

## A New Normal After the COVID-19 Pandemic

Midway through the second year of the coronavirus disease 2019 (COVID-19) pandemic, the increasing number of people vaccinated against this devastating disease gives hope that the pandemic will be controlled and allow a return to normal life. Although we are understandably weary of restrictions, working from home (for the privileged) or working under fear of exposure and infection, the social disruptions, and economic instability, a return to life as usual before COVID-19 would miss many opportunities to learn from this pandemic and work toward increased equity and health for all. In a post-pandemic United States, we need to think differently about infectious diseases.

The foundation for prevention of and response to infectious diseases begins with a robust public health infrastructure. The quality and quantity of the US response to the COVID-19 pandemic varied greatly across counties, states, and regions because of inadequate funding, lack of planning, and limited support from the federal government. Although the United States spends more per capita on health care than any other country, only 1.5% to 2.5% is spent on public health.<sup>1</sup> As COVID-19 infections increased during the spring of 2020, stockpiles of personal protective equipment rapidly depleted, leaving frontline health care workers under-protected and facing dilemmas on how to balance patient care with personal risk. Guidelines to protect health care workers varied by institution, changed frequently, and deviated from long-established approaches for protection against airborne illnesses. Greater coordination across public health systems and sharing best practices can avoid wasted effort. The initial response was delayed from a false sense of safety that the pandemic was under control or isolated to other locations. But we live in a connected world where the ease of international travel facilitates the rapid global spread of infection. Because of all these factors, we need to increase funding and coordination among public health agencies across the United States and renew support for international public health through the World Health Organization and other agencies.

This continuing education issue of the *Journal of Midwifery & Women's Health (JMWH)* focuses on infectious disease in midwifery practice; these articles can help us orient toward infectious disease management in new ways and to give infections the attention needed to better protect patients as individuals and on the population level. I would like to highlight 3 recommendations for focusing on efforts to address infectious diseases in this country: (1) increase use of effective practices to prevent transmission of viral infections, (2) use a health equity lens in prevention and treatment, and (3) use innovative approaches to increase access to health care.

A remarkable consequence of social distancing, mask wearing, and increased hand hygiene has been the dramatic drop in influenza cases, hospitalizations, and deaths during the 2020 to 2021 influenza season. Influenza surveillance by the Centers for Disease Control and Prevention has found that the incidence of influenza has been approximately 1%

of a typical year.<sup>2</sup> In anticipation of the 2021 to 2022 influenza season, we should renew our efforts to encourage influenza vaccination, use of hand hygiene, and mask wearing. Even when effective vaccines are available, there are significant barriers to acceptance of vaccines by the public.<sup>3</sup> This issue of *JMWH* provides different insights into addressing this problem. Vines<sup>4</sup> outlines how midwives can address the trust gap in communities of color about health care and vaccinations through active listening, motivational interviewing, storytelling, and increased workforce diversity. Dehlinger<sup>5</sup> describes a quality improvement project to increase influenza vaccination rates in a multisite urban academic health care facility during the 2019 to 2020 influenza season. The case study by Kraus<sup>6</sup> demonstrates how vaccine hesitancy can lead to perinatal measles infection. We also need to increase utilization of prevention strategies for diseases like HIV for which no vaccines exist. Ruppe<sup>7</sup> discusses how pre-exposure prophylaxis for HIV infection is an underutilized yet feasible approach to protect individuals at higher risk of HIV infection. The articles by Pesch about cytomegalovirus<sup>8</sup> and by Hunter about parvovirus B-19<sup>9</sup> highlight the importance of hygiene practices in protection against perinatal transmission through body fluids and respiratory droplets.

Strategies to prevent infectious diseases need to incorporate a health equity lens and engagement with communities of color, who are most affected by disparities in infectious diseases. Communities of color have faced disproportionate COVID-19 infection rates, hospitalizations, and deaths.<sup>10</sup> The cause for these health disparities is likely multifactorial and includes a greater burden of chronic disease; employment in lower-paying, public-facing occupations like restaurants and grocery stores; crowded housing; and racism inside and outside of the health care system.<sup>11</sup> It is time to move from recognition of health disparities to positive action to address these differences through bold public policy. There are many low-wage workers who cannot afford to stay home if they or family members are ill because they risk lost wages or termination. Many workers understandably choose to work when they are ill, putting themselves and their coworkers at risk. When health care workers come to work sick, they also risk the health of their patients. During the past year, many employers have excluded workers with any symptoms suggestive of COVID-19, undoubtedly excluding those with more benign respiratory illnesses. This has likely contributed to reduced transmission of all respiratory illnesses. Universal paid sick leave and employment protections would protect us all, but especially employees with lower wages and at the greatest risk.

Many midwifery practices increased the use of telehealth visits for routine prenatal care to protect staff and patients from COVID-19 transmission. We do not know how this shift in care has impacted health outcomes, although qualitative studies have demonstrated that patients felt less connected and reassured by these types of visits.<sup>12</sup> When in-person care returns to normal levels, health care systems should examine



how telehealth can be used as a strategy to increase access to care when appropriate and acceptable to patients, rather than as a way to restrict in-person care. Policies need to support appropriate payment for telehealth services and prohibit charges for 2 visits when the need for in-person care is identified at a telehealth visit. It is especially important to maintain access for partners and support people, who advocate for patients of color and mitigate the power differentials inherent in prenatal care. The COVID-19 pandemic has increased innovative approaches to bring health care into communities as demonstrated by licensing many types of health care workers as vaccinators, including pharmacists, dentists, and retired workers. These innovations need to be extended in creative ways to make health services more accessible to all communities.

In the coming months, as pandemic restrictions are lifted, consider how you can develop a new normal rather than returning to pre-COVID-19 routines. Although this editorial focuses on infectious disease implications, there are so many other aspects of life we may want to assess as we anticipate the return to “normal.” Our ability to adapt to the many challenges of the COVID-19 pandemic shows that we can change systems and behaviors when there is a sense of urgency and desire to do better.

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