

Women with Delayed Prenatal Care

DEFINITION

Women with delayed prenatal care is the percentage of women beginning prenatal care in the second or third trimester of pregnancy or receiving no prenatal care at all. Data are reported by place of mother's residence, not place of infant's birth.

SIGNIFICANCE

Early prenatal care is important to identify and treat health problems and influence health behaviors that can compromise fetal development, infant health and maternal health. Women receiving late or no prenatal care are at increased risk of poor birth outcomes such as having babies who are stillborn, low birthweight or who die within the first year of life.¹

Prenatal care offers the opportunity to screen for and treat conditions that increase the risk for poor birth outcomes. Effective prenatal care screens for and intervenes with a range of maternal needs, including nutritional needs, social support, mental health, substance use, domestic violence, and unmet needs for food and shelter. Prenatal care visits provide an opportunity for health care professionals to assess and educate parents on issues such as newborn care, including breastfeeding, safety and infant development.^{2,3}

Timely initiation of prenatal care is especially important for women who face multiple risks for poor birth outcomes, including poverty and low maternal education. Enhanced prenatal care services available to women with high-risk pregnancies who are enrolled in Medicaid include risk assessment, case management, smoking cessation, nutritional and psychosocial counseling, health education, transportation and home visits.⁴

In Rhode Island between 2002 and 2006, 10.7% of women giving birth either received no prenatal care or did not begin care until the second or third trimester, up from 9.4% in 2001-2005.⁵ Pregnant adolescents in Rhode Island are the most likely to delay prenatal care; 22.8% of teens ages 19 and under, compared with 9.5% of women ages 20 and over, delayed prenatal care between 2002 and 2006.⁶

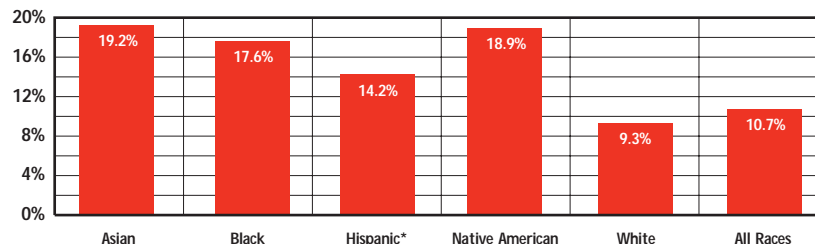
Late or No Prenatal Care		
	1995	2005
RI	1.3%	2.2%
US	4.2%	3.5%
National Rank*		3rd
New England Rank**		3rd

*1st is best; 37th is worst

**1st is best; 4th is worst

Source: U.S. Centers for Disease Control and Prevention. (2007). Births: Final data for 2005. *National Vital Statistics Reports*, 56(6). This ranking is based on the 37 states with comparable prenatal care data.

Women with Delayed Prenatal Care by Race/Ethnicity, Rhode Island, 2002-2006



Source: Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1997-2006. Data for 2006 are provisional. *Hispanics may be included in any racial category.

◆ Between 2002 and 2006 in Rhode Island, Asian and Native American women were more twice as likely as White women to delay prenatal care.⁷ Black and Hispanic women were also more likely to delay prenatal care than White women.⁸

◆ Between 2002 and 2006, the rate of delayed prenatal care in the core cities (14.3%) was nearly twice the rate in the remainder of the state (7.6%). West Warwick was the only core city with a rate of delayed prenatal care (10.4%) better than the state rate (10.7%).⁹

RItE Care's Impact on Prenatal Care

◆ RItE Care, Rhode Island's Medicaid managed care program, has improved access to prenatal care for women. Targeted interventions expanded the number of obstetric care providers serving Medicaid patients and improved the adequacy of prenatal care to women in the program.¹⁰

◆ Between 2002 and 2006, uninsured women in Rhode Island were nearly two and a half times more likely to delay prenatal care (40.6%) than women enrolled in RItE Care (16.7%).¹¹ Between 1995 and 2005, the percentage of women enrolled in RItE Care or Medicaid who began prenatal care in the first trimester increased from 80.4% to 83.8%.¹²

Women with Delayed Prenatal Care

Table 16.

Delayed Prenatal Care, Rhode Island, 2002-2006

City/Town	# Births	# Delayed Care	% Delayed Care
Barrington	774	32	4.1%
Bristol	1,010	83	8.2%
Burrillville	807	63	7.8%
Central Falls	2,012	317	15.8%
Charlestown	419	33	NA
Coventry	1,863	122	6.5%
Cranston	4,427	365	8.2%
Cumberland	1,862	113	6.1%
East Greenwich	539	29	5.4%
East Providence	2,589	211	8.1%
Exeter	300	21	NA
Foster	222	18	NA
Glocester	423	30	NA
Hopkinton	445	52	NA
Jamestown	210	19	NA
Johnston	1,387	96	6.9%
Lincoln	932	66	7.1%
Little Compton	165	11	NA
Middletown	1,023	89	8.7%
Narragansett	558	47	8.4%
New Shoreham	59	8	NA
Newport	1,530	200	13.1%
North Kingstown	1,388	103	7.4%
North Providence	1,703	138	8.1%
North Smithfield	485	30	NA
Pawtucket	5,616	758	13.5%
Portsmouth	890	73	8.2%
Providence	14,943	2,233	14.9%
Richmond	501	24	4.8%
Scituate	454	25	NA
Smithfield	743	36	4.8%
South Kingstown	1,247	92	7.4%
Tiverton	686	74	10.8%
Warren	570	49	8.6%
Warwick	4,337	321	7.4%
West Greenwich	273	12	NA
West Warwick	2,002	208	10.4%
Westerly	1,306	155	11.9%
Woonsocket	3,233	481	14.9%
Unknown	1	0	NA
Core Cities	29,336	4,197	14.3%
Remainder of State	34,597	2,640	7.6%
Rhode Island	63,934	6,837	10.7%

Source of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 2002-2006. Data for 2006 are provisional.

During 2004, data on delayed prenatal care began to be collected via a review of medical records, rather than via self report by the mother. Due to this change in methodology, data in this indicator are not comparable to data included in any other Factbooks. Additionally, data from the 2006 and 2007 Factbooks are also not comparable to data included in Factbooks from any other years.

NA: Percentages were not calculated for cities and towns with fewer than 500 births, as percentages for small denominators are statistically unreliable.

The denominator is the total number of live births to Rhode Island residents from 2002 to 2006.

Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

References

¹ U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. (n.d). *Trends in the well-being of America's children and youth 2003*. Washington, DC: Government Printing Office.

² Kirkham, C., Harris, S. & Grzybowski, S. (2005). Evidence-based prenatal care: Part I. General prenatal care and counseling issues. *American Family Physician*, 71(7), 1307-1316, 1321-1322.

³ Hagan, J. F., Shaw, J. S. & Duncan, P. M. (Eds.) (2008). *Bright futures: Guidelines for health supervision of infants, children, and adolescents (3rd ed.)*. Elk Grove Village, IL: American Academy of Pediatrics.

⁴ *Opportunities to use Medicaid in support of access to health care services: Maternal and child health services*. (n.d). Retrieved January 7, 2008 from www.hrsa.gov/medicaidprimer/maternal_child_part3onl.y.htm

^{5,6,7,8,9,11} Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1995-2006.

¹⁰ Silow-Carroll, S. (2003). *Building quality into RIte Care: How Rhode Island is improving health care for its low-income populations*. Washington, DC: The Commonwealth Fund.

¹² Griffin, J. (2007). *Health indicator data book: A comparison of access and quality measures for Rhode Islanders <65 years old by health insurance coverage – trends 1995-2005*. Cranston, RI: Rhode Island Medicaid Research and Evaluation Project, Rhode Island Department of Human Services.