

## Early and Adequate Prenatal Care

### About the Title V Block Grant

The federal Title V Maternal and Child Health (MCH) Block Grant helps states ensure the health of all mother and children. As part of Minnesota's Title V Block Grant activity requirements, the MDH conducts a statewide needs assessment every five years. The needs assessment provides guidance to Title V activities for the next five years by identifying priority issues. This fact sheet describes one of Minnesota's priority issues.

### Seriousness of the Issue

The US Healthy People 2010 goal is that 90 percent of pregnant women will start prenatal care in the first trimester. <sup>1</sup> Women who have late or no prenatal care are unlikely to receive important components of comprehensive, preventive care including:

- Genetic testing and counseling
- Identification of and treatment of medical conditions that impact pregnancy including hypertension, diabetes, anemia, sexually transmitted infections, HIV
- Education to achieve and maintain healthy weight for pregnancy and good nutrition
- Review and update of immunizations
- Oral health assessment and treatment
- Screening and referral for mental health, intimate partner violence, and substance use/abuse
- Interventions to prevent preterm birth

Minnesota women have not achieved the 90 percent goal set by Healthy People 2010. In 2006, 76.9% of live births were to Minnesota women receiving adequate or better prenatal care, 14.3% were to women receiving an intermediate level of care, and 8.8% were to women receiving inadequate care. <sup>2</sup>

### Racial and Ethnic Disparities

According to Minnesota birth certificate data, rates of inadequate/no prenatal care are three to seven times higher among populations of color compared to rates of White pregnant women. Rates have improved over time but disparities remain especially between Whites and American Indians and Whites and African Americans.



Maternal and Child Health Section  
P.O. Box 64882  
St. Paul, MN 55164-0882  
(651) 201-3760  
[www.health.state.mn.us](http://www.health.state.mn.us)

### Inadequate or No Prenatal Care (%) (using GINDEX<sup>3</sup>)

	1989-1993	2003-2007
African American	20.1	8.1
American Indian	27.2	16.0
Asian	20.6	5.1
Hispanic	14.7	7.0
White	3.3	2.3

Source: MDH. Populations of Color in Minnesota- Health Status Report. Update Summary. Spring 2009.

Similarly, rates of adequate prenatal care also differ among populations of color as compared to Whites.

### Adequate/Intensive Prenatal Care (%) (using GINDEX)

	1989-1993	2003-2007
African American	47.0	64.4
American Indian	37.3	48.8
Asian	43.1	71.6
Hispanic	51.8	62.3
White	78.4	83.1

Source: MDH. Populations of Color in Minnesota- Health Status Report. Update Summary. Spring 2009.

Women with late or no prenatal care are more likely to have a poor birth outcome such as prematurity and/or low birth weight. Such births are more likely to result in infant death and/or increase costs of health care and social and educational services as well as create hardships for families. <sup>4</sup>

Trends in disparities for infant mortality, low birth weight, and preterm birth among populations of color parallel trends for inadequate prenatal care, although no causal link has been determined. <sup>5</sup> Regardless, prenatal care offers an opportunity for early risk assessment, intervention, and monitoring for those most at risk for adverse birth outcomes.

### Barriers to Early and Adequate Prenatal Care

Minnesota's PRAMS survey of new mothers 2004-2007 identified barriers to care from their perspective. Listed from most to least frequently reported were:

- No money/insurance
- Did not have Medicaid card
- Could not get appointment when wanted
- Did not want anyone to know of pregnancy

## Early and Adequate Prenatal Care – page 2

- Too many other things going on
- Doctor/plan would not start care earlier
- No transportation
- No child care
- Could not take time off work

These barriers indicate that pregnant women may not be connected to or knowledgeable about existing care systems, may be ambivalent about their pregnancy, and have other responsibilities. They also indicate a lack of health care system access and capacity.<sup>6</sup>

### Evidence-Based Strategies

Research has documented the effectiveness of early and adequate prenatal care in assuring healthy maternal and infant outcomes.<sup>7</sup>

More recently, research and policy makers have focused on Preconception and Interconception Care as part of continuous primary health care for women of reproductive age. This approach is designed to assure that women are healthy before becoming pregnant, that pregnancies are planned or intentional, and that they are spaced at intervals that promote healthy birth outcomes for babies and good health for mothers.<sup>8</sup>

Preconception Care provides an opportunity for preventive counseling and intervention in the following areas:

- Weight and physical fitness
- Nutrition and folic acid intake
- Substance use, including tobacco, alcohol, and other drugs
- Stress and depression
- Intimate partner violence
- Family planning and child spacing
- Immunizations
- Exposure to environmental and occupational hazards
- Oral health
- Sexually transmitted infections/HIV
- Chronic disease and medication management including teratogens

As part of Minnesota's health care reform efforts, a "Basket of Care" describing routine prenatal care for women with a confirmed singleton intrauterine pregnancy was developed under MDH leadership in collaboration with the Minnesota-based Institute for Clinical Systems Improvement (ICSI) using national guidelines as references.<sup>9</sup> A range of 10 to 14 prenatal care visits over the three trimesters of pregnancy is described as well as a list of the care components.<sup>10</sup>

Targeted outreach and education to at risk populations, raising providers' awareness of racial and ethnic disparities, and increasing capacity of existing health care systems are all important strategies to consider in efforts to improve Minnesota's rates of early and adequate prenatal care. In addition, providing continuous insurance coverage to women of reproductive age so they can access primary preventive health care with a provider they know and trust is another key strategy with potential to not only improve the rates of prenatal care but also improve health outcomes of women and their infants.

### Current Resources and Capacity

Programs and strategies promoting early and adequate prenatal care include:

- Medicaid eligibility to cover pregnancy up to 275 percent of the Federal Poverty Level
- Public health nurse home visiting programs
- Women, Infants, & Children Nutrition Program
- Twin Cities Healthy Start
- Health Plan Perinatal Incentive Programs
- Infant mortality reduction programs funded by MDH's Eliminate Health Disparities Initiative
- Doula programs
- Positive Alternatives programs
- The Nest Incentive programs

Funding for the above list includes substantial state and federal funds including grant funds. The programs appear to be stable for the near future.

<sup>1</sup> U.S. Department of Health and Human Services. *Healthy People 2010. Objectives for improving health.* 2<sup>nd</sup> Edition. Washington D.C. November 2000.

<sup>2</sup> National Center for Health Statistics, final natality data. Retrieved August 31, 2009 from [www.marchofdimes.com/peristats](http://www.marchofdimes.com/peristats)

<sup>3</sup> GINDEX: A prenatal care index that measures adequacy of prenatal care by combining the measures of the month or trimester care began, the number of prenatal care visits, and the gestational age of the infant/fetus at the time of birth.

<sup>4</sup> CDC. *An ounce of prevention: What are the returns?* October 1999.

<sup>5</sup> MDH. *Disparities in Infant Mortality.* January 2009.

Accessible at: [www.health.state.mn.us/divs/chs/infantmortality/infantmortality09.pdf](http://www.health.state.mn.us/divs/chs/infantmortality/infantmortality09.pdf)

<sup>6</sup> MDH. Minnesota Pregnancy Risk Assessment Monitoring System (PRAMS) 2004-2007. Accessible at: [www.health.state.mn.us/divs/cfh/prams](http://www.health.state.mn.us/divs/cfh/prams).

<sup>7</sup> CDC. 1999. *Healthier mothers and babies*. MMWR Vol. 48:38. pp. 849-859.

<sup>8</sup> Moos MK et al. *Healthier women, healthier reproductive outcomes: Recommendations for the routine care of all women of reproductive age*. Am J Obstet Gynecol 2008. Dec (6 Suppl 2): S 280-289.

<sup>9</sup> American Academy of Pediatrics (AAP), American College of Obstetricians and Gynecologists (ACOG) 2007. *Guidelines for perinatal care*. 6<sup>th</sup> edition. Washington D.C.

<sup>10</sup> MDH.

[http://www.health.state.mn.us/healthreform/baskets/obstetric090622\\_FinalReport.pdf](http://www.health.state.mn.us/healthreform/baskets/obstetric090622_FinalReport.pdf)