Aligning Maternal Health Policies with Birthing People's Preferences and Experiences

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October 2023

The US's maternal mortality and morbidity rates are strikingly high, especially among Black and Indigenous individuals. Documenting the birthing experiences and preferences of Black, Indigenous, and Latinx pregnant and parenting women and others who can become pregnant is critical to informing and shaping policy conversations around initiatives and programs designed to improve outcomes and mitigate maternal and infant health inequities. Our team conducted in-depth phone interviews with 19 women and focus groups with 26 women nationwide to understand their experiences and preferences for care throughout pregnancy, delivery, and postpartum. We focused our recruitment on Black, Latinx, and Native American/Indigenous pregnant and postpartum individuals. Important takeaways include ensuring that those who are pregnant/postpartum are provided with full, relevant information needed to make informed decisions and feel they have bodily autonomy. Participants shared frustration with the lack of pregnancy and delivery care options and feelings of coercion and powerlessness regarding decisions about their bodies during pregnancy. These findings reinforce the need to align the birthing preferences and lived experiences of women of color and other pregnant/postpartum individuals of color and center their voices in the policy conversation.

Source: Illustration by Scott Siskind for the Urban Institute.

Background

The maternal mortality rate in the US exceeded that of any other high-income country in 2021, disproportionately impacting women of color (Hoyert 2023; Kassebaum et al. 2016).[1] Recent evidence from Maternal Mortality Review Committees in 36 states showed that 84 percent of maternal deaths were preventable and most occurred following delivery (Trost et al. 2022).

Concerns about these outcomes and stark inequities are driving consideration of alternative approaches to support prenatal, postpartum, and delivery care (Green et al. 2021). Federal initiatives, including the Black Maternal Health Momnibus Act of 2021 and the 2022 White House Blueprint for Addressing the Maternal Health Crisis, sought to change the health care system (White House 2022).[2] The 2021 Commonwealth Fund brief identified a set of recommendations aimed at improving outcomes for birthing people that focus on system-wide changes, noting that models of community-based health care delivery that include doulas, nurse-midwifery care, and freestanding birth centers could improve maternal health outcomes and patients' experiences and support more effective, more respectful, and less costly care (Zephyrin et al. 2021).

This research seeks to add to this conversation by documenting the preferences and lived experiences of Black and Brown mothers who recently gave birth. This information is critical for informing policy and assessing the degree to which current maternal health policy proposals align with the preferences of individuals of color who experience pregnancy and childbirth.

Key Findings

Prenatal Period

Approximately half of the women we spoke with shared that their most recent pregnancy was unplanned.[3] Several women shared they considered obtaining an abortion after finding out they were pregnant. Women considered this option for several reasons, including the additional mental and financial strains of having another child. While all the women we spoke with decided against terminating their pregnancy, those we interviewed in Texas mentioned that part of their reasoning concerned the major financial and geographical barriers to accessing abortion care after recent abortion policy changes, including the overturning of *Roe v. Wade*.

Most women we interviewed received care from an OB-GYN in a traditional care setting. Several women in our Texas and New Hampshire focus groups received care from midwives and doulas. For many women, insurance coverage and geographic proximity ultimately determined where they received care. For those living in underserved rural areas fraught with hospital and clinic closures, traveling one to two hours for prenatal and delivery care was common.

Women, especially first-time moms, expressed a desire to have a provider who is caring, relationship-oriented, knowledgeable, and a clear communicator during the prenatal period. Many Black women we spoke with shared their preference for having racially concordant providers, and if one is not available, they prefer a provider with shared experiences who "respects [them], sees [them] as a human being," and understands the landscape of Black maternal morbidity and mortality in the US.

For women with negative experiences with their care provider, lack of full information and education regarding their care options and delivery plan were major reasons for their dissatisfaction. Several women who chose midwifery care expressed dissatisfaction with previous care experiences and how that galvanized them to seek alternatives. All women we spoke with emphasized the importance of respecting a pregnant person's decisionmaking power and autonomy and how violating this can result in feelings of helplessness and result in procedures or processes they did not feel they fully consented to.

Labor and Delivery

Most women delivered in a hospital under the care of an OB-GYN. Many participants did not feel their care team respected their birthing decisions; some initiated interventions without consent. Participants recounted stories of having IVs inserted by nurses without explanation, having Pitocin dosages changed without permission, and having complaints of pain/postdelivery complications dismissed. Other women shared positive birthing experiences where their providers fully briefed them before implementing any interventions and where they felt the decisionmaking power was in their hands. However, the research team heard these stories less frequently.

Women who received care from doulas and midwives shared that both advocated and supported them throughout the experience, helping them "maneuver the [health] system." For instance, one

woman explained that because of COVID-19 restrictions limiting who could be with her, she felt she had to be “hypervigilant” giving birth alone compared with previous birthing experiences where she had her doula and husband by her side. Women appreciated having someone to advocate for their birth plan and keeping them informed when complications arose. Many women we spoke with gave birth during the height of the COVID-19 pandemic and faced limitations to guest attendance during and after their labor and delivery.

Source: Illustration by Scott Siskind for the Urban Institute.

Postpartum Period

Women we spoke with consistently shared that their postpartum care visits felt short, perfunctory, and impersonal. Several women indicated they did not report their feelings of postpartum depression or anxiety to their providers for fear of judgment and stigmatization. For those who did share their feelings, many said their postpartum screenings consisted of providing resources rather than a conversation between them and their provider to discuss their feelings. Several women said they preferred a more comprehensive visit to discuss other social needs and connection to community services so they could “have a support system leaving the hospital.”

In addition, many women expressed a desire for postpartum visits to continue beyond six weeks postpartum to check for postdelivery complications. Women shared stories of complications, including a separated pubic symphysis (separation of the pubic bones), a broken tailbone, postpartum depression, and paralysis from the waist down.

Women with Medicaid shared continuous coverage postpartum for 12 months could reduce stress and allow access to care over a longer period, including accessing contraception. One woman with

Medicaid coverage shared that she chose an IUD over birth control pills for contraception because she "didn't know if [she] could afford the pills without insurance" and the IUD "would last the longest." Several women also emphasized flexibility in what services are covered under Medicaid, including doulas, midwives, and lactation consultants. Moreover, women shared they would prefer improved ease of scheduling visits by having automated scheduling initiated by their provider's offices.

Discussion of Findings and Policy Implications

A key takeaway from the findings was that several women felt powerless to make informed decisions throughout their pregnancies that may have been improved by more comprehensive, patient-centered care. Furthermore, this extended to care in the postpartum period, where women seek more ongoing and coordinated care. Many responses to address the concerns and meet the preferences expressed by the people we spoke with are aligned with policy solutions recommended in the Momnibus and The White House Blueprint for Addressing the Maternal Health Crisis (White House 2022).

First, women desire providers who treat patients with compassion and respect so they can develop a relationship with them and feel comfortable raising questions and concerns. These findings indicate the need for providers to receive more patient-centered training to develop more effective communication and interpersonal skills to ensure women are active participants in the decisions around their bodily autonomy.

Second, women prefer providers who can equip them with information about the breadth of their care options, including different provider types (OB-GYNs, midwives, doulas, and community health workers) and birthing locations (birth centers and hospitals) available to them based on their risk level beginning in the prenatal period. Investments in different provider types by expanding care teams and birthing locations could meet this need. For women living in more rural and remote areas with fewer provider options, telehealth could play a role in providing maternal health services (Hill and Burroughs 2020).

Third, many Black women shared their preference for having racially concordant providers with shared experiences and who understood the maternal mortality landscape in the US. Policies that diversify the demographic makeup and types of maternal health care providers in the workforce could be critical to improving care experiences and outcomes and help women feel more comfortable with their providers. As mentioned in our findings above, women who received care from doulas and midwives shared positive experiences of feeling supported during their birthing experiences.

Furthermore, women with Medicaid preferred extending postpartum Medicaid coverage to 12 months to access care over a longer period. Women also shared preferences for having more ongoing, comprehensive postpartum visits to address their overall health. While preferences for additional visits align with the American College of Obstetrics and Gynecology's recommendation that women attend a series of postpartum care visits, improving the substance and usefulness of those visits requires trusted partnerships and corresponding compensation for all involved (ACOG 2018).

Finally, women shared their preferences for shifting the maternity care model from a clinical focus to a more holistic approach to include screenings and support for the social determinants of health. An integrated maternal health system where different providers communicate across services could achieve more comprehensive patient care, including mental health services and food security. Alternative payment programs focusing on maternal health are beginning to address this need. Ramping up quickly and spreading evidence on what works and why will be critical.

Conclusion

Our study brings attention to the birthing preferences and lived experiences of women of color to help center their voices in the policy conversation. Our findings support the need to systematically assess people's preferences for proposed policies designed to improve their experience and care. An app called Irth (as in Birth without the B for bias) allows Black and Brown women to provide feedback on their birthing experiences in their community and is an example of a platform that can elevate the voices of women of color.[4]

Moreover, policies that expand the maternity care workforce and birthing options could give women of color greater autonomy throughout the pregnancy and during and after the birthing process. Expanding options, education, and capacity around pregnancy and birth is essential for enhancing the experiences of underserved and historically marginalized women.

Methods and Data Sources

Before starting data collection, we received approval from the Urban Institute's Institutional Review Board to conduct stakeholder interviews, phone interviews, and focus groups. To inform our research approach and interview questions, we conducted nine stakeholder interviews with maternal health experts, advocates, and clinicians. We also drew on the stakeholder interviews to connect our findings from phone interviews and focus groups to utilizing connections from these stakeholders, we conducted outreach for focus group recruitment to community-based organizations across the US that serve Black, Native American/Indigenous, and Latinx pregnant or recently postpartum women.

Inclusion criteria for focus group participation included having been pregnant or given birth in the last three years (2020–2023). Those organizations that had capacity assisted us in recruiting for and hosting focus groups, resulting in six focus groups at four locations: rural New Hampshire, Washington DC, rural North Carolina, and Texas. In total, 26 people were interviewed through these focus groups, with most interviewees identifying as Black/African American. Focus groups lasted two hours, during which participants were asked about their birthing experiences and preferences and their thoughts on geographically relevant maternal health policies through a data walk. A data walk is an interactive activity where participants walk in small groups around a room and view information on several topics, including those related to the local context, posted around the room on large poster paper. After viewing the data, the participants share their thoughts about the information. Our team analyzed the

focus group information into different themes by reviewing the notes from each site and discussing the major themes that emerged across sites.

Concurrently, our team completed individual phone interviews with women who had given birth in the last five years (2017–2022). These women were recruited from the summer 2022 fielding of the Health Reform Monitoring Survey after indicating they would like to be contacted for follow-up interviews. We focused our recruitment on study participants from the survey sample of Black, Latinx, and Native American women who had a child within the last five years. A total of 19 participants were interviewed, with most interviewees identifying as either Black/African American or Latinx. Most participants experienced their last pregnancy between 2018 and 2022. The interviews were around 20 to 25 minutes long. The protocol questions for the phone interviews and focus groups asked similar questions about the birthing experience from prenatal to postpartum, with the phone interviews focused more on opinions on different provider types. Our team analyzed the information into different themes by reviewing the notes from each interview and discussing the major themes that emerged across the interviews.

Some birthing people's experiences and preferences may not be generalizable for birthing people nationwide since we spoke with a small group of people. Therefore, our findings and conclusions should be interpreted with these limitations in mind.

Notes

[1] "Pregnancy Mortality Surveillance System," Centers for Disease Control and Prevention, accessed July 27, 2023, https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm.

[2] US Congress, House, *House Black Maternal Health Momnibus Act of 2021*, HR 959, 117th Cong., 1st sess., introduced in House February 8, 2021.

[3] To reflect how the interviewees identify, we use the terms "women" and "mothers" throughout this piece. However, we recognize that not all people who become pregnant and give birth identify as women.

[4] "Irth App," Narrative Nation, accessed August 5, 2023, https://irthapp.com/.

References

ACOG (American College of Obstetricians and Gynecologists). 2018. "Optimizing Postpartum Care." *Committee Opinion: Optimizing Postpartum Care* 131 (5).

Green, Carmen L., Susan L. Perez, Ashlee Walker, Tracey Estriplet, S. Michelle Ogunwole, Tamika C. Auguste, and Joia A. Crear-Perry. 2021. "The Cycle to Respectful Care: A Qualitative Approach to the Creation of an Actionable Framework to Address Maternal Outcome Disparities." *International Journal of Environmental Research and Public Health* 18 (9): 4933. https://doi.org/10.3390/ijerph18094933.

Hill, Ian, and Emmy Burroughs. 2020. "Maternal Telehealth Has Expanded Dramatically during the COVID-19 Pandemic: Equity Concerns and Promising Approaches." Washington, DC: Urban Institute.

Hoyert, Donna L. 2023. *Maternal Mortality Rates in the United States, 2021*. *Health E-Stats*. Hyattsville, MD: National Center for Health Statistics.

Kassebaum, Nicholas J., Ryan M. Barber, Zulfiqar A. Bhutta, Lalit Dandona, Peter W. Gething, Simon I. Hay, Yohannes Kinfu et al. 2016. "Global, Regional, and National Levels of Maternal Mortality, 1990–2015: A

Systematic Analysis for the Global Burden of Disease Study 2015." *Lancet* 388 (10053): 1775–1812. https://doi.org/10.1016/S0140-6736(16)31470-2.

Trost, Susanna, Jennifer Beauregard, Gyan Chandra, Fanny Njie, Alyssa Harvey, Jasmine Berry, and David A. Goodman. 2022. *Pregnancy-Related Deaths Among American Indian or Alaska Native Persons: Data from Maternal Mortality Review Committees in 36 US States, 2017–2019.* Atlanta: Centers for Disease Control and Prevention

White House. 2022. *White House Blueprint for Addressing the Maternal Health Crisis*. Washington, DC: White House.

Zephyrin, Laurie C., Shanoor Seervai, Corinne Lewis, and Jodie G. Katon. 2021. "Community-Based Models to Improve Maternal Health Outcomes and Promote Health Equity." New York: The Commonwealth Fund. https://doi.org/10.26099/6s6k-5330.

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Acknowledgments

This brief was funded by the Commonwealth Fund. We are grateful to them and to all our funders, who make it possible for Urban to advance its mission.

The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders. Funders do not determine research findings or the insights and recommendations of Urban experts. Further information on the Urban Institute's funding principles is available at urban.org/fundingprinciples.

The authors especially thank Eona Harrison, Laurie Zephyrin, Morenike Ayo-Vaughan, and Noel Manu for contributions to this research and important feedback and support along the way. The authors also thank Jenny Haley and Genevieve Kenney for their thoughtful comments and suggestions and Sarah LaCorte for editorial assistance.

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