Challenges to Equity in Maternity Care

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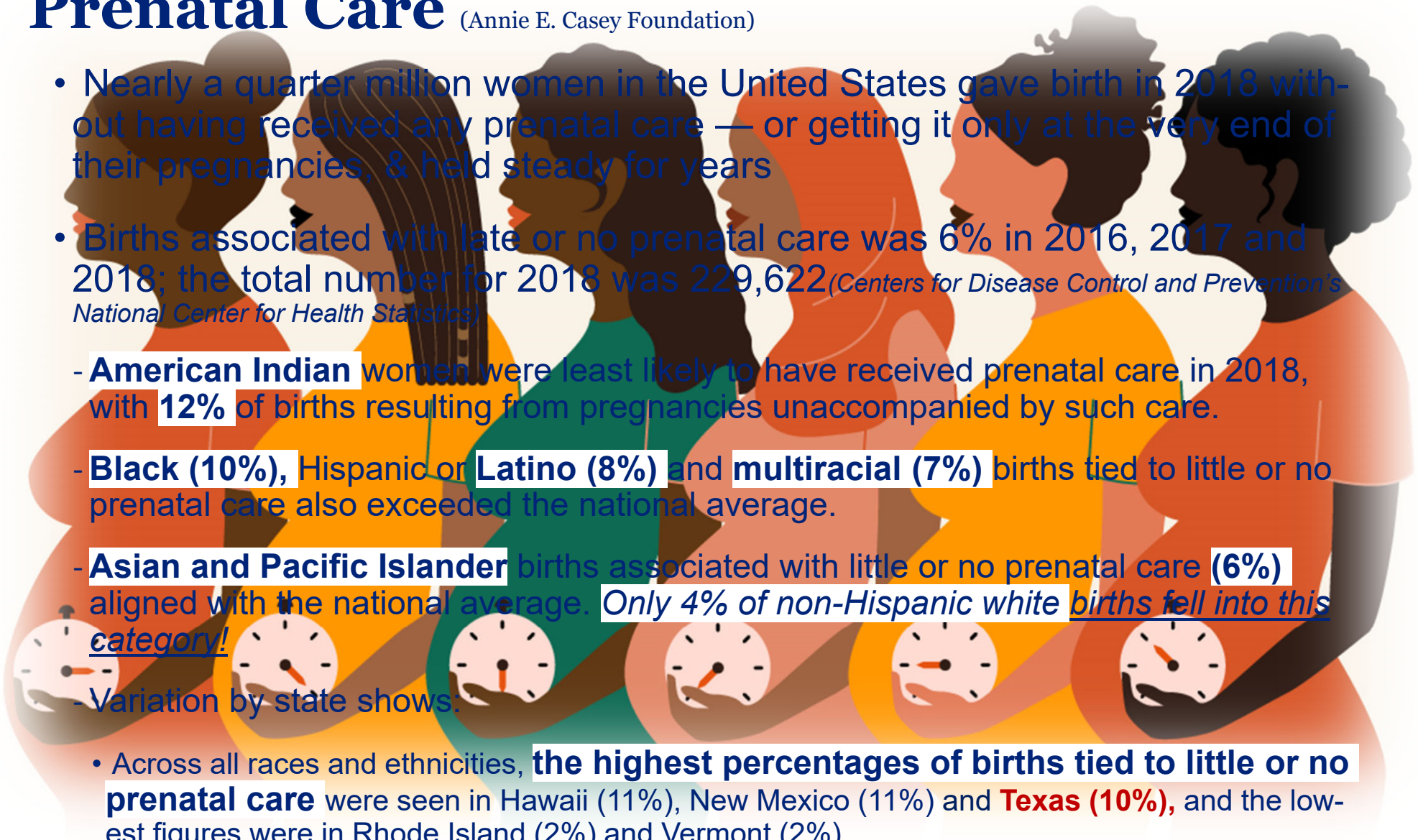
Disclosure

I have no actual or potential conflict of interest in relation to any product or service mentioned in this program or presentation.

Learning Objectives

- Examine the statistics of the maternal crisis and the incidence of failed prenatal care.
- Identify the characteristics of the women who fail to seek prenatal care.
- Recognize the barriers to getting prenatal care and to receiving VBAC.

Incidence of Women with Little to No Prenatal Care (Annie E. Casey Foundation)



- Nearly a quarter million women in the United States gave birth in 2018 without having received any prenatal care — or getting it only at the very end of their pregnancies, & held steady for years

- Births associated with late or no prenatal care was 6% in 2016, 2017 and 2018; the total number for 2018 was 229,622 *(Centers for Disease Control and Prevention's National Center for Health Statistics)*

  - **American Indian** women were least likely to have received prenatal care in 2018, with **12%** of births resulting from pregnancies unaccompanied by such care.

  - **Black (10%),** Hispanic or **Latino (8%)** and **multiracial (7%)** births tied to little or no prenatal care also exceeded the national average.

  - **Asian and Pacific Islander** births associated with little or no prenatal care **(6%)** aligned with the national average. *Only 4% of non-Hispanic white births fell into this category!*

  - Variation by state shows:

    - Across all races and ethnicities, **the highest percentages of births tied to little or no prenatal care** were seen in Hawaii (11%), New Mexico (11%) and **Texas (10%),** and the lowest figures were in Rhode Island (2%) and Vermont (2%).

CHARACTERISTICS OF MOTHERS & BARRIERS TO PRENATAL CARE

Characteristics of Women Who Do Not Seek Prenatal Care and Implications for Prevention

Primary reasons were noted:

- 30% had **problems with substance use** (Women with substance use disorders were significantly more likely to be older, unemployed multigravidas)
- 29% experienced **denial of pregnancy**
- 18% had **financial reasons**
- 9% **concealed pregnancy**
- 6% **believed they did not need** prenatal care due to multiparity

Intervention programs need to target specific groups of women for **education** and intervention **based on their rationale for not seeking prenatal care.**

(Journal of Obstetric Gynecologic & Neonatal Nursing 38(2):174-81 -Mar-Apr 2009 ;38(2):174-81.)

Barriers to Use of Prenatal Care

There are four categories of obstacles:

1. **Financial barriers** due to being un/under insured i.e. little or no coverage for maternity care
   a) Pregnancy and childbirth can be a great financial burden
   b) Related to Gaps in private insurance, role of Medicaid, uninsured
2. **Inadequate Capacity** in the prenatal care system relied on by low-income women
   a) Inadequate numbers of, and long waiting times for appointments at community facilities in those who are unable or unwilling to use the private care system
   b) Wait times of 2-3 weeks for initial appointment, even up to 14 weeks! (in one study)
   c) Availability of maternity care providers
3. **Problems in the organization**, practices, and atmosphere of prenatal services themselves
   a) **Inadequate coordination among services** - MD practice of asking women to wait until at least two menstrual periods have been missed before scheduling a prenatal appointment**
   b) **Transportation difficulties -** long distances to reach a provider, limited/no transportation; Medicaid provided transportation – few know about
   c) **Inhospitable provider practices** - care can also be influenced by the attitudes and styles of provider
   d) **Cultural barriers**
   e) **Difficulty in taking time off from work -** Clinic hours are working hours, clinic closed at lunch; evening/weekends best and for childcare
4. **Cultural and personal factors** that can limit use of care.**

Barriers to Use of Prenatal Care

1. Difficult relationship and failure of communication
2. Language incompatibility
3. Cultural preferences - Experts cite the failure of providers to appreciate the cultural preferences of some patients as an important barrier to care**
4. Physical surroundings - Dreary, usually very crowded, and uncomfortable (eg. too few chairs in the waiting rooms, leaving patients to stand in corridors)
5. Lack of easily available - Where exactly to go for prenatal services, 5-18% do not know where to seek care

Barriers to Use of Prenatal Care

The use of prenatal care is influenced by:

- A woman's attitudes toward her pregnancy and toward prenatal care
- Her knowledge about such care
- Her knowledge of whether she sees it as useful
- Her cultural values and beliefs
- A variety of other personal characteristics often called life-style
- Certain psychological attributes

Barriers to Use of Prenatal Care – Her Attitude

A woman's attitudes toward her pregnancy and toward prenatal care:

- The use of prenatal care is influenced by a woman's attitudes toward her pregnancy and toward prenatal care, her knowledge about such care and whether she sees it as useful, her cultural values and beliefs, a variety of other personal characteristics often called life-style, and certain psychological attributes.
- Attitudes toward pregnancy that may influence *efforts to seek prenatal care* :
  - Planned or unplanned **
  - Views her pregnancy positively or negatively**
- May *influence prenatal care* in 3 ways:

1. Women who did not plan their pregnancy may be **less aware of the signs** of pregnancy and therefore may recognize their pregnancy later
2. Women **who view their pregnancies negatively** may delay prenatal care while they decide whether to continue the pregnancy
3. An unplanned pregnancy is likely **to evoke ambivalent feelings**, even in women who decide to continue the pregnancy. This ambivalence may result in late entry into or sporadic use of prenatal care.

In the United States, more than half of all pregnancies are unplanned

Barriers to Use of Prenatal Care – Her Attitude *(continued)*

- Her knowledge about such care and whether she sees it as useful,
- Some believe that pregnancy is a normal event not needing medical supervision, or that care is needed only if a pregnant woman feels ill
- May actually be unaware of what prenatal care is
- Previous, unsatisfying experiences with prenatal services may also act as a deterrent.
- Women who believe the service is important and should be initiated early are more likely to begin care in the first trimester than those attaching less importance to early care

The predictive value of positive attitudes toward prenatal care should not be overestimated

Barriers to Use of Prenatal Care – Her Knowledge

Not knowing the signs of pregnancy:

Studies show that between 16-33% of women who received insufficient care did not know the signs of pregnancy

Barriers to Use of Prenatal Care – Her Cultural Values and Beliefs

- Among some **cultures**, pregnancy is regarded as a healthy condition not requiring medical treatment or a physician's advice

  - Furthermore, the perception of what constitutes a health problem may vary between patient and provider. ***

- **Fear as a barrier**:

  1. Fear of providers or medical procedures**
  2. Fear of others' reactions to the pregnancy

     a) Many adolescents also fear the pregnancy itself and parental response

     b) Teens concerns about confidentiality may be significant, may choose to protect their secret rather than seek prenatal care

  3. Fear that one's illegal status in the country will be discovered & reported to INS; created substantial anxiety among undocumented families
  4. Fear that such health-compromising habits as substance abuse** or smoking will be uncovered and pressures to change brought to bear

     a) Fear that if their use of drugs is uncovered, they will be arrested and their other children taken into custody.

Barriers to Use of Prenatal Care - Lifestyle

- Issue of **drug abuse** during pregnancy
- **Homelessness** is also associated with poor use of prenatal care
  - Unfortunately, homelessness has increased in recent years, and the majority of homeless families are single-parent households headed by women
- **Risk of Social Isolation/Support from Family and Friends**
  - Having friends and family to offer emotional support and tangible assistance and having well-developed skills in overcoming isolation, may minimize or eliminate barriers to prenatal care
  - Positive interest in the pregnancy by the father, for example, or the presence of someone with whom to share the knowledge of pregnancy—the probability of using prenatal care increase
  - Lack of close ties to family and friends may limit use of prenatal care.
- **Stress**
  - For some women, the pressures of daily life are such that prenatal services are of low priority (very worried or upset during the pregnancy due to lack of money, problems with the baby's father, housing difficulties, lack of emotional support, and related burdens)

Barriers to Use of Prenatal Care - Psychological Attributes

- Factors, such as depression and in particular, denial, have also been associated with poor use of prenatal care
- Denial that one is pregnant can occur in women of any age, it is often reported in studies of pregnant adolescents. The prevalence of denial and concealment in adolescents is related to:
- Related to embarrassment about their changing bodies
- Reluctance to share personal information about their sexuality
- Lack of knowledge about where to obtain birth control
- Confusion about the safety and proper practice of contraception
- Fear of parental disapproval and punishment
- Fear of pelvic examinations and other medical procedures

Denial of Pregnancy

(Pub Med: J R Soc Med 2011 Jul;104(7):286-91.)

- Is an important condition that is more common than expected
- Incidence at 20 weeks gestation of approximately 1 in 475
- Proportion of cases persisting until delivery is about 1 in 2500, *a rate similar to that of eclampsia.*
- Poses adverse consequences including:
  - Psychological distress
  - Unassisted delivery
  - Neonaticide
- Difficult to predict which women will develop denial of pregnancy
- There are a number of forms of denial of pregnancy, including psychotic and non-psychotic variants
- Women who deny pregnancy tend to experience dissociative psychopathology but not all pregnant women who dissociate deny pregnancy
- Is a 'red flag' that should trigger referral for psychiatric assessment
- Poses challenging legal and ethical issues including:
  - Assessment of maternal capacity
  - Evaluation of maternal (and possibly fetal) best interests
  - The possibility of detention in hospital

RACIAL DISPARITIES IN RESPECTFUL MATERNITY CARE DURING PREGNANCY & VAGINAL BIRTH AFTER CESAREAN (VBAC)

Racial Disparities in Respectful Maternity Care During Pregnancy & Vaginal Birth After Cesarean (VBAC) in Rural USA

The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), Vol 52, Issue 1 –Jan 2023

1. Across the United States, more than 500,000 infants are born to people who live in rural communities each year *(March of Dimes, 2022).*
2. Rural residents have greater rates of severe maternal morbidity and mortality (Kozhimannil et al., 2019) and infant mortality (Beal, 2021; Ely et al., 2014).
3. Re less likely to give birth in hospitals with NICUs (Kozhimannil, Hung, et al., 2016).
4. Black and Indigenous women who live in rural areas are at even greater risk for severe maternal morbidity and mortality and infant mortality than White women who live in rural areas and are more likely to have inadequate access to prenatal care and other evidence-based support for maternal and infant health *(Baldwin et al., 2002; Basile Ibrahim, Interrante, et al., 2022; Basile Ibrahim, Tuttle, et al., 2022; Kozhimannil, Interrante, Tofte, et al., 2020; Singh, 2021).*
5. Indigenous women who live in rural areas more frequently lack access to obstetric critical care (Kroelinger et al., 2020)
6. Although vaginal birth after cesarean (VBAC) is considered a safe, cost-effective option for most women with histories of one or two cesareans (American College of Nurse-Midwives, 2017; American College of Obstetricians and Gynecologists, 2019; Guise et al., 2010), rates of VBAC have remained low (<15% of pregnant women with histories of cesarean annually) across the United States since the early 2000s (Martin et al., 2019).

Racial Disparities in Respectful Maternity Care During Pregnancy & Vaginal Birth After Cesarean (VBAC) in Rural USA

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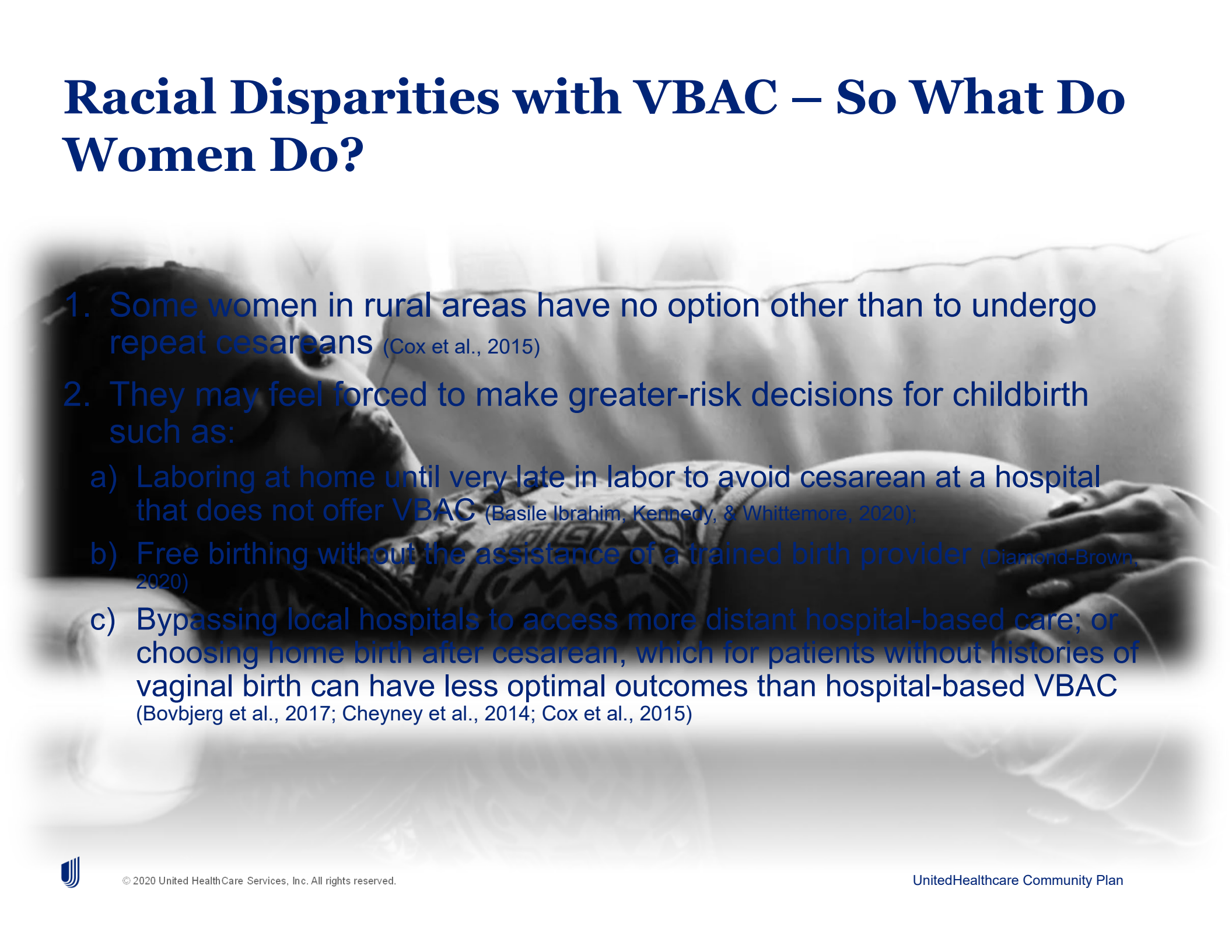
7. Rates of VBAC were significantly greater in urban hospitals than in rural hospitals from 1997 to 2021 (Kozhimannil et al., 2014; Sieck, 1997; Wendling et al., 2021).
8. Less than half (38%) of rural hospitals with obstetric services routinely offer VBAC (Heinrich et al., 2016)
9. Women who lived in rural areas, as determined by a residence county population of less than 100,000, were 23% to 44% less likely to have a VBAC compared with women who lived in counties with populations greater than 100,000 (Basile Ibrahim, Kennedy, & Holland, 2020)
10. Giving birth in a rural hospital was associated with a lower likelihood of VBAC than giving birth in an urban hospital (Guise et al., 2010)
11. The lack of access to VBAC in rural hospitals may be associated with the capacity to *immediately provide for a cesarean* if one is needed, which varies markedly by types of communities (100% urban, 88% suburban, and 76% rural) (Korst et al., 2011)

U.S. Surgeon General Report – National Goal & Mandate to Centers for Medicare & Medicaid Services (2019)

In light of these significant health inequities based in race and place, the U.S. Surgeon General (Adams & U.S. Department of Health and Human Services, 2020) and the U.S. Department of Health and Human Services (2020) set a national goal of decreasing racial disparities related to maternal morbidity and mortality, and the Centers for Medicare & Medicaid Services (2019) made improving access to maternal health care in rural communities a priority.

Racial Disparities with VBAC – So What Do Women Do?



1. Some women in rural areas have no option other than to undergo repeat cesareans (Cox et al., 2015)
2. They may feel forced to make greater-risk decisions for childbirth such as:
   a) Laboring at home until very late in labor to avoid cesarean at a hospital that does not offer VBAC (Basile Ibrahim, Kennedy, & Whittemore, 2020);
   b) Free birthing without the assistance of a trained birth provider (Diamond-Brown, 2020)
   c) Bypassing local hospitals to access more distant hospital-based care; or choosing home birth after cesarean, which for patients without histories of vaginal birth can have less optimal outcomes than hospital-based VBAC (Bovbjerg et al., 2017; Cheyney et al., 2014; Cox et al., 2015)

Racial Disparities with VBAC – Identify the Barriers

- It is *essential* to first ***document the experiences*** of these women who sought VBAC, decision can not be made based on assumptions
- Review of experiences of these women, such as below:
  - Access to VBAC
  - Type of maternity care provider
  - Travel times
  - Autonomy in decision making
  - Respectful maternity care

Study – Retrospective

1. Total mothers participants: 1,711 participants from all 50 states
2. 299 (17.5%) indicated that they lived in rural communities
3. Median age of participants from rural areas was 33 years
4. 31 rural participants self-identified as a member of a racialized group, which represented 10.4% of participants from rural areas
5. Rural participants were more likely to be high school graduates and less likely to hold graduate degrees than metropolitan participants ($p < .001$)
6. Compared to metropolitan participants, rural participants were more likely to identify as White, non-Hispanic and were less educated, factors previously associated with a decreased likelihood of VBAC (Basile Ibrahim, Kennedy, & Holland, 2020)
7. Participants from rural areas more frequently reported one or more life adversities since becoming parents than metropolitan residents (e.g., being unable to meet financial obligations, being unable to buy enough food, having their heat or electricity turned off, being unable to find work, lacking health insurance, housing instability, intimate partner violence, involvement of Child Protective Services, incarceration of self or partner, and problems with drug/alcohol dependency).
8. Medicaid was the primary type of health insurance for 32.1% of rural participants compared to 18.6% of metropolitan participants ($p < .0001$)

Study – Findings

1. Participants from rural and metropolitan areas expressed a nearly universal preference for VBAC, and most were able to plan or attempt a VBAC
2. 199 (66.6%) rural participants had VBACs, as did a similar proportion of their metropolitan counterparts
3. **ACCESS**: More rural participants had family doctors as their maternity care providers (4.4% vs. 1.9%), and fewer had obstetricians (61.9% vs. 64.6%) compared with metropolitan participants (p = .002*). S*ome participants traveled several hours to locate and access providers and/or hospitals that would offer a VBAC. *Rural participants emphasized their inability to access VBAC in their local communities, which was often the result of hospital policies that did not support routine care for VBACs (often referred to as "VBAC bans"*
4. **TYPE OF PROVIDER**: Fewer rural participants had a dedicated birth support person or doula for their most recent birth than metropolitan participants (33.8% vs. 40.2%, p = .03)
5. **TRAVEL TIME**: Regarding travel time to give birth, 19.4% of rural participants traveled more than 60 minutes versus 4% of metropolitan residents (p < .0001)
6. **AUTONOMY & RESPECT**: autonomy in decision making and respectful maternity care did not differ significantly between total rural and metropolitan participants.

   - Rural participants from racialized groups reported that they experienced significantly less respectful maternity care than White, non-Hispanic rural and all metropolitan participants (rural racialized: 65.0; rural White, non-Hispanic: 67.4; metropolitan racialized: 65.2; and metropolitan White, non-Hispanic 68.3; p = .04).

Lack of Respect *(continued)*

1. With intersecting marginalized identities, participants who lived in rural communities and identified as *members of racialized groups experienced* ***significantly less respect*** during maternity care than White, non-Hispanic rural participants and all metropolitan participants.
2. *This finding is consistent with previous studies in which researchers found that non-Hispanic Black (Gadson et al., 2017) and African American (Salm Ward et al., 2013) women experienced maternity care that was more discriminatory and that Black women, Indigenous women, and women of color experienced care that was less respectful and autonomous (Basile Ibrahim et al., 2021; Vedam et al., 2019) compared to their White, non-Hispanic counterparts.*
3. Women who had hospital-based VBACs (Vedam et al., 2019), identified as women of color (Vedam et al., 2019), and declined care (Attanasio & Hardeman, 2019) or had a difference in opinion with their providers about the best choice of care (Basile Ibrahim, Knobf, et al., 2020; Vedam et al., 2019) were more likely to ***report experiences of mistreatment or disrespect*** in interactions with their maternity care providers.

Racial Inequity – Impact

- Rural residents from racialized groups may face greater barriers to accessing care as a result of their rurality which includes: greater travel distance to care, maternity workforce shortages, less access to specialty services; (Kozhimannil, Henning-Smith, et al., 2016) and structural racism, which disproportionately harms Black and Indigenous people who give birth (Crear-Perry, Green, & Cruz, 2021).
- The inequity likely contributes to the disproportionate burden of maternal and infant morbidity and mortality and premature death among rural residents and rural communities with a greater proportion of Black or Indigenous residents (Crear-Perry, Correa-de-Araujo, et al., 2021; Henning-Smith et al., 2019; Kozhimannil, Interrante, Tofte, et al., 2020).

The intersection of racial injustice and geographic limitations on access to health care presents a pernicious challenge.

Clinical Considerations for VBAC ? – How Important

- Clinical considerations are less important for patients when considering VBAC than social factors (Meddings et al., 2007)
- Clinical contraindications to VBAC are relatively rare (American College of Obstetricians and Gynecologists, 2019).
- Receiving dedicated birth support from doulas (dedicated, nonclinical birth support personnel) has been associated with:
  - Positive birth outcomes
  - Including lower rates of cesarean birth
  - Greater rates of vaginal birth (ACOG Committee on Obstetric Practice, 2019; Gruber et al., 2013)
- Furthermore, women from racialized groups and with lower income may experience *doula care as a buffer to the structural inequities* that render them more vulnerable to poor outcomes (Kozhimannil & Hardeman, 2016)

Maternity Care Deserts – Cause for Concern re: Barrier to VBAC

Definition: counties without a hospital or birth center offering obstetric care and without any obstetric providers

- In rural counties that have a greater percentage of population in poverty, more women without health insurance, and lower median household income than counties with full access to maternity care and urban maternity care deserts (March of Dimes 2022).

- Associated with increases in births in hospitals without maternity units, out-of-hospital births, and preterm births (Kozhimannil et al., 2018),

- Causes:
  - May be created when rural hospitals close or cease their inpatient maternity care services.
  - Rural hospitals that close their maternity care services tend to be smaller (Hung et al., 2016) and located in more remote rural communities (Kozhimannil, Interrante, Tuttle, et al., 2020), in rural communities with greater proportions of Black residents, and in communities with more limited maternity care workforces (Hung et al., 2016, 2017)

WHAT'S YOUR STORY? …

HOW CAN YOU HELP TO MAKE A CHANGE IN YOUR DAILY WORK?

Thank You