told me, ‘How am I supposed to know if you’re really pregnant?’ Just having people be rude to you for no reason. That was hard, that was difficult.”—Bi-/multi-racial or ethnic participant
- “I applied for CalFresh, but they asked me for things about the child, but they did not tell me precisely what; I did not know what to send, and they rejected the application. It’s something that does make me a little depressed because that’s the help I could hope for.”—Bi-/multi-racial or ethnic participant
- “WIC is really like they call you and they send stuff in the mail. It’s real convenient with them, but with Welfare, they want you to come into the office. Me, I have little kids, so I can’t just get up and go to their office because I don’t want them to get sick. WIC is helpful but not so much the Welfare.”—Black/African American participant

Sub-theme 3. Challenges accessing COVID-19-related resources

- “I feel like it’s been very difficult because most of the people say you have to have symptoms of coronavirus, but then for us, we had to get tested because we were around it. They needed to prove that I didn’t have the coronavirus, but then when I tried to take the test, they were saying, ‘Oh, you have to show symptoms in order to take the test.’ It was like they were putting me in a run around for a while. We had to wait another week to take the test, a free test. It was at a church that they were doing. We were so lucky because if I wasn’t able to take that test, I couldn’t see the doctors and I couldn’t make sure that I was okay and the baby was okay.”—Bi-/multi-racial or ethnic participant
- “They want you to really be having [COVID-19] . . . I guess they don’t want to waste tests. Like the symptoms aren’t serious to them, they just sent me to the third floor [without being tested].”—Latinx participant
- “For me, the COVID testing, they’ve been real judgmental. I felt like if somebody’s sicker than they usually are, I feel like they just need to be tested because just sending them back home and not knowing if they really got the stuff, and then they’re going back home to their family or others because they don’t want to test them. That’s how I felt when I went. They didn’t want to test me, so if I do got it, I’d have bring it back to my family. I think that’s unsafe. I’m telling them, ‘I’m not usually sick like this.’ I feel like this should be an alert to them or something. Me being pregnant, I should’ve definitely been up for a COVID test because I have a baby also inside of me. I’m already high-risk. That hurt my feelings when they turned me away. I’m like, ‘Wow, I just pray to God I haven’t got it.’”—Latinx participant
- “For my sister-in-law, she was the one that had the coronavirus, she was able to get some people on Facebook. She tried to ask our family members, but they were all working. She put it on Facebook that she had the coronavirus and that she needed to get food. Thankfully, a couple people from churches came over and they dropped off the food. It was still hard because it was like they could only provide for so much. We were trying to call Walmart to see if they could bring food over. It was hard because we couldn’t figure out what resources we could get or who we could call.”—Bi-/multi-racial or ethnic participant

WIC: women, infants, and children.

However, there were notable examples of participants with concern about testing eligibility, lags in receiving test results, and limited social and economic support for those who tested positive for COVID-19. Limited information around testing eligibility, specifically, how to get tested as an asymptomatic person, created challenges for pregnant people and their families. One participant described how decisions on who could receive testing were subjective and

increased the risk of exposure to other household members when sick individuals were turned away. This participant also described how the lack of prioritization of pregnant individuals for COVID-19 testing was a stressor (Table 2).

Participants noted that delays in receiving COVID-19 results (up to three weeks) may have contributed to Fresno’s rise in COVID-19 cases, “because if a person has it, they’re still going to go out because she had to work or something

Table 3. Themes and quotes: opportunities to improve access to community and social service resources.

Sub-theme 1. Linkages through perinatal staff and other community programs

- “She offered to help me get a breast pump through my insurance and a belly band, and she walked me through doing my maternity leave paperwork. She’s really good about that.”—Latinx participant
- “When I got with the Black Infant Health, which is a blessing, it was nice to have the groups. They gave me suggestions with the WIC and other people I can link up with. They told me about being able to get the rights for prenatal care. They gave me a lot of information I didn’t know about. I found about being able to use the food stamps and how to get food, and not having to worry about going out in public. I really had no bad experiences.”—Black/African American participant
- “When I go to my prenatal care, there’s this girl, she helps me to submit applications to the social services. She’s never in a rush. She’s always very nice.”—Latinx participant
- “They [provider/staff] helped me get my unemployment and my sick leave from work. They were pretty helpful.”—Latinx participant

Sub-theme 2. Recommendations for improving service access and delivery

- “With a reasonable explanation about what they need from you to give help because they only tell you, “We need things.” They do not explain satisfactorily what they want, and how do you understand them? Kindness. Many times, or perhaps they are having a bad day, or that’s their character, and they speak loudly to you or things like that. I think it is also very helpful because some get upset. After all, perhaps you do not understand something, and you ask them to explain well as if they answer something terrible. They should improve it a lot in that sense.”—Bi-/multi-racial or ethnic participant
- “I would change the way they communicate. I understand you have to do it on the phone but be understanding. I know the changes is difficult, and they’re learning through this process the same way we are. It’s just, try to be a little more patient with people, and a little bit more understanding of the situation versus giving attitude and being rude. I feel like, they could have had a difficult call before you and then when they got to you, it’s like they’re taking all their frustration out on you. It’s like, “Okay, I’m just asking a question, and I feel like you’re making me feel dumb.”—Black/African American participant
- “Honestly, I think it would probably be to have like a—I don’t know what to call it, like a customer support line, because I tried calling welfare before and it takes a really long time to get in contact with them. Maybe have more workers on the phone to help people who have questions for online, or just don’t know what they’re doing in general.”—Black/African American participant
- “Sometimes, if you go over the income limit for even \$1, they no longer help you. I think that they could change that: if you go over a little, they could still help. Sometimes they say that everyone pays the price because sometimes people don’t use the benefits specifically for their children. Maybe that’s why too, I don’t know. If they are going to give and support, it would be good, but they could still help even if one goes a bit over the income limit. Once, I applied for Medi-Cal, and [my income] went over for \$3, so they cut the Medi-Cal, and we had to pay because they say that the limit was exceeded.”—bi-/multi-racial or ethnic participant
- “I would say checking up on the moms more often. I feel like for me, I’m too busy to call everybody else and be like, ‘Hey, I need help with this, this and this.’ I think it would be nice if they were like, ‘Hey, how are you doing today?’ I know it sounds like a lot, but it would help out a lot too. I feel like after the coronavirus they dropped us a lot more.”—Black/African American participant

WIC: women, infants, and children.

and she was around people.” Support resources for individuals who did test positive were challenging to access. A participant shared that a family member who tested positive resorted to social media to solicit support with groceries during self-quarantine and eventually church members were able to provide meal deliveries (Table 2).

Improving access to community and social service resources

Linkages through perinatal staff and other community programs. Participants also highlighted activities or programs that ameliorated some of the challenges they experienced (Table 3). These included linkages to community and social resources (e.g. WIC, SNAP, lactation support, etc.) during prenatal or postpartum care from providers or staff, as well as programs like Black Infant Health, where participants were able to leverage information and learn from the experiences of other pregnant people on how to navigate the challenging systems. As one participant described, perinatal staff provided support with applications to social services in a manner that was patient

and personable. Similarly, another participant described receiving support with getting lactation tools from an insurance payer. Participants also described how Black Infant Health was an important source of support for accessing resources. One participant who was enrolled in Black Infant Health shared about learning about a transportation service: “I was notified through the program, the African American program [Black Infant Health] that I’m in. They actually told me about it because I was not aware of it until I was informed by them.”

Recommendations for improving service access and delivery. Participants provided recommendations for improving client experiences with accessing social and community services (Table 3). These recommendations were aimed at increasing transparency, decreasing wait times, and improving the quality of staff–client interactions. Recommendations to improve transparency included increasing the frequency of information sharing by community and social service agencies to ensure that clients are receiving up to date information. For example, one participant described how their recommendation would be to:

Continue to put out updated information, if not daily, at least weekly. On websites, on the doors of the buildings, to continue to send out automated telephone messages, letting people know in the community, how services will be handled during that time. I think that was helpful, and that will be helpful in the future.

Like those who emphasized perinatal providers as a central resource, one participant described the importance of having perinatal providers try to connect clients to information:

It would be extremely helpful for me if I was able to go to my provider and they can tell me, ‘Oh, I don’t know, per se, but here is a site that you can access to give you a little bit more information about what’s going on,’ or ‘Here’s a number,’ or just more resources. I think moving forward, if we provided people with a little bit more information about what is going on and how this impacts them, their visits, and their personal prenatal care, that would be extremely helpful.

Other recommendations that emerged to improve experiences included more thorough explanations of enrollment processes, customer support hotlines to reduce wait times, and curbside pickup options for WIC, similar to other retailers: “I feel like the WIC stores should do drive-ups. Like the drive-ups at Target where they’ll bring the groceries to you.” Another participant offered a solution for individuals who minimally exceeded income limits which resulted in the termination of their services. They shared that while income limits may be in place to prevent fraudulent activity, they are often too stringent for families with clear need. There were also some recommendations to improve client-staff interactions. For instance, a participant expressed how the COVID-19 pandemic introduced changes to systems that both clients and staff had to accommodate, which in some cases resulted in frustration and poor communication from staff. One participant suggested that increasing empathy and care in communication with clients would improve interactions. Similarly, another participant recommended increasing engagement with pregnant and postpartum clients outside of service-related interactions. This is particularly important for people who may be engaging with several different service agencies simultaneously and experiencing fatigue and isolation because of remote service delivery.

Discussion

The purpose of this study was to describe experiences of accessing community and social service resources among Black, Latinx, and multi-racial pregnant people with low incomes during the COVID-19 pandemic (March 2020–November 2020) in Fresno, CA. In the United States, many people faced challenges related to food and financial insecurity, and these challenges were more prevalent among historically oppressed groups (race/ethnicity and income) during the pandemic.⁴ Our study adds to this

literature by showing how people also experienced challenges accessing community and social resources to cope with social stressors during the perinatal period. These access challenges included convoluted enrollment processes, increased wait times for accessing services, and poor communication between beneficiaries and service providers. These challenges compounded some participants’ experience of psychosocial stressors—an important risk factor related to adverse birth outcomes.^{26,27} Despite these difficulties, participants were also able to describe resources that were supportive when overcoming access challenges and recommendations to improve service delivery. Linkages to community and social resources by perinatal providers and staff, or other community programs (i.e. Black Infant Health) were helpful for overcoming barriers to resources. Recommendations to improve service delivery included increasing accessibility through drive-up programs and improving communication between staff and clients.

Physical and financial barriers to food access were prevalent among US adults during the pandemic, particularly for some racial and ethnic groups, which contributed to increases in WIC participation among vulnerable families.²⁸ In this study, WIC was a critical resource for participants during the pandemic, and California’s WIC transition from paper vouchers to electronic benefits transfer and remote service delivery during the early phases of the pandemic was favorable among participants. These findings are similar to studies examining experiences with WIC electronic benefits transfer in other settings.^{29–31} Participants viewed the implementation of remote WIC programming and enrollment favorably compared to other community and social resources—which they described as lacking transparency and being too bureaucratic. Future work should document and disseminate the implementation strategies employed in WIC program delivery that contribute to client satisfaction. For instance, in a study of California’s increase in WIC enrollment during the pandemic, Whaley and Anderson (2021) found that the US Department of Agriculture waivers increased flexibility for local WIC agencies to modify service delivery to meet community needs.¹⁸ These waivers improved transitions to remote service delivery by allowing local agencies to waive or postpone in-person eligibility determinations (e.g. bloodwork, body measurements) and allowed agencies to provide benefits in bulk for extended periods of time, to reduce frequency of contact.¹⁸ Similar strategies could be adapted to address the barriers posed by income limits, as discussed in this study, to improve implementation of other community and social service resources.

Our findings showed that Black Infant Health was a supportive resource for navigating and receiving linkages to other resources among Black participants. Several studies indicate that because of discrimination and institutionalized racism, that is, intertwined systems of oppression designed to privilege, or disadvantage groups based on social status,³²

people of color and Black birthing people in particular, experience poor access to quality care.^{33–36} As Slaughter-Acey et al. in 2013 found, lower income Black pregnant people who feel less empowered are less likely to initiate timely prenatal care to avoid harmful experiences of racialization and discrimination.³³ This finding is echoed in research showing that Black women and birthing people receive fewer referrals for lactation support, and experience poorer quality lactation support due to biased provider assumptions that Black women would not breastfeed.³⁶ Thus, the Black Infant Health Program, which leverages a relationship-based and affirming empowerment approach, fills an important gap in supportive resources for Black families to mitigate racism in perinatal care and support.³⁷ Experiences of discrimination and access to care barriers have also been documented among Latinx birthing people.^{38–40} In 2020, Fryer et al. found that Spanish-speaking women reported barriers related to discrimination based on undocumented status and language barriers stemming from a lack of interpretation services.⁴⁰ While the results of this study did not indicate that Latinx participants had experiences with programs that improved their access to community and social resources (e.g. Fresno Barrios Unidos), this could be a byproduct of the data collection approach which oversampled Black/African American pregnant people by engaging Black Infant Health clients. Future research should explore experiences of care and supportive community resources in Latinx communities.

Participants provided many recommendations to improve delivery of community and social resources including implementing curbside pick-up options to improve access among pregnant people and their families. Improvements to the infrastructure for delivery programs, curbside pick-up, and online grocery shopping solutions have been cited as important strategies to reduce barriers to food access among vulnerable groups.⁴¹ Participants valued linkages to support resources from prenatal care staff and providers and had recommendations to improve information sharing among providers. Thus, interventions to improve patient–provider communication and information exchange, such as implicit bias initiatives, health education materials, and use of diverse communication platforms remain critical.^{42–44}

Strengths and limitations

Our study is not without limitations. First, as a qualitative study of a select sample of individuals in one geographic community, findings may not be generalizable to other contexts. In addition, our study only engages the experiences of Black, Latinx, and multi-racial individuals, which may not be generalizable to other groups in Fresno or the Central Valley, CA. While participants discussed a diverse array of experiences, the community and social services addressed here are not exhaustive and may not provide a full review of resources available to pregnant

people in Fresno during the pandemic. Furthermore, the interview questions posed in this study focused on the challenges to accessing resources; although positive experiences did emerge, the findings may not encompass all the perceived benefits of the social and community resources reviewed. Finally, we did not explore trends by race and ethnicity or other intersecting identities which are known to correlate with inequities in access and experiences of service delivery. For instance, we did not capture whether some groups were experiencing more COVID-19-related stressors relative to others, and subsequently accessing more resources. However, as it relates to WIC (the program accessed the most by participants) we did not note racial or ethnic differences in experiences accessing resources.

Despite these limitations, we believe that this study contributes important findings regarding the experiences of pregnant people during the pandemic that can be used to inform the implementation of support resources during pregnancy—particularly for organizations and programs seeking to provide remote options for their clients.

Conclusion

Addressing access gaps for supportive community and social resources among marginalized communities, particularly in times of heightened need, such as the COVID-19 pandemic, is critical. The findings presented in this study highlight the mechanisms through which pregnant people navigated challenges and present opportunities to improve community and social service delivery. Social interventions that address stressors during the perinatal period are essential for improving the health and well-being of pregnant people and their families. This study offers potential targets for improving social and community programs' ability to provide remote services and partner with trusted community programs like Black Infant Health and perinatal health providers to offer affirming support.

Declarations

Ethics approval and consent to participate

This study received human subjects approvals from the Institutional Review Boards of the University of California, San Francisco (IRB#: 19-28319) and California State University, Fresno (IRB #: 922). All participants provided verbal informed consent prior to participation.

Consent for publication

Not applicable.

Author contribution(s)

Bridgette E Blebu: Conceptualization; Formal analysis; Methodology; Writing – original draft; Writing – review & editing.

Miriam Kuppermann: Funding acquisition; Writing – original draft; Writing – review & editing.

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Supplemental material

Supplemental material for this article is available online.

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