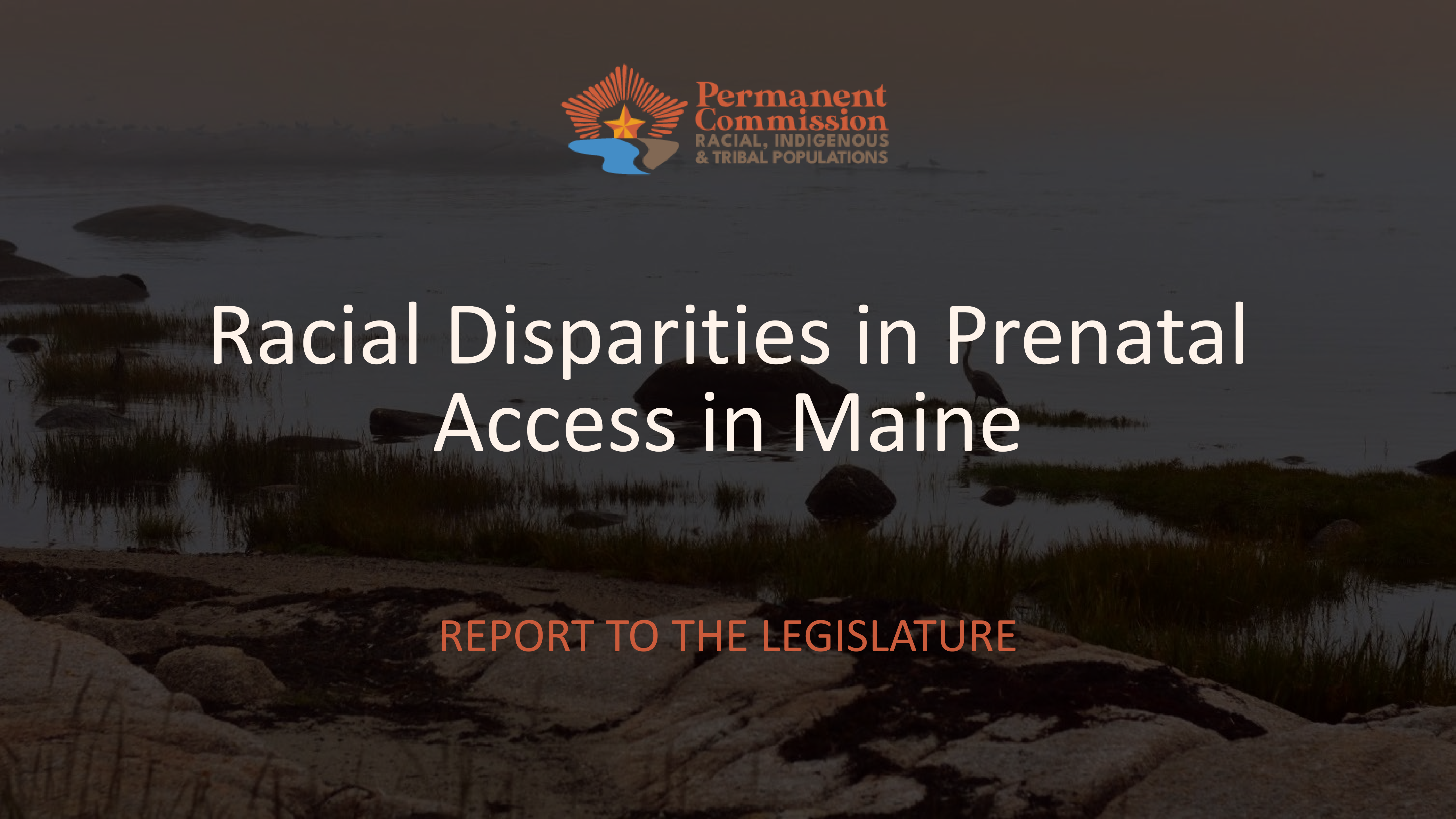


Permanent
Commission
RACIAL, INDIGENOUS
& TRIBAL POPULATIONS

Racial Disparities in Prenatal Access in Maine

REPORT TO THE LEGISLATURE

Terminology

- Maternal Mortality: Death while pregnant or within 42 days of the end of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.
- PRAMS: Pregnancy Risk Assessment Monitoring System
- BIPOC: Black/African American, Indigenous, and other Peoples of Color
- Structural racism: A system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity.
- Institutional Racism: Policies and practices within and across institutions that, intentionally or not, produce outcomes that chronically favor, or put a racial group at a disadvantage.

LD 1113 Directives:

- Study the extent of disparities in access to prenatal care for the State's racial, indigenous and tribal populations through data and other information;
- Study the causes of the disparities in access to prenatal care, including through interviews with those women who had no prenatal visit until the last trimester or had no prenatal care at all; and
- Recommend solutions to disparities in access to prenatal care in the State.

The Problem

MATERNAL HEALTH IN THE UNITED STATES IS THE WORST IN THE DEVELOPED WORLD.

ACCESS TO PRENATAL CARE IS ONE APPROACH THAT IMPROVES MATERNAL HEALTH FOR ALL COMMUNITIES.

BIPOC COMMUNITIES NOT ONLY HAVE WORSE MATERNAL HEALTH OUTCOMES IN MAINE, THEY HAVE REDUCED ACCESS TO PRENATAL CARE.

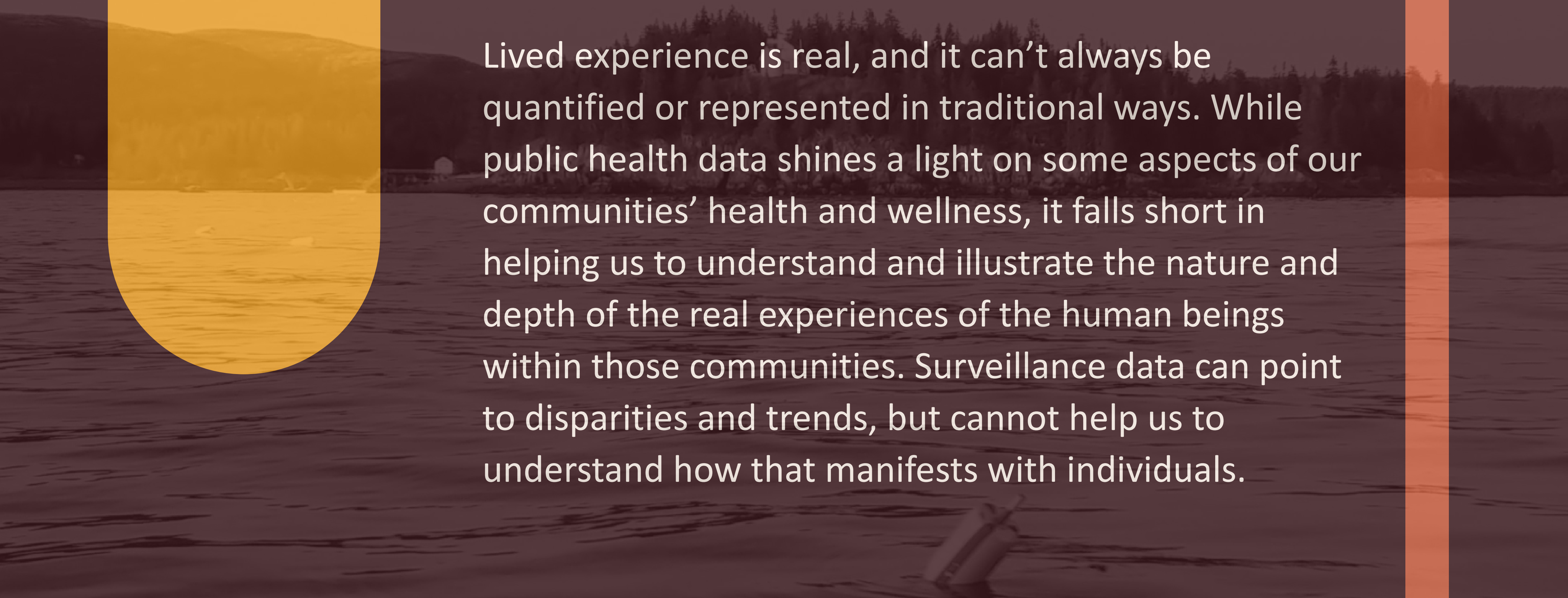
Three-Fold Approach

Conduct a literature review, assess and compile currently available quantitative data, interview key informants.

Advisory Group comprising community experts and representatives of identified communities.

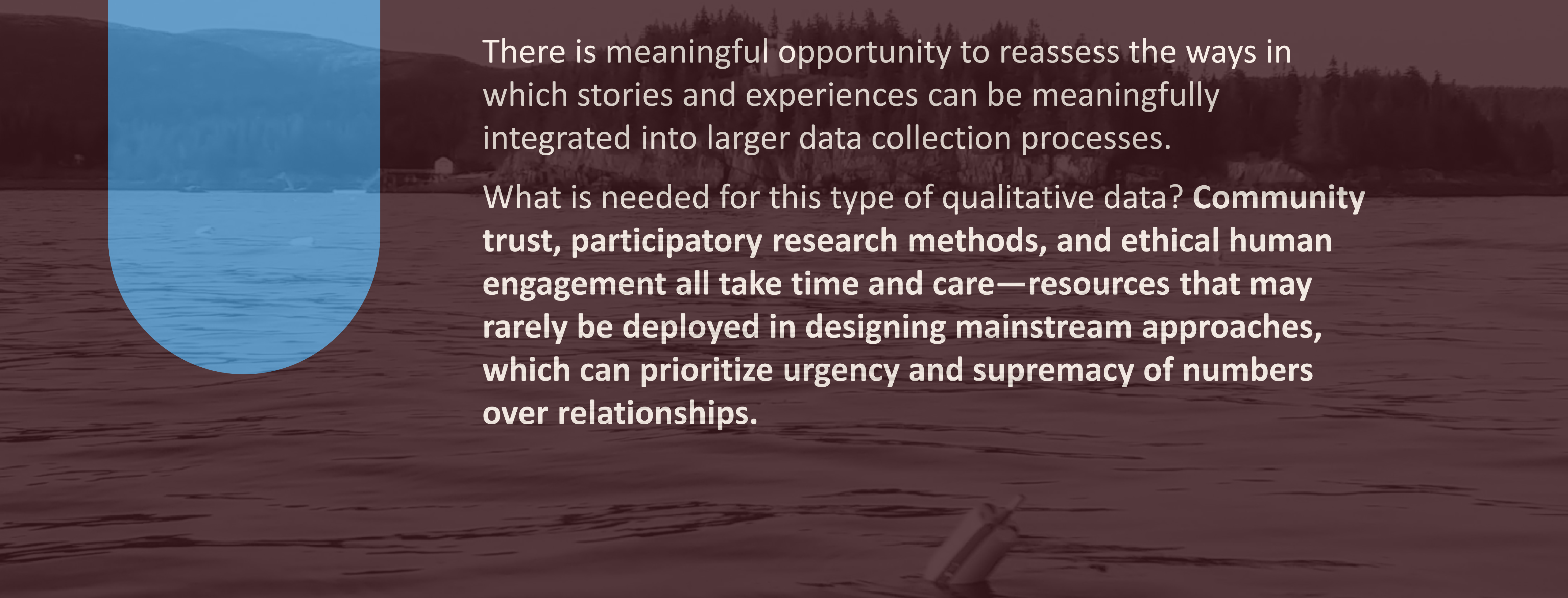
Advisory Group members engaging in efforts to gather qualitative data from their communities

Data:
A Critical Gap



Lived experience is real, and it can’t always be quantified or represented in traditional ways. While public health data shines a light on some aspects of our communities’ health and wellness, it falls short in helping us to understand and illustrate the nature and depth of the real experiences of the human beings within those communities. Surveillance data can point to disparities and trends, but cannot help us to understand how that manifests with individuals.

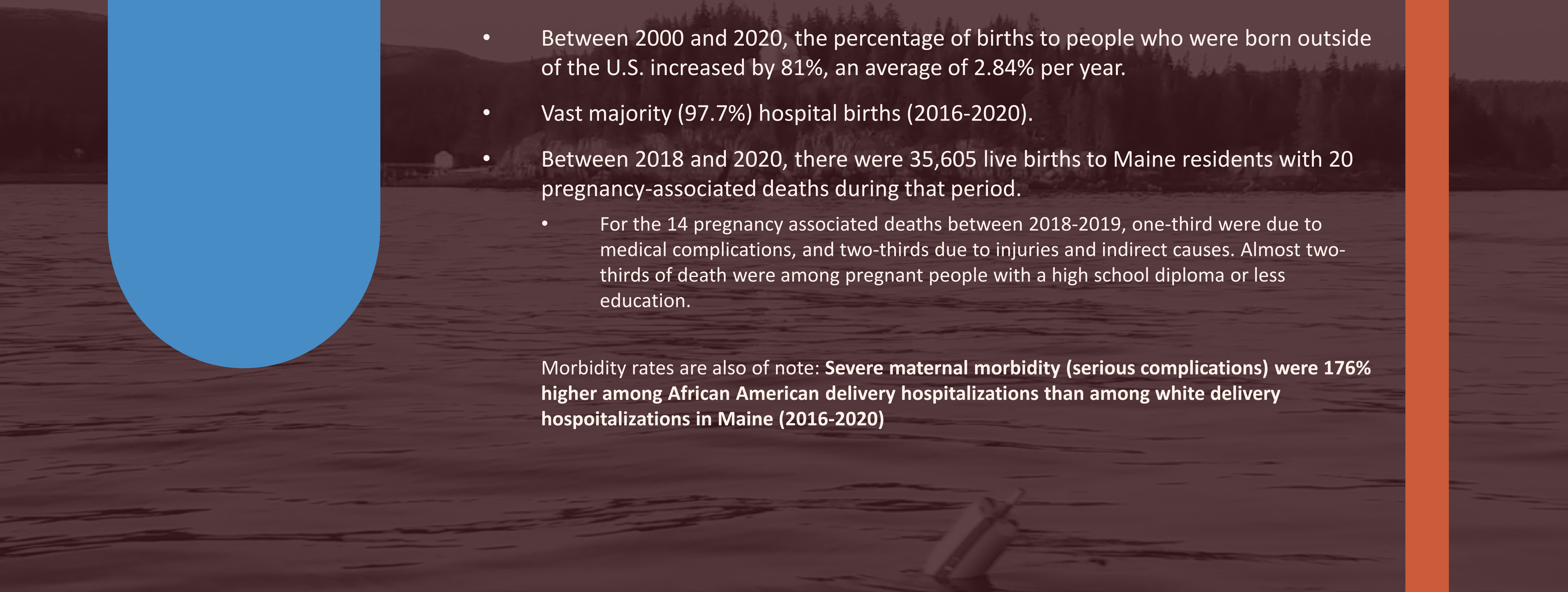
Lived Experience as Data



There is meaningful opportunity to reassess the ways in which stories and experiences can be meaningfully integrated into larger data collection processes.

What is needed for this type of qualitative data? **Community trust, participatory research methods, and ethical human engagement all take time and care—resources that may rarely be deployed in designing mainstream approaches, which can prioritize urgency and supremacy of numbers over relationships.**

Some Key Findings on Maternal Outcomes in Maine



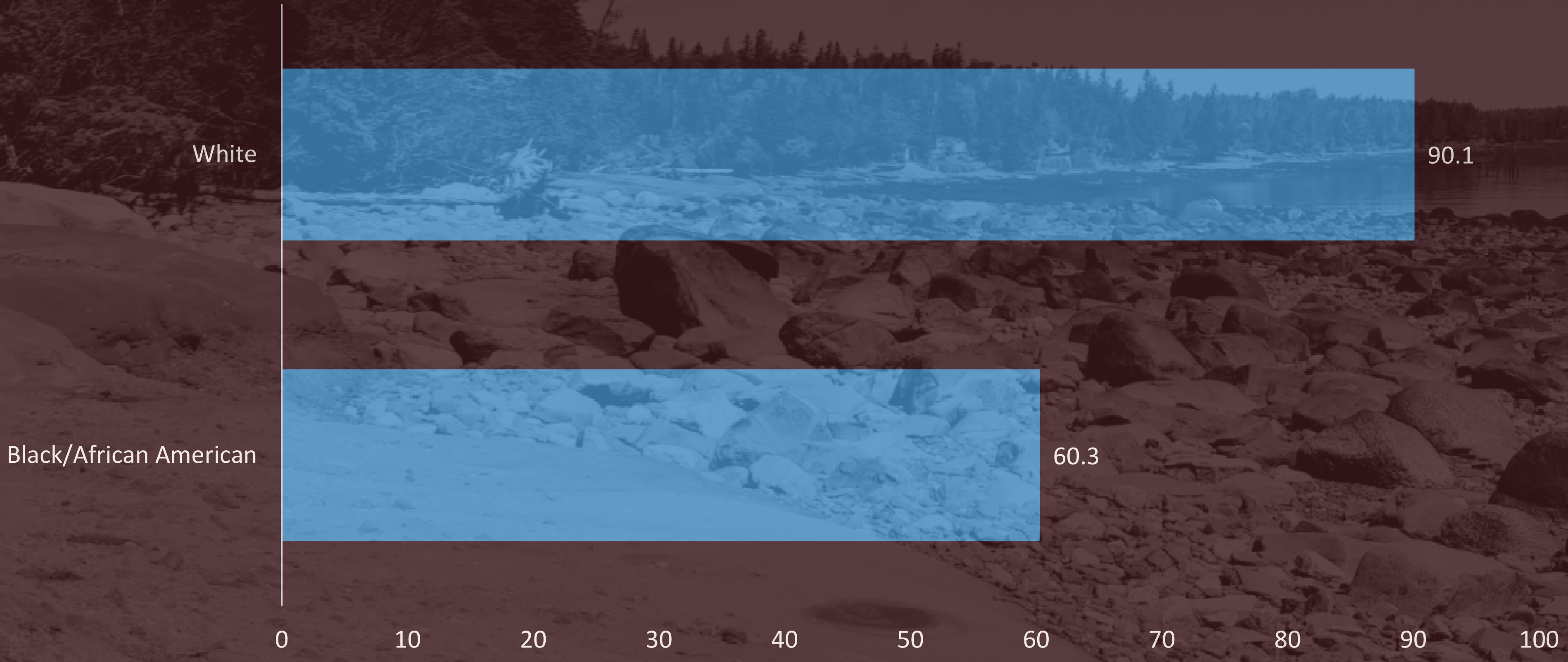
- Between 2000 and 2020, the percentage of births to people who were born outside of the U.S. increased by 81%, an average of 2.84% per year.
- Vast majority (97.7%) hospital births (2016-2020).
- Between 2018 and 2020, there were 35,605 live births to Maine residents with 20 pregnancy-associated deaths during that period.
  - For the 14 pregnancy associated deaths between 2018-2019, one-third were due to medical complications, and two-thirds due to injuries and indirect causes. Almost two-thirds of death were among pregnant people with a high school diploma or less education.

Morbidity rates are also of note: **Severe maternal morbidity (serious complications) were 176% higher among African American delivery hospitalizations than among white delivery hospoitalizations in Maine (2016-2020)**

Access To Prenatal Care By Race/Ethnicity

Maine PRAMS: 2019

"Got Prenatal Care as Early as Wanted"



Disparity Drivers

Many factors drive the disparities we observe in maternal health outcomes among BIPOC communities. Our report groups them into four broad categories—racism, structural barriers, the social determinants of health, and community norms—and summarizes the national and local research.

Racism

STRUCTURAL RACISM

- Provider behavior and discrimination
- Miscommunication and lack of trust between patient and provider
- Previous negative experiences leading to differences in care-seeking behavior

POORER QUALITY OF CARE

- Lack of agency and autonomy
- Concerns dismissed and treatment delays
- Language barriers

CHRONIC STRESS

- Experiences of racism and trauma – stress hormone spikes (cortisol leading to chronic inflammation)
- Trauma and stress related to migration
- Environmental/social factors

DISTRUST OF SYSTEMS

- Previous negative experiences resulting in care delays
- Fear of child welfare system, especially because of overrepresentation and for people may experience problematic substance use.

Structural Barriers

Lack of Providers

- Lack of availability due to rurality
- Lack of representation – nationally, racial and ethnic groups make up 12.3% of physician workforce while comprising 40% of population.

Lack of Insurance

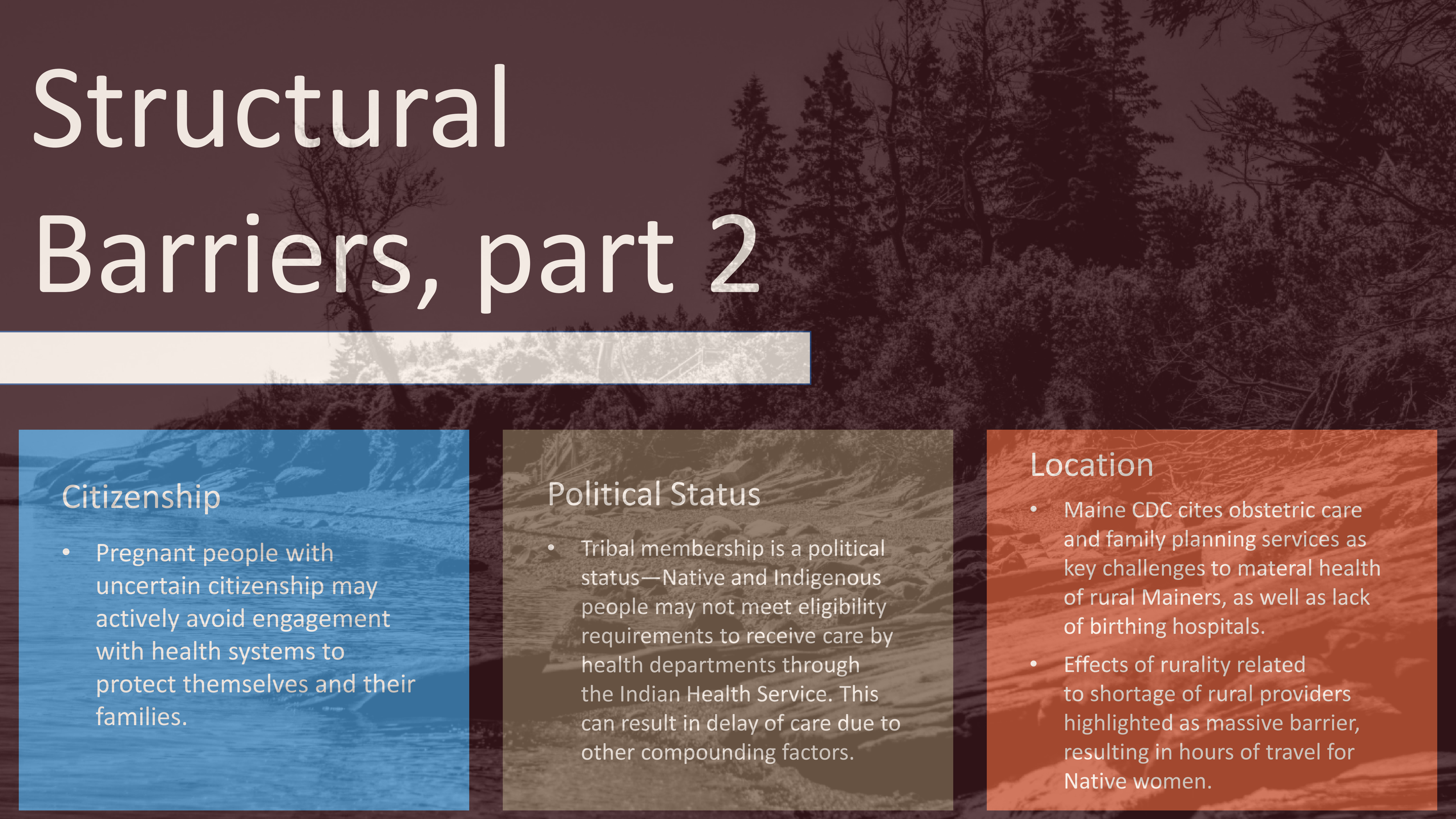
- Lack and disruption of coverage at higher rates before, during, and after pregnancy.
- People of reproductive age in ME (15-49) are more likely to be uninsured than population at large.

Barriers related to insurance echoed throughout work

- "Some doctors won't take women that... have different insurance, or if you are uninsured or waiting for MaineCare"

MaineCare Cited Specifically

- Challenging to navigate
- For many, pregnancies have progressed into second and third trimester by the time coverage kicks in.



Structural Barriers, part 2

Citizenship

- Pregnant people with uncertain citizenship may actively avoid engagement with health systems to protect themselves and their families.

Political Status

- Tribal membership is a political status—Native and Indigenous people may not meet eligibility requirements to receive care by health departments through the Indian Health Service. This can result in delay of care due to other compounding factors.

Location

- Maine CDC cites obstetric care and family planning services as key challenges to materal health of rural Mainers, as well as lack of birthing hospitals.
- Effects of rurality related to shortage of rural providers highlighted as massive barrier, resulting in hours of travel for Native women.

Social Determinants of Health

Socioeconomic Factors

- Cost of care, cost or lack of access to transportation or childcare for other children, employment that doesn't allow for time off for appointments, not being able to afford time off.

Maternal Age

- Nationally, people under the age of 20 are least likely to receive prenatal care early and are most likely not to receive it at all. There are wide ranges across racial groups in terms of adolescent birth rates.

Regional Factors

- Where you live can be hugely impactful, as noted. Report points to living on Reservation and trade-offs experienced.

Other Regional Factors of Note

- Lack of transportation (broadly), lack of public health infrastructure, lack of culturally competent/appropriate services and providers

Community Norms

"Pregnancy is not a sickness"

- In some immigrant communities, a preference for curative care instead of preventative may prevent people from seeking prenatal care.
- Individuals need clear explanation as to why they need to seek care.

Skepticism about practices

- Rushed labor and quick introduction of medical interventions like C-section cited; fear of death during cesearan birth. Many have had previous unsafe C-sections.

Competing Priorities

- A lot to handle as new resident, like housing, food insecurity, employment, care of other children, financial constraints.

Structural Barriers

- Lack of knowledge about navigating unfamiliar health care system
- Language barriers

Recommendations

EXPAND COMMUNITY-LED DATA GATHERING AND ALIGN WITH STATEWIDE SYSTEMS

INVEST IN RELATIONSHIP-CENTERED CARE

ADDRESS STRUCTURAL INEQUITIES

ENHANCE STATEWIDE DATA COLLECTION TO BETTER SERVE COMMUNITIES

SUPPORT COMMUNITY-LED EDUCATION

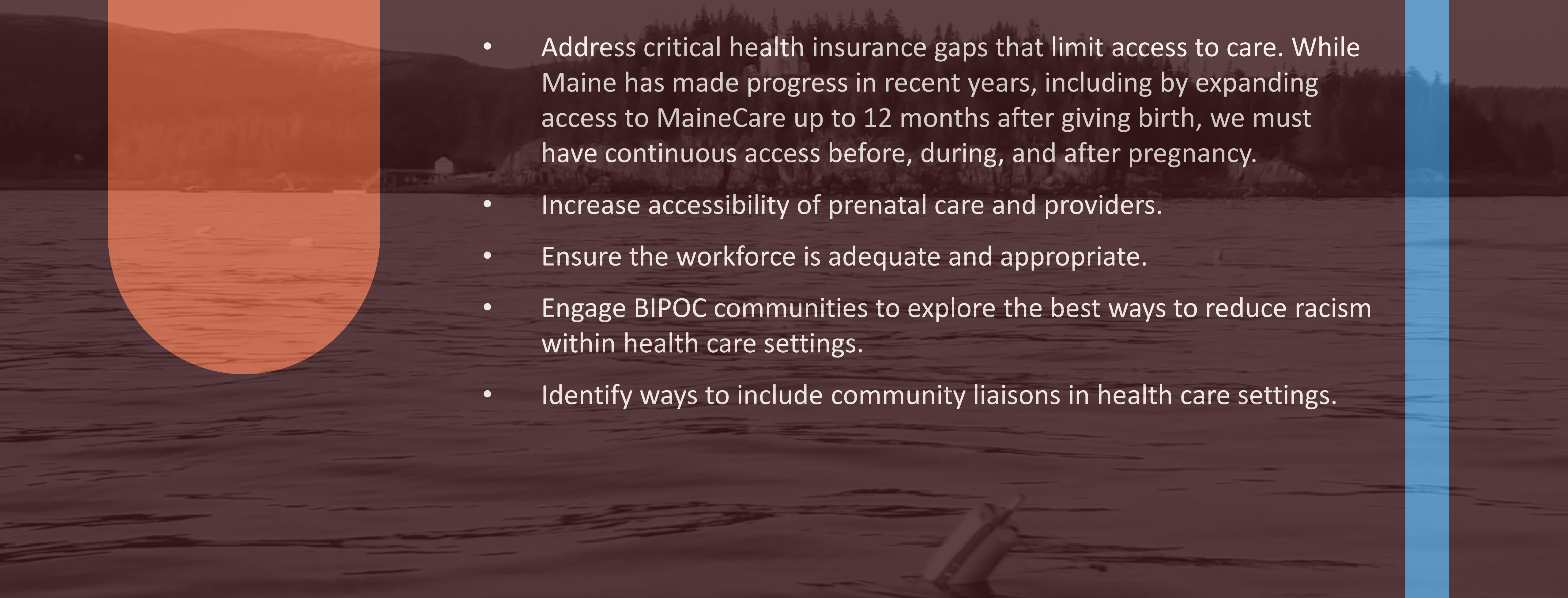
Community-Led Data Gathering

- Invest in systems that support community-led and culturally-specific fact finding, story gathering, and qualitative data gathering. **Maine's data and information systems need to be expanded and improved** to meaningfully center the experiences of BIPOC communities.
- Consult with Maine CDC, including MCH Director, Maine DHHS and DHHS Child Health Officer, and the Maine Perinatal System of Care Workgroup **to ensure efforts in the state are aligned**.

Invest in Relationship-Centered Care

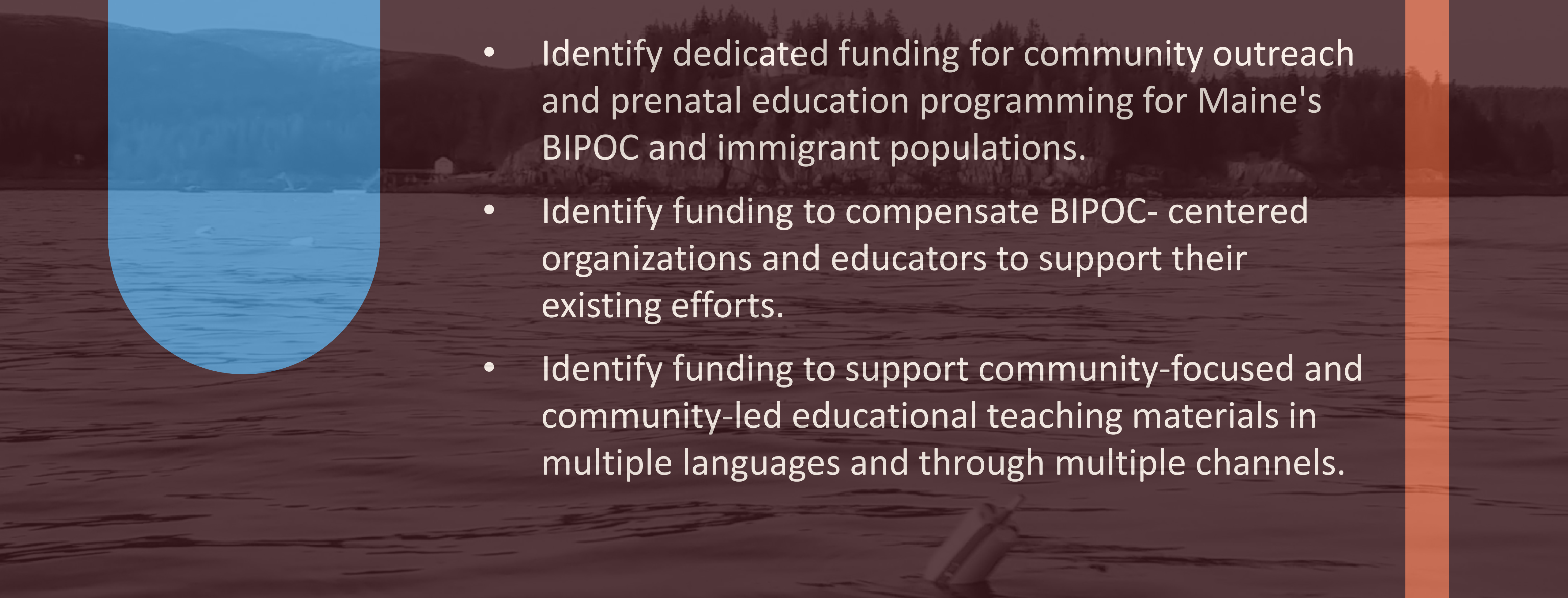
- "Listen to the direct needs to folks and let them lead the direction of their pregnancy and birth while providing optimum support." One way to do this is by expanding access to doula and pregnancy supports.
- Expand access to midwifery and non-hospital births.
- Build trust between providers and pregnant people.
- Provide support for communities before, during, and after pregnancy.

Address Structural Inequities

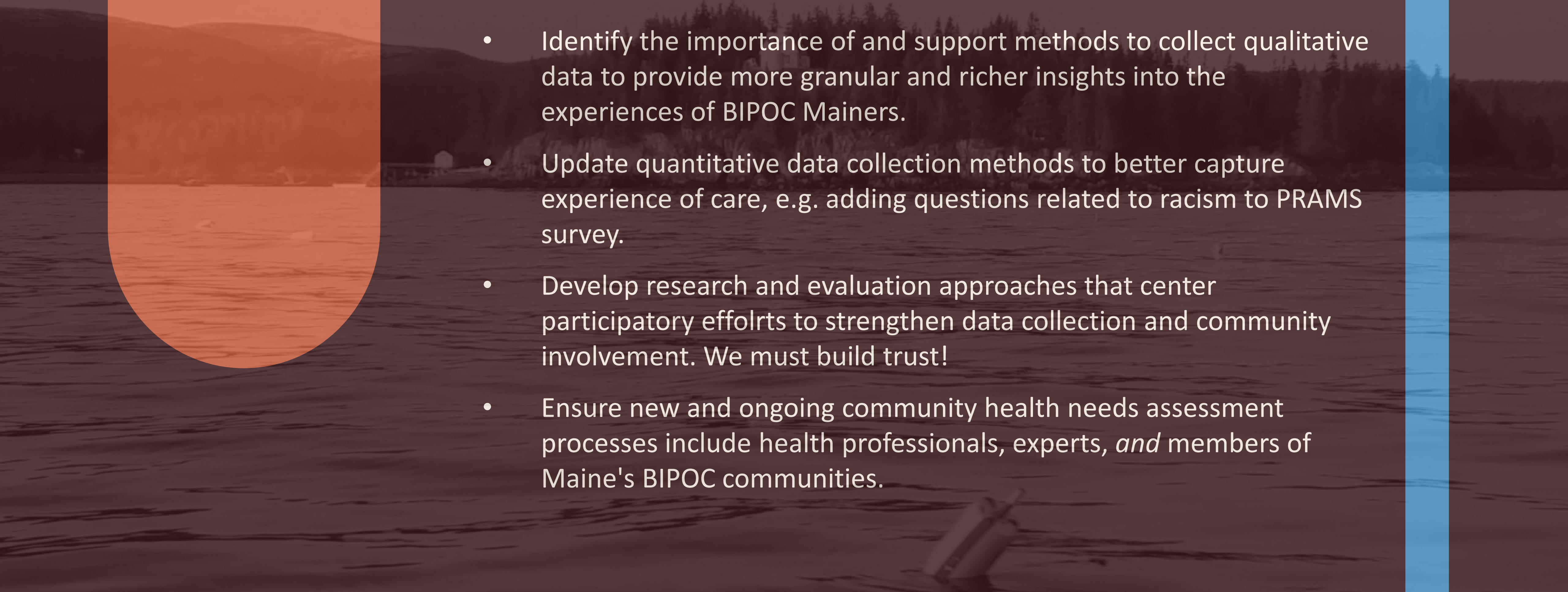


- Address critical health insurance gaps that limit access to care. While Maine has made progress in recent years, including by expanding access to MaineCare up to 12 months after giving birth, we must have continuous access before, during, and after pregnancy.
- Increase accessibility of prenatal care and providers.
- Ensure the workforce is adequate and appropriate.
- Engage BIPOC communities to explore the best ways to reduce racism within health care settings.
- Identify ways to include community liaisons in health care settings.

Support Community-Led Education



- Identify dedicated funding for community outreach and prenatal education programming for Maine's BIPOC and immigrant populations.
- Identify funding to compensate BIPOC- centered organizations and educators to support their existing efforts.
- Identify funding to support community-focused and community-led educational teaching materials in multiple languages and through multiple channels.



Enhance Data Collection to Better Serve Communities

- Identify the importance of and support methods to collect qualitative data to provide more granular and richer insights into the experiences of BIPOC Mainers.
- Update quantitative data collection methods to better capture experience of care, e.g. adding questions related to racism to PRAMS survey.
- Develop research and evaluation approaches that center participatory effolrts to strengthen data collection and community involvement. We must build trust!
- Ensure new and ongoing community health needs assessment processes include health professionals, experts, *and* members of Maine's BIPOC communities.

Permanent Commission
RACIAL, INDIGENOUS
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Thank you!

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Permanent Commission Co-Chairs:
Rep. Rachel Talbot Ross and Ambassador Maulian Dana (Penobscot Nation)