MARYLAND PRAMS
Pregnancy Risk Assessment Monitoring System

Focus on

Initiation of Prenatal Care

Among Maryland Women Giving Birth 2009-2011

December 2014

"I think it's really important to stress getting care in the first trimester."

Prams mother

One of the Healthy People 2020 goals is to increase the proportion of pregnant women who receive early prenatal care (care beginning in the first trimester).

Early and regular prenatal care visits are an important way to optimize pregnancy outcomes for both mother and baby. It offers a timely assessment of risk factors, health status, educational needs, and management of ongoing disorders or pregnancy associated conditions.

Prevalence of Initiation of Care in The First Trimester

The Maryland PRAMS survey included two questions about initiation of prenatal care:

1) How many weeks or months pregnant were you when you had your first visit for prenatal care? Do not count a visit that was only for a pregnancy test or only for WIC (the Special Supplemental Nutrition Program for Women, Infants, and Children).

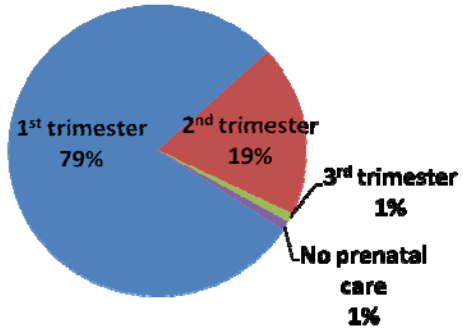
_____Weeks OR _____Months

_____I didn't go for prenatal care

2) Did you get prenatal care as early in your pregnancy as you wanted?

___No
___Yes

Figure 1. Trimester Prenatal Care Began, 2009-2011



For women who delivered during 2009-2011, 79% initiated care in the first trimester and 1% did not receive any prenatal care (Figure 1). PRAMS defines the first trimester as the first three months of pregnancy or the time of pregnancy up to but not including 13 weeks gestation.

Between 2007 and 2011, the annual percentage of Maryland women who initiated prenatal care during the first trimester has generally risen, and reached its highest rate (82%) in 2011. This 2011 rate surpassed the Healthy People 2020 objective that 77.9% of pregnant women receive care in the first trimester.

The rate of initiation of prenatal care during the first trimester increased for White non-Hispanic, Black non-Hispanic and Hispanic women but decreased for Asian women (Figure 2). The greatest improvement in rate of first trimester care initiation was among Hispanic women—the 2011 rate increased 47% from 2007.

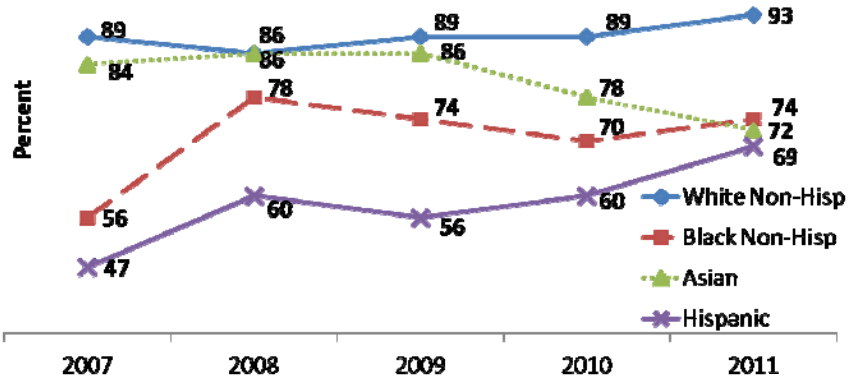
Factors Associated with Initiating Care After the First Trimester

Table 1. Percent of Mothers Initiating Prenatal Care After the First Trimester, 2009-2011

Factor	%
Age, years	
<18	47
18-19	38
20-24	30
25-34	17
35+	16
Race/Ethnicity	
White, Non-Hispanic	10
Black, Non-Hispanic	28
Asian, Non-Hispanic	21
Hispanic	38
Education, years	
<12	43
12	30
13-15	19
16+	7
Insurance, at delivery	
Private	8
Medicaid	36
Military	12
None	60
WIC during Pregnancy	
No	9
Yes	35
Pregnancy Intention	
Intended, used ART*	4
Intended, no ART*	10
Wanted later	29
Unwanted	39
Physical abuse, year before or during pregnancy	
Yes	34
No	20

**ART = Assisted Reproductive Technology

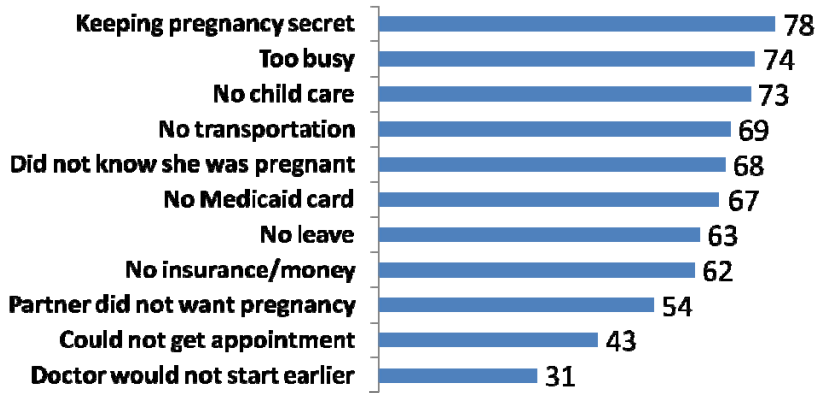
Figure 2. First Trimester Care by Race/Ethnicity, 2007-2011



The prevalence of late (after 1st trimester) prenatal care was highest among women who were uninsured (60%) and lowest among users of assisted reproductive technology (4%) (Table 1). Both maternal age and education were directly related to early prenatal care. The older the mother or the more years of education completed, the more likely that prenatal care was initiated in the first trimester.

Among women who reported that they did not access prenatal care as early as desired, 78% who "wanted to keep the pregnancy secret" did not initiate prenatal care in the first trimester. Being too busy and lack of childcare or transportation were other factors likely to result in late prenatal care (Figure 3).

Figure 3. Factors Likely to Result in Late Prenatal Care, 2009-2011



Stressors and Late Prenatal Care

Table 2. Percent of Mothers Initiating Prenatal Care After the First Trimester by Stress Factors, 2009-2011

Factor	%
Separation/divorce	
Yes	31
No	20
Homeless	
Yes	45
Partner lost job	
Yes	28
No	19
Mother lost job	
Yes	35
Partner did not want pregnancy	
Yes	35
Could not pay bills	
Yes	33
Partner in jail	
Yes	32
No	20

Stressful situations, experienced by the mother during the year before the baby was born, were associated with late (after the first trimester) prenatal care initiation. Leading reasons for late prenatal care included mothers who reported that they were homeless (45% accessed prenatal care late), lost their jobs even though they wanted to keep working (35%) or whose partners did not want the pregnancy (35%). (Table 2).

Women who reported that they were homeless had greater than twice the prevalence of late prenatal care as those who were not homeless (45% vs. 19%). Women who had problems paying the bills also had approximately twice the prevalence of late prenatal care (33% vs. 17%).

"I don't think it was right for me to have to wait so long for my Medicaid card."

"I think that if I had gotten prenatal care sooner, my son wouldn't have been 2 months early. "

PRAMS mothers

Discussion

Four out of every five women who delivered in 2009-2011 initiated prenatal care during the first trimester. The trend in mothers receiving early (first trimester) prenatal care has generally been improving in Maryland since 2007 and reached its highest prevalence in 2011 (82%).

However, there are still many women who accessed prenatal care late (after the first trimester). Over 40% of mothers who were uninsured, under 18 years of age or had not finished high school initiated prenatal care after the first trimester. An unwanted pregnancy by the mother or partner was significantly associated with late prenatal care. Promotion of LARC (long acting reversible contraception) may be beneficial for women who are not planning to become pregnant.

Help with other stressors such as lack of health insurance coverage, homelessness, child care or transportation may also improve access to early prenatal care.

PRAMS Methodology

Data included in this report were collected from the Pregnancy Risk Assessment Monitoring System (PRAMS), a surveillance system established by the Centers for Disease Control and Prevention (CDC) to obtain information about maternal behaviors and experiences that may be associated with adverse pregnancy outcomes.

In Maryland, the collection of PRAMS data is a collaborative effort of the Department of Health and Mental Hygiene and the CDC. Each month, a sample of approximately 200 Maryland women who have recently delivered live born infants are surveyed by mail or by telephone, and responses are weighted to make the results representative of all Maryland births.

This report is primarily based on the responses of 4,548 Maryland mothers who delivered live born infants between January 1, 2009 and December 31, 2011 and were surveyed two to nine months after delivery.

Limitations of Report

This report presents only basic associations between maternal factors and initiation of prenatal care. Unexamined inter-relationships among variables are not described and could explain some of the findings in the report.

Maryland PRAMS data are retrospective and therefore subject to recall bias. They are also based on the mother's perception of events and may not be completely accurate.

Resources

Healthy People 2020
Maternal, Infant and Child Health
www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant-and-child-health

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