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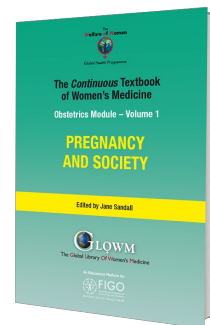
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Chapter

How Social Inequities in Maternity Care Impact Marginalized Groups

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AUTHORS

Michaela Smith

Canadian Institute for Substance Use Research, University of Victoria, Victoria, Canada

Cecilia Benoit

Canadian Institute for Substance Use Research & Department of Sociology, University of Victoria, Victoria, Canada

INTRODUCTION

Reducing health inequities for socially disadvantaged pregnant women and their infants, and increasing access to affordable quality reproductive services is a pressing concern in many countries. This chapter reviews studies examining this problem and recommendations to address it, primarily focusing on high-income countries. Special attention is given to the role of midwifery and community-based programs in reducing poor health outcomes among structurally marginalized women facing multiple social inequities.

UNDERSTANDING THE SOCIAL CAUSES OF HEALTH INEQUITIES

In the past few decades there has been a resurgence of interest in the social causes of health inequities among and between individuals and populations. The social determinants of health approach aims to identify not merely how these factors individually impact health within a population, but also the reasons why there are variations in health outcomes and how these differences are shaped by an individual's unequal access to key resources.¹ Deficiencies in social and economic resources contribute to unfair and unjust differences in health among groups in the population, known as 'health inequities'.²

Although often conflated, some argue that there is an important distinction between health inequalities and health inequities.^{2,3} Health inequalities are linked to genetic, biological, social and other factors that result in differences in health status which may or may not be unfair, whereas health inequities refer to avoidable and unjust "social processes underlying the unequal distribution of these factors between groups occupying unequal positions in society".³ Health inequities can be worsened by stigmatizing and discriminatory policies and practices that result in exclusion from social structures such as social networks, social institutions and broader political and economic structures. Exclusionary processes, including legal sanctions against midwifery and allied professions and fee-for-service costs for reproductive

services, contribute to health inequities.^{4,5} Enhanced inclusion in social structures and participation strategies can improve health outcomes for socially excluded groups by reducing health inequities.⁶

Some scholars have gone on to argue that certain social determinants are more 'fundamental' than others because of their direct and enduring influence on a range of health inequities.⁷ Link and Phelan⁸ argue that socioeconomic status is the most important factor determining health because access to key resources such as money, power, prestige and social connections appears to trump all other determinants (e.g., having money and a broad social network can minimize certain health disadvantages related to age, geographic location or ethnicity). Benoit *et al.*⁹ make the case that gender is an additional fundamental determinant for it too influences one's access to these important social resources. At the same time, they argue these fundamental determinants need to be investigated as interconnected and "intersecting" axes of discrimination with no particular determinant, such as gender or class or race, being privileged over the other.^{10,11} As Kozhmannil *et al.*¹² state these fundamental health determinants "pattern in inequitable, unjust, and unconscionable ways the access to and quality of care that pregnant patients and their infants receive."

IMPACT OF SOCIAL INEQUITIES FOR MARGINALIZED GROUPS WOMEN IN HIGH-INCOME COUNTRIES

Research has established that various barriers to adequate maternity care for marginalized women and their families persist in high-income countries, even in countries that have publicly invested in universal healthcare coverage for their respective populations, which has included comprehensive maternity care.^{13,14} As Downe *et al.*¹⁵ state: "[m]arginalized women decide whether or not to access antenatal care through a process of 'weighing up and balancing out' personal issues and circumstances within their social context, and in the context of the care provision they anticipate and encounter." Further, if they make the decision to access care, those with social risk factors are more likely to experience care that is paternalistic and does not meet their needs in the perinatal period.¹⁶ Among socially disadvantaged women, there are a number of personal circumstances that influence accessing appropriate care, often interacting and intersecting with broader structural or institutional barriers. The barriers structurally marginalized women face during the perinatal period can have serious consequences on their health and well-being during early parenthood.

Socioeconomic status is one of the most frequently discussed barriers to accessing maternity care. Poverty and related issues impede women's ability to find maternity care that is accessible, reliable and of adequate quality. In fact, poverty has been singled out as the most significant factor predicting inadequate prenatal care.¹⁷ A common financial barrier is paying for transportation to maternity care services.^{18,19,20} For women without an affordable and reliable method of transportation, initiating and maintaining consistent antenatal care can be difficult to achieve. This is also the case for poor women in some countries who are required to pay for some or all of their antenatal care.^{15,21} Other financial barriers include childcare costs and money lost for taking time off work to attend antenatal care clinics.^{18,19,22}

When financial barriers impede women from accessing the appropriate maternity care needed, their health and that of their newborns is compromised. Kim *et al.*²³ found that neighborhood socioeconomic deprivation was significantly associated with adverse birth outcomes, including preterm birth and infants of low birth weight. Similarly, poorer health outcomes were found for mothers who are less educated, have lower household incomes or live in neighborhoods characterized by lower socioeconomic position.²⁴ Relatedly, Flenady *et al.*²⁵ note "socially marginalized and disadvantaged women often have twice or more the risk of stillbirth when compared to their more advantaged counterparts."

Indigeneity and minority ethnicity status often intersect with economic inequities in antenatal care seeking. Corbett *et al.*²⁶ found that women in New Zealand who identified as Maori or Pacific Islander were six times more likely to initiate antenatal care later in the pregnancy, compared to those of European descent or other ethnicities. Further, the odds of late initiation were twice as high for those with "inadequate social support, lower maternal education level, economic hardships, and transport and access difficulties".²⁶ In the Canadian context, indigenous women are significantly more likely to have received inadequate care than non-indigenous women and to have started prenatal care after the first trimester.¹⁷ Ethnicity has also been shown to impact health inequities for pregnant women and their newborns. These differences are particularly pronounced for infants born to mothers of minority ethnic status, as they are more likely to

die before their first birthday and to have higher rates of stillbirth and preterm birth and lower average birth weights.²⁷ Ethnicity has also been found to intersect with migrant status to create compounded disadvantage for some mothers in high-income countries. In the UK, "analyses of infant and neonatal outcomes by maternal migrant status (UK born vs. foreign born) show persistent patterns of disadvantage over time for babies of foreign-born mothers compared with babies of UK-born mothers"²⁷. Kim *et al.*²³ similarly found that fetal, neonatal and infant mortality is higher among refugee and non-refugee migrants. Phillimore²¹ explored some of the reasons why those of minority status, including migrants, have different patterns and rates of utilization of maternity care and found that there were both legal barriers related to immigration as well as institutional barriers that were posing problems for these disadvantaged groups. Cultural concerns were particularly impactful when interacting with health care institutions, as a lack of culturally appropriate care and time constraints limiting the development of this care caused additional barriers to timely access of care; even more difficult were language barriers between health care seekers and providers.²⁰ Phillimore²¹ concludes that:

"the maternity system was insufficiently flexible to meet the needs of an emergent superdiverse population and could in itself operate as a barrier that reduced access to antenatal care or the efficacy of antenatal care. The persistence of high infant mortality rates in long-established minority populations raises questions about how responsive the maternity system is to new and diverse communities."

Characteristics of health care providers and their routine practices sometimes pose additional barriers to appropriate or quality care for women who are socially disadvantaged. Insufficient communication skills or judgmental care can lead to avoidance or non-compliance.^{15,19} Origlia *et al.*²⁸ found that experiences of discrimination linked to low socioeconomic and other marginalized statuses led some women to avoid antenatal care in the future or withhold disclosure about potentially stigmatizing information with health care providers in future encounters. Heaman *et al.*¹⁸ also identified that the time constraints that are commonplace in public clinics also created barriers at the provider level when clients feel the providers rushed them or did not take adequate time to listen to them or address their cases appropriately.

Another significant barrier is incomplete knowledge about the options when seeking out maternity care.²⁸ This results in a scenario where groups most at risk to inadequate maternal and infant outcomes due to economic hardship have access to the least appropriate models of care. Sutherland *et al.*²⁹ found that women with lower social economic status in Australia disproportionately utilized public primary care, which followed a more traditional medical model of care. Less than half of study participants reported their antenatal care was 'very good.' At the same time, disproportionately fewer women from lower social economic status groups utilized primary midwifery care, which was the highest rated model, indicating that there is in fact inequity in accessing certain models of care for those in socially disadvantaged positions compared to those in more advantaged positions.²⁹ This research indicates that not only are socially disadvantaged groups lacking information about the options for maternity care that are available to them, but also that these different options of care are often out of reach for those who might benefit the most from utilizing these higher quality services.

REDUCING HEALTH INEQUITIES FOR MARGINALIZED PREGNANT WOMEN

While many of the studies cited above have clearly identified troubling discrepancies in access to and quality of maternity care for marginalized women and their infants, much of this research has also identified important interventions for how to improve care for these populations and enhance maternal and infant health.

At the broadest level, the fundamental right of all pregnant women to have control over the decisions related to their own bodies and health care should be guaranteed by national governments in all countries. Work needs to be done to expand the care options of for rural and remote women who are obliged to give birth in distant urban centers under official 'evacuation' policies.³⁰ Furthermore, actions need to be taken to support health care providers in being educated in 'cultural safety' care practices.^{18,30,31} Fenton and Jones³² describe cultural safety as "about empowering people and facilitating the achievement of positive outcomes by recognizing cultural identity and the impact of personal culture on professional practice." In addition, primary care providers in maternity care:

"have a responsibility to play a role in dismantling racism through self-education and a shift in perception and practice. Clinical efforts to improve the quality of care must stand on a foundational belief that clinicians wield power, privilege and a responsibility for creating equity in obstetrics."¹²

Midwifery care, which focuses on the holistic well-being of pregnant women and their families, and includes emotional, social, and cultural well-being, is particularly effective for those who are facing intersecting disadvantages.³³ In a Cochrane Review investigating randomized trials comparing midwifery-led continuity of care models to other care models for childbearing women, Sandall *et al.*³⁴ found that midwifery care reduced the likelihood of preterm birth by 24%. Research of a free-standing birth center serving mainly low-income African-American women³⁵ showed similar results regarding preterm birth rates, and also found that average birth weights were higher in the birth center group than in those receiving traditional medical care. Higher mean birth weights were also found among the low-income clients of certified nurse-midwives in the United States compared to similarly disadvantaged clients receiving care from physicians.³⁶ In a scoping review of comparisons between midwifery-led and physician-led care in a number of high-resource countries, McRae *et al.*³³ reported that mean birth weights for infants of women of low socioeconomic status were higher among midwifery clients. Visintainer *et al.*³⁷ conclude that the indigent mothers in their study "receiving prenatal care and labor and delivery services through a nurse-midwife program experienced a substantial reduction in the risk of low birth weights." In a Canadian study attempting to establish if and how midwifery-led care influences birth outcomes for marginalized women in particular, McRae *et al.*³⁸ showed a statistically significant reduction in odds of negative health outcomes for infants born to women of low social-economic class receiving antenatal midwifery versus physician-led care. In another study by Benoit *et al.*³⁹ found that postpartum depression scores of pregnant women receiving continuous midwifery care were similar to those of high-income pregnant women in continuous physician care, despite the authors' finding that lower income was linked to depression in the postpartum period. This suggests that the care provided by midwives was able to mitigate the effect of income on postpartum depression, possibly through the social support that midwives were able to provide disadvantaged women in their course of care.

Another intervention that has been shown to reduce preterm birth among socioeconomically disadvantaged women is group antenatal care, such as that provided by groups like Centering Pregnancy.^{40,41} Hetherington *et al.*⁴² identified that despite being challenged by poverty and other barriers, those who participated in group antenatal care had "equal or better outcomes than women in individual care." Furthermore, those in group antenatal care reported having received comparatively more information about different subjects, such as breastfeeding, baby care, and other lifestyle topics, likely because they had more time to discuss these subjects in the group setting. The result was greater overall satisfaction score with their care providers.⁴² For women who are marginalized in society and potentially facing multiple forms of disadvantage, utilizing interventions such as midwife-led continuity models^{33,34} and the Centering Pregnancy program^{40,41} that provide an opportunity for building social support networks, sharing information on a broad variety of topics and allowing for longer periods of time to build relationships with their care providers appears to be effective in minimizing the effects of this disadvantage on their pregnancy outcomes.

Community-based maternity programs for women facing intersecting forms of disadvantage are another opportunity for minimizing inequities in maternity care. HerWay Home, located in Victoria, Canada, is an example of one such intervention that is integrated into local health and social service networks to provide care for women affected by poverty, problematic substance use and other challenges.⁴³ Establishing and supporting these types of community programs has been shown to be successful in beginning to mitigate some of the social determinants of health for pregnant women by providing them with housing supports, food subsidies, etc., and at the same time providing an inclusive clinic to support new fathers.⁴⁴ Beeber *et al.*⁴⁵ reported on a similar community intervention with low-income women in the United States. The authors found that providing access to mental health nurses for additional support beyond primary care and building self-efficacy led to a significant decrease in depressive symptoms for the experimental group compared to controls who received usual care from primary care providers. Utilizing public health nurses in a manner that is acceptable to socially disadvantaged women, such as in home visits that minimize the costs associated with transportation, childcare and other factors identified earlier as barriers to care, can be a critical tool to improving outcomes; this entails training community nurses with "the skills important in effective home visiting, including relationship-building, and therapeutic use of self and resources to promote family health and child

development⁴⁶. Public health nurses who are able to flexibly provide care to marginalized women in their homes can in turn have a positive effect on “maternal well-being, interaction, and parenting⁴⁶ and in reducing premature delivery, low-birth weight and decreased infant mortality, such as was found by Koniak-Griffin *et al.*⁴⁷ among disadvantaged adolescent mothers.

These types of comprehensive reproductive services can only be effective when primary health care providers share the information of their existence and how to access them with their clients who can potentially benefit from the additional supports.⁴⁸ Kozhimannil *et al.*⁴⁹ concluded in regard to doula care, “while emerging research shows that the known benefits of doula care may be even greater among vulnerable populations, those who could benefit most from doula care frequently have the least access to it.” This means policy and funding decisions need to prioritize interventions that improve access to a variety of evidence-based care for socially disadvantaged mothers and their infants⁵⁰ and integrate these equity interventions into the formal care system and ensuring that primary care providers are educated about them.⁵¹ For physicians and midwives providing maternity care, this may be better achieved through “increased and diversified clinical experience” during their education and post-qualification in order to “adequately equip them in addressing the increasing complexity” of their clients’ needs.³¹ This will also require moving from multidisciplinary care to more integrative equitable care model that emphasizes a team-based approach with collaboration and communication central to providing high-quality care for all pregnant women and their infants, regardless of their social-economic circumstances or ethno-cultural backgrounds.

PRACTICE RECOMMENDATIONS

- **Reducing health inequities for pregnant women and their infants and increasing access to affordable quality reproductive care is a pressing global concern.**
- **Disadvantaged women face health inequities that are avoidable, unjust and beyond their individual control.**
- **Improved education for primary care providers on the complex disadvantages faced by their potential clients and the evidence-based interventions that have been shown to mitigate these disadvantages.**
- **Increased integration of evidence-based resources, programs and interventions into the formal health care network so that there is more seamless access and referrals for primary care providers and their clients.**
- **Social policy that supports an integrative and holistic model of care, including that provided by midwives, primary care nurses and doulas, so that those providing this type of care are supported and utilized as integral components of the health care system for all – including those facing various forms of social disadvantage.**

CONFLICTS OF INTEREST

The authors of this chapter declare that they have no interests that conflict with the contents of the chapter.

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