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Health Equity

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Relevant Terms

Ableism—a set of beliefs or practices that devalue and discriminate against people with disabilities and often rests on the assumption that disabled people need to be "fixed"
Bias—prejudgments in favor of or against a particular thing, person, or group, typically in a manner considered to be unfair
Classism—the systematic assignment of characteristics of worth and ability based on social class; the systematic oppression of subordinated class groups to advantage and strengthen dominant class groups
Cisgenderism—societal assumptions about gender expression matching sex assignment at birth
Critical race theory—an academic and legal framework that denotes that structural racism is part of American society—from education and housing to employment and healthcare; racism is embedded in laws, policies, and institutions that uphold and reproduce racial inequalities
Disability—any condition of the body or mind that makes it more difficult for the person with the condition to do certain activities and interact with the world around them
Discrimination—the unfair or prejudicial treatment of people because of their actual or perceived group membership (e.g., membership based on identities such as race, gender, age, sexual orientation, ability, and more); may include both overt and covert behaviors, such as microaggressions or indirect or subtle behaviors that reflect negative attitudes or beliefs typically toward an individual of a group that has been minoritized
Eugenics—the scientifically erroneous theory of "racial improvement" and "planned breeding," which gained popularity during the early twentieth century; eugenicists use methods such as involuntary sterilization, segregation, and social exclusion to rid society of individuals deemed by them to be unfit
Food apartheid—an analytic framework to understand and address the structural causes of inequitable access to food
Food desert—an area with limited or no access to fresh, healthful foods, often found in impoverished urban areas or geographically remote areas
Food insecurity—uncertainty about the availability of adequate and safe nutrition
Health disparity—a difference in the incidence, prevalence, and burden of disease in a specified population as compared with the general population
Health equity—a commitment to give every person the opportunity to attain their full health potential with no one disadvantaged from achieving this potential due to social position or other socially determined circumstances
Health inequity—systematic differences in opportunities groups have to achieve optimal health because of their social position or other socially determined circumstance
Heterosexism—the assumption that all people are or should be heterosexual; excludes the needs, concerns, and life experiences of lesbian, gay, bisexual, and queer people while giving advantages to heterosexual people
Internalized racism—the acceptance of stereotypes and discriminatory beliefs that casts one's own racial group as inferior, less capable, and less intelligent than that of the racial majority group
Interpersonal racism—racism that occurs between two individuals; prejudice and discrimination that may be intentional or unintentional
Intersectionality—a critical theoretical framework that describes how intersecting systems of oppression such as racism, ableism, sexism, cisgenderism, heterosexism, and classism structure individual-level experiences, particularly for people marginalized at multiple intersections
Lifecourse—an approach that acknowledges that current health is shaped by exposures to physical, environmental, and psychosocial factors from pregnancy onward
Maternity care desert—areas where there is low or no access to maternity care, no hospitals or birth centers offering pregnancy and birth care, and no perinatal providers

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Medical mistrust—lack of confidence in healthcare providers and the healthcare system; a rational or expected response to distinct historical experiences of mistreatment and discrimination in the healthcare and research settings linked to group identity, personal experience, vicarious experiences, and oral histories
Microaggressions—verbal, nonverbal, and environmental slights, snubs, or insults, whether intentional or unintentional, which communicate hostile, derogatory, or negative messages to target persons based solely on their membership in a marginalized group
Poverty—an annual income less than the US federal poverty threshold, which is based on family size and composition
Prejudice—a preconceived opinion that is not based on reason or actual experience, typically negative in nature
Race—a social construct primarily based on phenotype (physical characteristics), ethnicity, and other indicators of social differentiation that results in varying access to power and social and economic resources
Racism—a system of structuring opportunity and assigning value based on physical (phenotypical) characteristics such as skin color and hair texture
Reproductive justice—a cross-disciplinary critical feminist theory, framework, and movement rooted in the lived experience of Black women that upholds the human rights to maintain personal bodily autonomy, have children, not have children, and parent children in safe and sustainable communities
Stereotype—oversimplified attitudes people hold toward those outside one's own experience who are different
Structural competency—awareness of forces that influence health outcomes at levels beyond individual interactions
Structural racism—the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, employment, healthcare, and criminal justice

Introduction

Health and well-being during the pregnancy continuum is not experienced equally among all populations in the United States. Some communities and populations experience significant and persistent **health disparities,** defined as differences in the incidence, prevalence, or burden of disease in a subgroup when compared to a larger population. It is important to recognize that the root causes of these disparities have no easy, quick solution. Healthcare providers will not be able to resolve the deep-seated societal and historical factors shaping these disparities during their brief interactions with the client. So, why is there a need to understand them? It is necessary for healthcare providers to understand the structural and social factors that impact a person's **lifecourse** and which subsequently affect the course of the pregnancy and present risks to the pregnant person and their fetus (Crear-Perry et al., 2021; Jones et al., 2019). Healthcare providers play a role in decreasing the nation's health disparities and promoting **health equity** by providing respectful, holistic care that addresses structural and social determinants of health. Comprehensive, multilevel assessment and intervention that involves a team of committed personnel and knowledge of local social services is necessary. A team-based approach to assisting the person to access available resources is a beginning step in optimizing health for the client, their child, and their family. Additionally, all healthcare providers can promote structural change through advocacy for equitable public policies and institutional practices, and by leading the way for new, respectful cultural norms around healthcare.

Key Conceptual Frameworks and Theories

This edition of this text highlights health disparities across a range of populations, explores the root causes of these disparities, and identifies potential solutions to achieve health equity. This chapter introduces current theories underlying the differences in health outcomes. All chapters that follow draw attention to the inequities specific to the content of the chapter in a text box titled *Health Equity Key Points*.

Reproductive Justice

Reproductive justice is a cross-disciplinary critical feminist framework, social movement, and theory that upholds the human right to maintain personal bodily autonomy, have children, not have children, and parent children in safe and sustainable communities. The reproductive justice framework is rooted in the lived experience of reproductive oppression experienced by Black women in historical and contemporary forms.

Origins of the reproductive justice movement

The concept of Reproductive Justice began to take shape when members of a women of color delegation returned from the 1994 International Conference on Population and Development in Cairo, Egypt. Shortly after, a group of African-American women caucused at the Illinois Pro-Choice Alliance Conference in Chicago. The group became known as Women of African Descent for Reproductive Justice. They decided to devise a strategy to challenge the proposed healthcare reform campaign by the Clinton Administration that did not include guaranteeing access to abortion. They integrated the concepts of reproductive rights, social justice, and human rights to launch the term "Reproductive Justice"—Loretta Ross

(Source: Graham, 2015).

Whereas the reproductive rights movement was originally framed around individualism related to the legal right to privacy, choice, and access and was primarily concerned with the right to abortion, the reproductive justice movement is centered on the lived experience of reproductive oppression of Black women (Ross & Solinger, 2017). For Black women, reproductive oppression has included abortion restriction as well as other forms of reproductive control, rooted in **eugenics**, that were designed to limit childbearing (e.g., forced sterilization; Ko, 2016). Additionally, structural racism, economic marginalization, and exploitation have generated communities with low resources that are not always safe or sustainable environments

for having and raising children. Chronic disinvestment and deprivation of Black neighborhoods have led to decreased opportunities in education and employment, increased policing and surveillance, and high levels of crime (Krivo et al., 2015). Implementing the reproductive justice framework includes implementing **intersectionality**, centering the most marginalized, working to achieve human rights, and working to dismantle racism (Ross & Solinger, 2017). Centering the most marginalized means prioritizing the needs of those that are disproportionately impacted by intersecting systems of oppression (e.g., racism, ableism, sexism, **heterosexism**, cisgenderism, and classism). The reproductive justice movement is grounded in a human rights framework, which recognizes that every person, regardless of identity or social group membership, has a set of inalienable rights, and it is the responsibility of governments and healthcare institutions to guarantee these rights and to ensure a system of accountability.

Intersectionality

Intersectionality describes how intersecting systems of oppression, such as racism, sexism, ableism, heterosexism, and classism, structure individual-level experiences, particularly for people marginalized at multiple intersections (Bowleg, 2012). For example, someone may experience marginalization at the intersection of their racial/ethnic *and* sexual *and* disability status) (Bowleg, 2012). This framework was developed by Kimberlé Crenshaw, a civil rights and **critical race theory** scholar (Crenshaw, 1989, 1991). She originally conceptualized intersectionality based on her observation that Black women stand at a "crossroads" or an intersection of marginalized identities. Black women faced hundreds of years of racism, but the civil rights movement focused primarily on the struggles of Black men. Similarly, the feminist movement and efforts to address sexism and gender **discrimination** were primarily concerned with the needs of White women and failed to advocate for the rights of Black women. Intersectionality calls us to think about how individuals and groups may be excluded or oppressed based on the marginalized identities that they hold and their relative distance from power.

> Intersectionality is a lens through which you can see where power comes and collides, where it interlocks and intersects. It's not simply a race problem here, a gender problem here, and a class or LGBTQ problem there. Many times, that framework erases what happens to people who are subject to all of these things.—Kimberlé Crenshaw
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> (Source: Columbia Law School, 2017).

Systems of Oppression and Their Impact on Health

Racism

This section provides an overview of **racism** and its conceptual underpinnings, with the caveat that there are no universally accepted definitions of racism. The definitions and conceptualizations presented below are commonly used, but as racism is increasingly studied, the understanding and conceptualization of racism will evolve. It is critical for healthcare providers to approach this topic with humility and a commitment to continual self-education.

Racism occurs across multiple levels: individual, interpersonal, and structural (Ford & Airhihenbuwa, 2010; Bailey et al., 2017; Dean & Thorpe, 2022). **Internalized racism** is sometimes referred to as internalized racial oppression, and it is a form of individual-level racism that includes the acceptance of **stereotypes** and discriminatory beliefs that cast one's own racial group as inferior, less capable, and less intelligent than that of the racial majority group (Gale et al., 2020; Williams & Williams-Morris, 2000). **Interpersonal racism** occurs between two individuals. **Structural racism** is "the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, employment, healthcare, and criminal justice" (Bailey et al., 2017, p. 1453). There are multiple pathways through which racism is theorized to impact health outcomes (see the text box titled *Pathways Linking Racism to Health Outcomes*).

> **Pathways linking racism to health outcomes**
>
> Physiologic response to chronic stress caused by exposure to multilevel racism.
>
> 1. Results in overactivation of the hypothalamic–pituitary–adrenal axis and release of cortisol and other maternal stress hormones that produce uterine contractions may lead to preterm birth (PTB).
> 2. Chronic stress weakens the immune system, making a pregnant person more prone to illness and infection that can induce poor outcomes such as PTB and hypertensive disorders.
> 3. Chronic stress causes a hyperinflammatory state that contributes to the pathogenesis of preterm labor and birth. The body's response to stress as a result of racism leads to measurable increases in biological markers that propagate the pathophysiologic processes contributing to racial disparities in PTB.
>
> Differential exposure to social and environmental risks such as neighborhood safety and housing.
> Differential access to socioeconomic opportunities.
> Differential access to quality healthcare and health information.
>
> Source: Borders et al. (2015); Black et al. (2014); Williams & Mohammed (2013).

Internalized Racism

Internalized racism is often a result of exposure to racism at other levels (i.e., interpersonal and structural). There is a dearth of research specifically examining the relationship between internalized racism and perinatal health outcomes and experiences. However, internalized racism is associated with negative psychological and mental health impacts including depression, anxiety, and low self-esteem (Gale et al., 2020).

Interpersonal Racism

The vast majority of the research examining racism and perinatal health focuses on the experience of interpersonal racism (Bailey et al., 2017). Significant relationships are demonstrated between racial discrimination and preterm birth (PTB), small for gestational age, and low birth weight (Alhusen et al., 2016; Black et al., 2014; Bower et al., 2018). Additionally, the greater the exposure to racially discriminatory events, the greater the negative impact on birth outcomes (Black et al., 2014). Experiences of racial discrimination occur both inside and outside of healthcare settings.

Structural Racism

Structural racism is a key driver of **social determinants of health** and contributes to significant health disparities in maternal and infant morbidity and mortality that persist in the United States. The impact of structural racism occurs across the reproductive lifespan and is not just confined to pregnancy (Chambers et al., 2021). Black women in particular have noted that structural racism intersects in many ways, through negative cultural attitudes; housing discrimination and inaffordability; differential access to quality healthcare; **bias** in the law enforcement system; exclusion from hidden resources and opportunities; reduced employment opportunities; diminished education options and disinvestment in community infrastructure; and the policing of Black families (Chambers et al., 2021). Structural racism, measured through exposure to racial residential segregation, incarceration inequality, and income inequality are associated with race-associated disparities in PTB, low birth weight, stillbirth, and severe maternal morbidity (Chambers et al., 2020, 2019, 2018; Janevic et al., 2021; Wallace et al., 2015; Williams et al., 2018).

Race-Associated Perinatal Health Disparities

It is critical for providers to understand the contributing factors to race-associated perinatal health disparities. Disparities and healthcare experiences are shaped by structural, not biological, factors. For many years, unacceptable theories that espoused a biologic definition of **race** blamed people of color for the poor health outcomes they experienced (Scott et al., 2019). These theories advanced the idea that there were intractable, biological differences between racial groups. The most accurate etiology of racial health disparities relies on an understanding of race as a social construct and the fact that racism, not race, causes and sustains these longstanding perinatal health disparities.

Inequities in perinatal healthcare, healthcare experiences, and outcomes across racial and ethnic populations must be addressed. A nation's maternal and infant mortality rates are indicative of the value and political will put toward safeguarding the health of its residents. In 2020, there were 23.8 maternal deaths for every 100,000 live births in the United States—a ratio more than double that of most other high-income countries (Hoyert, 2022; Organization for Economic Co-Operation and Development [OECD], 2022). In contrast, the maternal mortality ratio was 3 per 100,000 or fewer in the Netherlands, Norway, and New Zealand. In addition, whereas worldwide the maternal mo rate has decreased by 43% since 1990, the United States remains the only industrialized nation in which the maternal mortality has increased in recent years (see Figure 1.1; Centers for Disease Control and Prevention [CDC], 2022a; OECD, 2022).

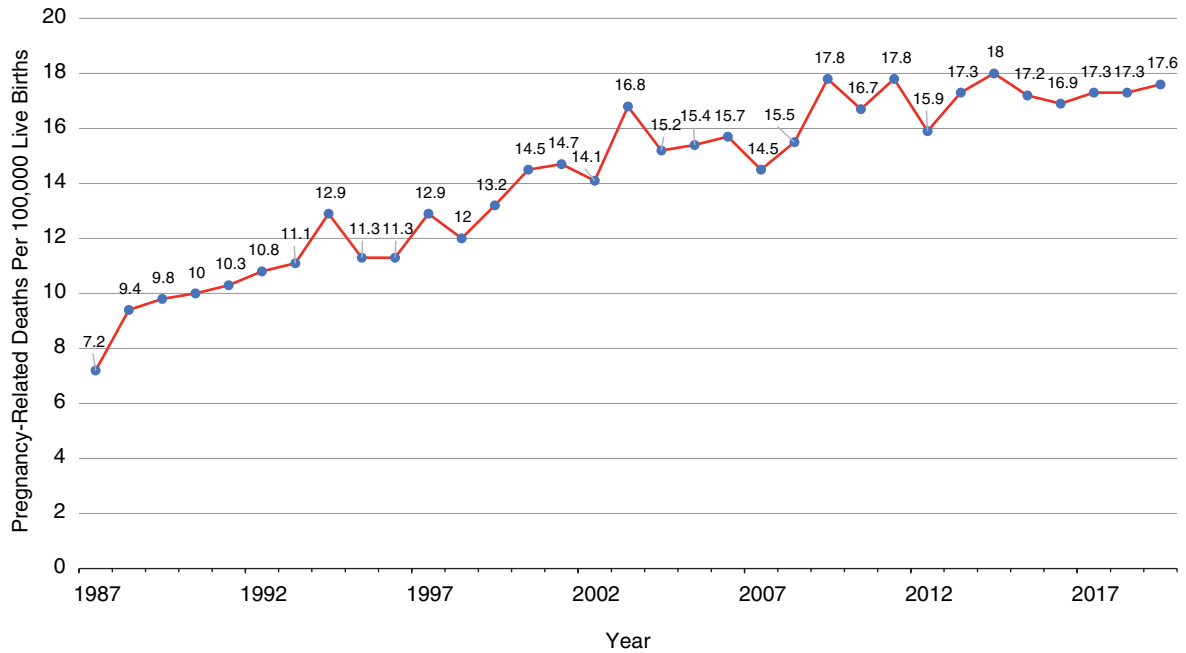

Figure 1.1 Trends in pregnancy-related mortality in the United States, 1987–2018. Adapted from CDC (2022a).

Table 1.1 Selected Maternal and Infant Outcomes by Race/Ethnicity

Outcomes	Total	White, Non-Hispanic, or Latinx	Black or African-American, not Hispanic or Latinx	American Indian or Alaska Native	Asian	Native Hawaiian or other Pacific Islander	Hispanic or Latinx
Preterm live births (percent, <37 weeks), 2020	10.1	9.1	14.4	11.6	8.5	12.1	9.8
Infant deaths, 2020 (number per 1,000 live births)	5.4	4.4	10.6	7.7	3.1	7.2	4.7
Maternal mortality (number per 100,000 live births through 42 days postpartum), 2020	23.8	19.1	55.3	[a]	[a]	[a]	18.2
Pregnancy-related deaths (number per 100,000 live births through one year postpartum), 2016–2018	17.3	13.7	41.4	26.5	14.1		11.3

[a] 2020 rates not reported by CDC due to low number of deaths in this group.
Source: Adapted from CDC (2022a); Ely and Driscoll (2022); Osterman et al. (2022); Organization for Economic Co-Operation and Development (2022).

Approximately 84% of these maternal deaths are preventable—a fact that simultaneously incites incredulity about our society's tacit acceptance of these deaths and also hope that change is possible (Trost et al., 2022). Black and Indigenous birthing people bear a disproportionate burden of this maternal mortality crisis with pregnancy mortality rates three to four times and almost twice, respectively, as high as White birthing people (CDC, 2022a). In addition to mortality, Black pregnant people also experience disparities in other key perinatal health outcomes including PTB, infant mortality, and severe maternal morbidity (Table 1.1).

Experiences of Care

In addition to experiencing persistent perinatal health outcome disparities, people of color also report that mistreatment, disrespect, racism, and discrimination are commonly experienced when receiving care during pregnancy, birth, and postpartum. In one recent study assessing mistreatment in pregnancy or birth in the United States, White women were the least likely to report being mistreated (14.1%; Vedam et al., 2019), while almost one-third of Native American reported being mistreated (32.8%); many Hispanic (25.0%) and Black (22.5%) women reported at least one form of mistreatment. Common forms of mistreatment included being shouted at, having their request declined or not responded to in a timely manner, having their physical privacy violated, and being threatened by their healthcare provider with withholding treatment (Vedam et al., 2019). Women of color consistently report that they are not listened to, are not provided with education needed to make an informed decision, or are excluded from decision-making during the perinatal period (Altman et al., 2019; Lori et al., 2011; Mclemore et al., 2018). Women of color also explicitly report experiencing differential treatment by healthcare providers or healthcare staff because of their race, class, insurance status, or other characteristics associated with membership in a group that has experienced marginalization (McLemore et al., 2018; Mehra et al., 2020; Okoro et al., 2020).

Strategies to Address Racism in Perinatal Health

In addition to identifying the effects of racism on perinatal health, it is imperative to implement sustainable and effective multilevel strategies to address racism. The perinatal healthcare provider should begin with intense and ongoing self-reflection of the internal attitudes and biases that might manifest in implicit and explicit ways in the client–provider interactions and through clinical decision-making (Koschmann et al., 2020). Clinicians who want to explore their biases around race and other salient domains, such as weight, gender, and disability, can take implicit association tests (https://implicit.harvard.edu/implicit/index.jsp) created by Project Implicit at Harvard University. This is a first step in becoming more aware of biases, and the healthcare provider can use their increased awareness as a jumping off point to foster internal change.

Healthcare providers can also work toward developing **structural competency**, an awareness of forces that influence health outcomes at levels beyond individual interactions (Metzl & Hansen, 2014). Viewing **health inequities** through a structural lens helps avoid placing blame on clients and sees health inequities not as individual but societal failings. This is a lens that requires continual refinement because our knowledge of how structural dynamics impact health is rapidly advancing. Being committed to developing this lens and growing in consciousness serves to empower the clinician to identify ways that they as individuals and as capable actors within the healthcare system can advocate for change and develop effective interventions.

Table 1.2 Culturally Affirming Models of Midwifery and Perinatal Support

Organization	Website
BeLovedBirth Black Centering in Oakland CA	https://www.alamedahealthsystem.org/family-birthing-center/black-centering
Changing Woman Initiative in New Mexico	https://cwi-health.org
CHOICES Center for Reproductive Health in Memphis, TN	https://yourchoices.org/midwifery-services
Community of Hope Family Health and Birth Center Washington, DC	https://www.communityofhopedc.org
Kindred Space in Los Angeles, CA	https://kindredspacela.com
Mamatoto Village in Washington, DC	https://www.mamatotovillage.org

There are also a number of promising strategies that can be implemented through policy and practice changes in the healthcare system to address racism by promoting healthy perinatal outcomes.

- *Expansion of postpartum Medicaid coverage:* Over two-thirds of maternal deaths occur in the postpartum period, and expanding postpartum Medicaid coverage from the first 60 days after birth through the first 12 months postpartum might help postpartum people remain connected to the healthcare system and provide opportunities to reduce preventable maternal mortality (Daw et al., 2020; Gordon et al., 2020; Kumar et al., 2021).
- *Restructuring and individualizing postpartum care beyond the six-week visit:* In 2018, the American College of Obstetricians and Gynecologists (ACOG) recommended that every person receive individualized postpartum care with multiple opportunities to engage with a healthcare provider (2021a). At a minimum, this includes a recommended contact with a healthcare provider in the first three weeks after birth (e.g., phone call, in-office visit, and home visit) and a comprehensive postpartum visit that occurs between 4 and 12 weeks. Additional visits such as blood pressure checks and other high-risk follow-up care are provided as indicated. The new guidelines emphasize that postpartum care is an ongoing process that should be individualized based on the person's health and social needs.
- *Integrating doulas into the perinatal health system:* Doulas provide information and health education, engage in advocacy, and provide practical and emotional support. Doula support is associated with reduced cesarean sections, increased vaginal births, decreased use of pain-relief medications, greater duration of breastfeeding, and improved satisfaction with birth (Bohren et al., 2017). National and state efforts to train, pay, and support doulas can help promote the sustainable integration of doulas into the healthcare system and normalize them as an integral part of the perinatal health team. As of publication, approximately half of all states provide Medicaid doula reimbursements or are in the process of implementing this coverage (Chen, 2022). Additionally, the US Department of Health and Human Services devoted $4.5 million dollars in 2022 to hire, train, and pay community doulas (2022).
- *Culturally affirming models of care:* The emergence of culturally affirming models of midwifery and perinatal support are increasingly seen as a promising intervention to transform the current landscape of perinatal care (see Table 1.2 for examples of Culturally Affirming Black and Indigenous Models of Care; Golden et al., 2022). These models prioritize racial/cultural concordance, incorporate cultural strengths, and emphasize social support, relationship-building, and culturally safety. Efforts to scale up and invest in these models of care are underway.

Ableism

Ableism is a set of beliefs and practices that devalue and discriminate against people with physical, intellectual, or psychiatric disabilities and often rests on the assumption that people with disabilities need to be "fixed" in some way (Smith, n.d.). Similar to racism, it is helpful to conceptualize ableism as a multilevel framework, including individual, interpersonal, and structural levels. Approximately one in four American adults has a disability (Okoro, 2018). Perinatal healthcare providers should anticipate that they will care for people with disabilities since about 12% of people with capacity for pregnancy have a disability (Courtney-Long et al., 2015) and people with disabilities are equally as likely to report a pregnancy as people without disabilities (Horner-Johnson et al., 2016). A **disability** is "any condition of the body or mind (impairment) that makes it more difficult for the person with the condition to do certain activities (activity limitation) and interact with the world around them (participation restriction)" (CDC, 2020). Disability categories include, but are not limited to, those disabilities that are acquired, congenital, intellectual, neurologic, sensory, mobility-related, psychiatric, and episodic. People with disabilities are not monolithic. Individuals may have one or multiple disabilities and not all disabilities are immediately visible. Additionally, one form of disability may impact two individuals in different ways.

Language considerations when caring for disabled people

The phrase "disabled people" is an example of identity first language. Disabled people who use identity first language prefer this approach because it posits "disabled" as a positive identity and affirms disability culture. Others prefer to use person-first language such as "people with disabilities." Person-first language puts the person before the disability, making sure not to reduce the person to their disability. However, this approach has been criticized because it implies that disability is negative. There is no one correct approach, and preferences for person-first or identify-first language will vary. This chapter uses both phrases interchangeably, as both are appropriate. Clients with disabilities may prefer one approach over another. Thus, healthcare providers should ask clients their preferred terminology.

Source: Andrews et al. (2022).

Perinatal health disparities exist among disabled pregnant and birthing people (Akobirshoev et al., 2019; Mitra et al., 2015; Ransohoff et al., 2022), and the causes are likely multifactorial. Some disparities may be related to medical complications associated with the individual's disability, but some may be due to implicit and explicit bias including negative attitudes around pregnancy among people with disabilities, and structural barriers. Disabled pregnant people report that their healthcare provider may have limited knowledge of their disability, appear unprepared to manage their pregnancy given this limited knowledge, and exhibit bias during clinical encounters (Mitra et al., 2016; Tarasoff, 2015). Structural barriers include inaccessibility of medical offices, examination rooms, scales, and other equipment during pregnancy (Mitra et al., 2016).

Perinatal disparities among disabled people

- There are increased rates of preterm birth and low birth among women with physical disabilities compared to women without disabilities.
- Black/African-American birthing people with intellectual and developmental disabilities experience higher risks of stillbirth and labor- and birth-related medical billing charges as compared to White birthing people with intellectual and developmental disabilities.
- Women with physical and intellectual disabilities are less likely to receive prenatal care in the first trimester than women without physical and intellectual disabilities.
- Infants born to women with disabilities were more likely to experience infant mortality and have a need for intensive care as compared to infants born to women without disabilities.
- Women with disabilities experience higher odds of experiencing early pregnancy loss than women without disabilities.

Source: Akobirshoev et al. (2019); Dissanayake et al. (2020); Mitra et al. (2015); Mwachofi Brodi (2017); Ransohoff et al. (2022).

Caring for Pregnant People with Disabilities

Healthcare providers should examine the assumptions, beliefs, and attitudes they have toward people with disabilities. Many healthcare providers operate within a framework called the medical model of disability, which frames disability as a problem (Andrews et al., 2022). However, the end of the twentieth century saw the rise of the social model of disability, which proposes that disability is actually socially constructed and that the exclusion of people with disabilities from full participation in society is based on and perpetuated by bias and prejudice toward disability. The diversity model builds on the social model of disability by acknowledging the impact of discrimination, racism, and bias and promoting disability pride that rebuffs internalized ableism and accepts disability as a natural part of human diversity.

Healthcare providers should engage in learning and be prepared to offer or to refer to relevant services and support. Doulas may also provide additional support to people with disabilities (Horton & Hall, 2020). Healthcare providers should also be aware of the landmark federal civil rights laws, which impact people with disabilities, and be knowledgeable about how these laws impact clinical practice (Table 1.3; Iezzoni et al., 2022).

Cisgenderism and Heterosexism

Cisgenderism, transphobia, homophobia, heterosexism, and heteronormativity all describe systems of oppression and discrimination against people who have gender identities and sexual orientations other than cisgender and/or heterosexual. A heteronormative and cisgenderist society makes assumptions about sexual desire only occurring between men and women, and gender expression matching sex assignment at birth. These assumptions exclude people with other identities, rendering them invisible and vulnerable to harm. There is ample evidence that the discrimination faced by people with these identities within and outside of the healthcare setting impacts health, including the experience of parenting and parenting stress (Appelgren Engström et al., 2022), inappropriate and unnecessary medical care (Hoffkling et al., 2017), and reduced screening and preventive care (Elk, 2021; Rosenberg et al., 2021). Health equity is supported by practitioners who provide inclusive care including use of correct names and pronouns, normalizing patient gender expression, efforts to educate themselves, and creation of accepting and respectful healthcare environments (Hoffkling et al., 2017); see Chapter 25, *Preconception, Pregnancy, and Postpartum Care of LGBTQ+ Individuals*.

Classism

Wealth distribution and unequal opportunities have broad implications for people's lives and health outcomes. The burden of health inequity is inequitably borne by people with lower socioeconomic status, due to lower quality healthcare resources, barriers to access, increased exposure to toxic environments and other

Table 1.3 Overview of Federal Civil Rights Laws for People with Disabilities

Year	Federal statutes	Major civil rights protections
1973	Section 504 of the Rehabilitation Act	Forbids organizations and employers from excluding or denying individuals with disabilities an equal opportunity to receive federal program benefits and services.
1990	Americans with Disabilities Act (ADA)	Landmark legislation that defined disability and empowered individuals to file suit for protection under the ADA. In the context of healthcare, it mandates that clinical practices must: • Provide equal access and "reasonable" accommodations" to people with disabilities. • Decisions about accommodation must take place within collaboration, incorporating both the healthcare provider's judgment about clinical appropriateness and the client's preferences and needs. • Not refuse to see a patient due to their disability. • Pay costs associated with providing reasonable accommodations. Patients cannot be required to provide their own accommodations. This law is enforced by the Department of Justice and the Office of Civil Rights in the Department of Health and Human Services.
2008	ADA Amendments Act (ADAAA)	Intended to clarify and expand the scope of the definition of disability which had previously been so narrowly defined that many people were excluded from the law's protections. Made it easier for individuals who were seeking protection of the ADA to establish that they have a disability that falls within the definition outlined in the statute.

Source: Adapted from ADA National Network (2017, 2020); Iezzoni et al. (2022).

health threats, and fewer sources of resilience, such as healthy food, safe outdoor green space, and mental health/wellness resources. In addition, overt discrimination is experienced by people based on their social class, both within the healthcare system, directly impacting care, and in everyday interactions, influencing stress and chronic health conditions. **Classism** has self-perpetuating aspects as well, when the experience of illness further impacts an individual's economic well-being (Fisher et al., 2021). Providers working with people who are economically marginalized must consider ways that their healthcare systems can promote respectful high-quality care regardless of ability to pay, which accommodates a variety of work schedules and transportation and childcare challenges among other barriers to healthcare. Supporting structural solutions to classist inequities in healthcare outcomes including universal healthcare coverage is another way providers can work to advance health equity.

Sexism

Individual-level misogyny and discrimination on the basis of sex assigned at birth is also an oppressive system impacting health equity. **Sexism**, the systematic privileging of people who identify as men, exists on a structural level as well, manifesting as wage and workforce participation gaps, restrictions on abortion access, patriarchal and conservative religions, and social policies (Homan, 2021). A "benevolent" sexism is experienced by pregnant people who receive paternalistic advice to avoid certain foods or activities or who are refused service in restaurants and bars, ultimately maintaining broader hostilities and social injustice (Sutton et al., 2011). The impact of sexism on health outcomes is greater for women who are also people of color, reflecting the exacerbation of effects based on intersectional identities (Homan et al., 2021; Rapp et al., 2021).

Social Determinants of Perinatal Health

In this section, we explore some of the major **social determinants of health**, describe how they might impact health and well-being during pregnancy, and offer practical suggestions for addressing the social determinants of health in the context of prenatal care. Healthcare providers may want to incorporate routine or targeted screening for needs related to these social determinants of health. We have included resources for screening for social needs in the *Resources for Healthcare Providers* section.

Food

Lack of financial resources impacts the ability to obtain adequate nutrition, which is a significant factor in maintaining a healthy pregnancy (Cox & Phelan, 2008; Harnisch et al., 2012; Procter & Campbell, 2014). **Food insecurity**, or concerns about one's ability to obtain adequate and safe nutrition, can lead to underweight, overweight, or obesity (Koller et al., 2022; Sarlio-Lähteenkorva & Lahelma, 2001; Townsend et al., 2001). Food insecurity in pregnancy is also associated with disordered eating, variations in gestational weight gain dependent on initial weight, and decreased likelihood of breastfeeding (Laraia et al., 2022). Inadequate nutrition can be characterized by insufficient intake of calories as well as deficiencies of vitamins and minerals in spite of adequate or excessive caloric intake. The latter often occurs when people purchase foods that are less expensive but have low nutritional value (Sarlio-Lähteenkorva & Lahelma, 2001). These foods often contain high amounts of saturated fats,

sodium, and calories but contain very little in the way of vitamins and minerals. Alternatively, people may experience cycles of food unavailability followed by availability, during which they overeat or indulge in energy-dense foods (Townsend et al., 2001). People with this type of eating pattern may be overweight, whereas those with a chronically insufficient caloric intake will likely be underweight or lose weight during pregnancy if the demands of the pregnancy outweigh intake. People with limited incomes are at risk of periods of no or low weight gain, followed by excessive weight gain, during pregnancy (Herring et al., 2012). In both cases, the pregnant person and fetus are not provided the nutrients and calories for optimal health. Food insecurity is a social determinant of health and is highly influenced by income and significant life events (e.g., death of a loved one, birth of a child, marriage, major illness, and job loss; Banks et al., 2021). Additionally, some groups may be more at risk for food insecurity including some racial and ethnic groups (e.g., Black, Latinx; Walker et al., 2021) and people with disabilities (Heflin et al., 2019). Structural factors, including racism and neighborhood segregation, can influence these relationships. Evidence of the impact of food insecurity on breastfeeding duration is mixed. One large study of the 2009–2014 National Health and Nutrition Examination Surveys found no relationship (Orozco et al., 2020), but other studies found decreased duration of breastfeeding (Dinour et al., 2020; Gross et al., 2019).

The availability of healthy food items, including fresh fruits and vegetables, is limited in low-income neighborhoods, causing them to historically be referred to as **food deserts** (Treuhaft & Karpyn, 2010). However, the term **food apartheid** is growing in popularity because it acknowledges that the inequitable distribution of good quality and healthful food options is not naturally occurring, like a desert, but rather is the consequence of intentional design through the structural factors designed to uphold racism such as racial residential segregation (Sbicca, 2012). Few grocery stores in low-income areas carry high-quality fresh food, while high-fat, high-calorie fast-food options are readily available. Clients trying to make healthier food choices may need to travel further to obtain these items, making the availability of transportation crucial to health status. For example, in Mississippi, the state with the highest level of adult and childhood obesity in the country, 70% of individuals eligible for food stamps travel at least 30 miles in order to find a grocery store that will accept food stamps. The presence of corner stores and liquor stores in low-income areas is 30% greater than in higher income neighborhoods and sheds light on what is readily available to low-income people in their home communities. The absence of vital healthy food options within certain communities is incongruous in a wealthy nation.

Addressing food security during the prenatal visit can be challenging due to stigma and fear. While there is no current recommendation for routine screening around food insecurity, prenatal care providers might consider adding it to their social history, especially when there are high rates of food insecurity in their clinical practice communities. Similar to other sensitive topics, routine screening might reduce barriers to disclosing, especially given that food insecurity might evoke shame, stigma, and fear of intrusive intervention by authorities. Healthcare providers should be prepared to provide relevant resources and referrals should their clients report food insecurity. In addition to the social services described in detail below, healthcare providers should be aware of community resources to deal with food insecurity, including soup kitchens, diaper banks, and food pantries (Belarmino et al., 2021).

Healthcare providers can refer clients to their local office of Women, Infants, and Children (WIC). The WIC program is federally funded and located in each state. Eligibility requirements are determined based on categorical, residential, financial, and nutritional risks. All pregnant people are eligible during pregnancy and up to six weeks after birth, early pregnancy loss, or pregnancy termination. Infants up to one year and children up to five years of age are also categorically eligible. Residential requirements are that the pregnant/postpartum person, infant, or child live in the state through which the benefit is administered. There is no requirement for the length of residency. Financial eligibility is determined by each state but must be between 100% and 185% of federal poverty requirements. Nutritional risk is determined either by the WIC office or by a healthcare provider. A preapplication assessment is available online to determine eligibility and lists the documentation needed as well as the address of the local WIC office (US Department of Agriculture, 2017).

Healthcare providers can also refer clients to apply for benefits through the Supplemental Nutrition Assistance Program (SNAP; formerly called the Food Stamp Program). The SNAP provides important nutritional support for low-income families and older adults and people with disabilities living on fixed incomes (Center on Budget and Policy Priorities, 2022). Persons may be eligible if their household income is at or below 130% of the federal poverty line; benefits may vary if they are disabled or elderly. Per-person SNAP benefits totaled approximately $127 per month (or about $4.16 a day) in 2021, although they were temporarily expanded due to the COVID-19 pandemic to $218 per month (or about $7.30 a day) (Center on Budget and Policy Priorities, 2022). Receiving SNAP benefits has been shown to reduce the likelihood of food insecurity by 30% (Mabli et al., 2013). SNAP benefits can be used in most grocery, convenience, large retail, and some online stores. Many farmers markets also accept SNAP benefits, and some may offer a matching program where clients can double some or all of their SNAP benefits.

Housing

Understanding the healthcare implications of poor housing compared to safe and sanitary housing is essential to providing comprehensive perinatal healthcare. Access to safe and comfortable shelter is significantly influenced and limited by poverty. Furthermore,

housing that is crowded, unsanitary, with poor lighting and aeration, utilities not up to code, containing peeling, lead-based paint, surrounded by violence and drug use, or infested with insects and/or rodents creates unsafe and stressful conditions that expose the pregnant person and fetus to physical, environmental, and psychological threats to health (Chaudhuri, 2004; Raugh et al., 2008). In pregnancy, psychological distress caused by living conditions can lead to biophysical changes, such as increased cortisol levels, that adversely impact fetal intrauterine growth and development (LeWinn et al., 2009; Obel et al., 2005).

Poverty plays a key role in the homelessness of families and individuals since the majority of persons experiencing homelessness cite the inability to afford housing and/or unemployment as the reasons behind their homelessness (National Alliance to End Homelessness, 2022). Rates of poverty have increased in recent years, and the homelessness rate continues to be a national crisis.

The healthcare needs of pregnant people experiencing homelessness can be varied and complex. Homeless women are more likely to have poorly managed chronic illness, communicable diseases, mental illness, substance abuse, chronic stress, and histories of physical and sexual abuse (ACOG, 2013). Unstable housing can result in delays or disruptions in healthcare for conditions that are easily prevented or managed; concerns about shelter, food, and safety often take priority over healthcare needs (McGeough et al., 2020). These concerns, along with barriers such as lack of transportation or childcare for other children, have historically interfered with the ability to obtain consistent prenatal care and continue to elude effective intervention. The cumulative effect of these stressors also places pregnant people experiencing homelessness at an increased risk for PTB (Cutts et al., 2015; DiTosto et al., 2021).

An assessment of a client's living arrangements should always be conducted during care, understanding that people experiencing homelessness might be hesitant to disclose. Some parents have been reported to child protective services and have had their children taken away because of homelessness (Smid et al., 2010). A punitive process such as this must be avoided; rather, clients should be assisted in obtaining safe and sanitary living arrangements. Building a trusting and compassionate relationship during prenatal care will increase the likelihood that clients will continue their care and enhance health outcomes. The healthcare provider should become familiar with available housing resources in order to educate clients of their options, in addition to making a referral to social services for further assistance.

Families in poverty are more likely to be headed by single mothers and are more vulnerable to experiencing homelessness. Single mothers who are also homeless experience compounded stress at a level higher than those dealing with either of the two conditions alone, creating significant concerns for health, fetal health, depression, lack of social support, unintended pregnancy, unemployment, or underemployment, low parenting satisfaction, and punitive parenting practices (Broussard, 2010; Crosier et al., 2007; Eamon & Wu, 2011; Finer & Henshaw, 2006; Wu & Eamon, 2011; Zhan, 2006).

Economic Stability

Pregnant clients with low income may experience challenges that affect the health of the individual and their fetus and place them at risk for poor outcomes. People with low income are likely to experience more stressors and hardship around the time of pregnancy than those with higher incomes; these life stressors can include job loss, homelessness, intimate partner violence, relationship dissolution, and incarceration (Braveman et al., 2010). Poverty is a risk factor in PTB and low birth weight (McHale et al., 2022). Furthermore, children who are born into impoverished environments are exposed to a variety of related stressors and have increased risk for poor behavioral, emotional, and physical outcomes including malnutrition, chronic disease, developmental delays, and low school performance (Engle & Black, 2008).

Clients with low income may benefit from referrals to a variety of social services. Insurance coverage for pregnancy care is a priority, so assistance to access Medicaid is an ideal starting point. Financial assistance for families with minor children is available under the Temporary Assistance to Needy Families program. An interdisciplinary approach that includes medical and social as well as legal services will provide the most comprehensive overview of available options. Since the breadth of many services is determined by income levels, it can be helpful for healthcare providers to help clients locate where they fall in respect to federal poverty thresholds. A basic understanding of how income will be defined by agencies offering medical, social, and legal assistance can help clients anticipate their eligibility. For example, the poverty threshold for families with two adults and one child is $21,811.00 whereas the threshold for one adult and three children is $27,575 (US Census Bureau, 2022).

Some clients may be single parents, and while adequate finances do not address all of the challenges that single parents face, they can relieve some of the burden of parenting alone. Obtaining child support from the other parent of the baby through legal means is another intervention that can alleviate some financial hardships (Huang & Han, 2012). The Office of Child Support Enforcement, a division of the US Department of Health and Human Services, exists to assist custodial parents in establishing paternity in cases of uncertainty or contest, determining the amount of support that is owed, and acquiring support from the noncustodial parent. Clients should be referred to their state Child Support Enforcement Office for information on the specific procedure and documentation required to initiate a case in that state. Links to information on collecting child support and contact information to state Child Support Enforcement Offices are available in the *Resources for Clients and Their Families* section.

Education

Education is touted by many to be an equalizer of inequity in multiple areas, but studies show that the impact of racism overshadows benefits of education on health outcomes for Black pregnant people (Homan et al., 2021). Nonetheless, education-based solutions are paramount to establishing health equity. Segregated school systems on racial and economic lines perpetuate systemic societal-level injustice that is reflected in health inequity. When students have health challenges, their education and ability to learn are compromised. Educational institutions are also important vehicles for educating people about health, health risks, and protective behaviors (Hahn & Truman, 2015). The relationship between a strong and just education system and public health is an essential component of achieving health equity.

Social and Community Context

Health equity and pregnancy and birth outcomes are strongly impacted by social and community support. Support may come from partners, family, friends, religious communities, professional networks, or cultural organizations. Higher social support may provide a buffering effect for some people against the impact of negative influences on health outcomes such as stress (Hetherington et al., 2015). Reporting inadequate social support is associated with being unpartnered, having economic challenges, and coping with mental health disorders, such as depression and anxiety (Bedaso et al., 2021), though many of these factors are interdependent and temporal associations are unclear. It is important to note that those who are unmarried but partnered may not have the same risk for poor outcomes as those who are unpartnered or partnered but in a bad relationship (Young & Declercq, 2010). Research also demonstrates that strong social support networks may override relationship status (Bilszta et al., 2008). Therefore, it is essential to assess client support networks and provide strategies for accessing that support when it is needed during pregnancy and postpartum. For example, a recent study showed that single parents drawing on informal childcare from members of their social networks had more positive employment trajectories than those without such support (Brady, 2016).

Healthcare Access and Quality

Access to high-quality healthcare is a critical component of health equity. In 2022, the March of Dimes report on **maternity care deserts** highlighted that approximately one out of every three people with the capacity for pregnancy and who are of reproductive age (35.6%) live in a maternity care desert. Maternity care deserts are counties in the United States that have zero hospitals or birthing centers and zero maternity care providers (see Table 1.4). Many individuals also live in areas with low (11.9%) or moderate (7.9%) maternity care access. While the vast majority of maternity care deserts are located in rural counties (81.4%), almost one in five maternity care deserts are urban (18.6%). Segregation of neighborhoods remains common in urban and rural communities in the United States (Arnett et al., 2016), limiting access to maternity care providers. For example, 2017 marked the closure of two labor and delivery units in Washington, DC, which mainly affected low-income communities. In 2014, only 75 labor and delivery units remained in Georgia out of 180 hospitals statewide. These closures represent a trend of declining access to maternity care for inner city and rural communities. The presence of maternity care deserts in the setting of poor maternal outcomes in the United States signals a critical need for investment in increasing a diversified perinatal healthcare workforce and expanding the number of facilities that provide obstetric care, including birth centers.

Table 1.4 Definitions of Maternity Care Deserts and Access to Maternity Care

Definitions	Maternity care desert	Low access to maternity care	Moderate access to maternity care	Full access
Hospitals and birth centers in county offering pregnancy and birth care	Zero	<2	<2	≥2
Pregnancy and birth care providers in county (OB/GYNS, and CNM/CMs)	Zero	<60	<60	≥60
Proportion of women 18–64 in county without health insurance	N/A	≥10%	<10%	N/A

N/A = not applicable.
Source: March of Dimes (2022).

Healthcare in the United States is increasingly unaffordable, limiting access to care. Medicaid is the largest payer for pregnancy-related services, and it covers over 42% of births in the United States (CDC, 2022a; Ranji et al., 2022). The expansion of the Affordable Care Act in 2014 was associated with a number of positive outcomes including greater continuity of insurance coverage in the preconception, pregnancy, and postpartum periods and decreased disparities between Black and White infants in PTB and low birth weight (Bellerose et al., 2022). Medicaid eligibility is generally income based, but variations by state exist and may be based on other characteristics such as immigration status. Providers should be aware of the insurance coverage options available in their state for pregnant people and aware of the insurance options accepted by prenatal care and birth settings. There can be a mismatch in the payment methods accepted by providers and payment methods used by clients, leaving many pregnant people unable to access prenatal healthcare (Arnett et al., 2016).

Healthcare quality varies widely in the United States, and poor perinatal health quality is a major contributor to

adverse outcomes and health disparities. Racial residential segregation shapes the quality of care delivered in the hospital setting. Black individuals giving birth in segregated hospitals (i.e., hospitals which serve a disproportionately high number of Black individuals) are at increased risk for severe maternal morbidity (Howell et al., 2016). Other factors shaping the quality of care provided during the birth hospitalization include the on-site availability of anesthesiology, implementation (or lack thereof) of structured approaches to improve processes of care and outcomes, staffing, and more (Howell & Zeitlin, 2017). These factors vary widely by hospital, and efforts to improve the quality of hospital-based perinatal care is an area of emerging research. Research on factors that influence the quality of care in community birth settings (i.e., home birth or birth center practices) is lacking but much needed.

Incarceration and Criminal Justice Involvement

It is estimated that approximately 4% of incarcerated people assigned female at birth (AFAB) are pregnant, but 80% have children (Wang, 2021; Kajstura, 2019). Incarceration has been rapidly increasing among people who are AFAB, rising from 26,378 in 1980 to 222,455 in 2019, representing an increase of more than 700% (Carson, 2021). Most are incarcerated for nonviolent crimes, such as drug possession, sex work, and property offenses (Carson, 2021).

There are disparities in women's rates of imprisonment; Black women were almost twice as likely to be imprisoned in 2015 as White women (Carson & Anderson, 2016). These disparities are rooted in structural racism and bias in the criminal justice system including arrests, pretrial detention and bail decisions, prosecutorial conduct, and sentencing (ACOG, 2021b; The Sentencing Project, 2021). In many cases, drug use and drug-related activities are precipitated by a relationship with a partner who is involved in drugs. Incarcerated women experience disease and mental illness at higher rates than women in the general population (ACOG, 2021b). Healthcare providers working in jails and prisons provide a vital service to this vulnerable population with complex healthcare needs.

Incarcerated people have an increased likelihood of having a history of substance use disorder, exposure to sexually transmitted infections, and intimate partner violence (ACOG, 2021b). People who have been incarcerated at any point in their pregnancy are also at risk for exposure to communicable diseases that are prevalent in places with close living arrangements, such as influenza, tuberculosis, and COVID-19, all of which have increased risks for people who are pregnant. Prenatal care can be the avenue by which incarcerated people receive comprehensive assessment and access treatment and interventions and can enable pregnant people to receive adequate screening, treatment, education, and referrals for problems that might otherwise go unattended (Dooley & Ringler, 2012). However, prenatal care is likely to be initiated later in the pregnancy with inconsistent and inadequate subsequent care (Testa & Jackson, 2020). For clients who are incarcerated, their pregnancies likely occurred in the midst of challenging life circumstances, and attention to the pregnancy may not be an urgent need compared to other hardships that require immediate attention. Managing stressful life circumstances often presents barriers to obtaining the prenatal care and the benefits that it can offer for this high-risk population. Clients with drug-related incarcerations can face barriers to federal programs such as WIC and housing assistance, which exacerbates the financial barriers that might interfere with timely and consistent prenatal care. The impact of criminal justice system involvement is not just limited to the incarcerated person; evidence shows that having a partner who is incarcerated also impacts pregnancy and birth outcomes, including PTB, low birth weight, small for gestational age, and neonatal intensive care unit admission (Yi et al., 2021).

Substance use that leads to incarceration can negatively impact fetal and maternal health. For those who are using drugs during their pregnancy, the fear of detection and punishment may play a role in the lack of timely and sufficient prenatal care. This prevents possible entry into drug rehabilitation to minimize fetal exposure to drugs and alcohol and maximize maternal health. Caring for a person who has been incarcerated should include a thorough assessment of the reasons for their incarceration, with an understanding that a history of substance use is a significant possibility. The healthcare provider must be familiar with the laws guiding local practice since some states require reporting of cases in which a fetus is being exposed to substances during the pregnancy or at birth. For clients who will give birth while incarcerated, anticipatory guidance as to the policies that will affect their care during labor is necessary (see Chapter 18, *Substance Use during Pregnancy*).

While organizations such as the American College of Nurse-Midwives (ACNM) (2016), the ACOG (2021b), the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN, 2011), and the National Commission on Correctional Health Care (2020) have taken a stance opposing the practice of shackling incarcerated people during labor, many state correction agencies still enforce this policy (Poehlmann & Shlafer, 2016). Healthcare providers not working within a jail or prison system may only rarely encounter an incarcerated client; providers of labor and birth services might, on occasion, attend the birth of a person who is incarcerated. Nonetheless, healthcare providers treat pregnant and postpartum people who have a history of incarceration, who are currently incarcerated, or who are at risk for future incarceration. Those working in a jail or prison system will likely be required to follow strict protocols for prenatal care services developed by prison administration officials. Early prenatal care for people who are at risk for incarceration is essential; the health education and counseling that is a hallmark of quality prenatal care has the potential to influence positive social and health-related changes (Dooley & Ringler, 2012; Hotelling, 2008). Doula care is an underutilized but effective model of care to provide compassionate support for labor and birth among pregnant people who are incarcerated (Shlafer et al., 2015, 2021). Examples of

Guidelines to consider for pregnant people experiencing incarceration

1. Recognize that a person's effort to attain prenatal care is a step toward caring for themselves and their baby and that they have likely overcome significant barriers to attend the appointment. Acknowledge efforts to prioritize their and their baby's health.
2. Develop a plan for assessment based on common risk factors.
3. Approach care through a trauma-informed lens and with awareness of gender-related needs.
4. Assess for the following:
   - reasons for incarceration
   - nature of life circumstances leading up to and following the period of incarceration
   - history of childhood and adult exposure to violence, including sexual, physical, and intimate partner violence (IPV)
   - thoughts about the pregnancy, including circumstances surrounding pregnancy, whether the pregnancy was planned or unplanned, plans for pregnancy, parenting, and child placement, involvement of the partner and family members, concerns about parenting, and structure of family and living arrangements
   - depression, anxiety, and emotional distress
   - sexually transmitted infections, including human immunodeficiency virus; provide treatment as needed according to practice guidelines
   - substance use, including last use, drugs used, and attempts at rehabilitation; refer to a specialist for initiation of opioid therapy for people with opioid use disorder
   - maternal attachment and role development in the prenatal and postnatal periods
5. Obtain permission to access any medical records for previous prenatal visits at other clinics.
6. Encourage timely follow-up and assist with removing any identified barriers to attending appointments, such as lack of transportation, lack of childcare for other children, and lack of insurance.
7. Provide education about breastfeeding and assist with needed arrangements for breastfeeding or pumping after birth.
8. Be aware of community options for doula support and refer as necessary.
9. Provide anticipatory education on the circumstances of labor and birth while incarcerated. Advocate for ceasing use of shackles to ensure freedom of movement during labor and birth.
10. Advocate for clients to be kept with their infants after birth.

Source: ACNM (2016); ACOG (2021b); AWHONN (2011); Clarke and Adashi (2011); National Commission on Correctional Health Care (2020).

longstanding doula programs that serve incarcerated pregnant people include the Minnesota Prison Doula Project (http://www.mnprisondoulaproject.org) and Birth Behind Bars (https://www.birthbehindbars.com/). Pregnant people with a history of incarceration may be especially motivated during pregnancy to make positive changes and can benefit from support.

Medical Mistrust

Medical mistrust contributes to healthcare disparities (Arnett et al., 2016; Ho et al., 2022). The vast majority of the research around medical mistrust centers on the perspectives and experiences of Black/African-American individuals, but Latinx and Indigenous individuals also report higher levels of mistrust in healthcare providers and institutions as compared to their White counterparts (Benkert et al., 2019). Among immigrants and people with economic challenges, financial constraints or lack of insurance increases susceptibility to care practices that limit patient autonomy, such as relegation to certain hospitals that accept uninsured clients and operate within certain parameters, based on either biased policy or the **prejudices** of the providers accustomed to working with the population. Medical mistrust can lead to underutilization of primary care services and overuse of emergency department services (Arnett et al., 2016; Benkert et al., 2019).

Medical mistrust is a response to historical and ongoing injustices that are rooted in racism and other systems of oppression. Federally funded forced sterilization took place in the twentieth century across the United States, particularly in the South and in Puerto Rico (Ko, 2016). The United States government also has a history of medical exploitation and experimentation on Black Americans. One well-known example is the Tuskegee Study of Untreated Syphilis in the Negro Male, a research study conducted between 1932 and 1972 to observe the natural progression of the disease among Black men (CDC, 2022b). Study participants were informed that they were receiving treatment for the disease, but researchers withheld treatment and actively discouraged them from seeking medical treatment. The study was eventually halted, and it precipitated the creation of national regulations and procedures to provide the ethical oversight of research. However, the Tuskegee study left behind a legacy of mistrust that continues to shape contemporary patterns of healthcare access and utilization. The mistrust continues in present day with a higher proportion of Black women reporting that they do not feel a connection with their providers and that they experience discrimination and **microaggressions** in the prenatal care setting (Lori et al., 2011). Ultimately, it is the responsibility of the healthcare system and healthcare providers to demonstrate trustworthiness and gain the trust of clients through respectful, dignified, and trauma-informed care (Jaiswal, 2019).

Affirming Individual, Family, and Community Strengths

A holistic approach to perinatal health equity promotion calls us to acknowledge that our clients and their families and communities embody unique strengths. Discussions around health equity often inadvertently advance narratives that portray marginalized groups through a predominantly risk-based lens. A common pitfall when discussing health disparities is to advance a deficit-based approach in which groups that have experienced marginalization are viewed solely as products of oppressive structural dynamics. Healthcare providers should avoid reducing clients to risk factors but rather utilize a strength- or asset-based approach to understanding all of the ways that clients, in relation to their families, communities, and wider structural factors, are able to cultivate and build these strengths to nurture their health and well-being.

Summary

The healthcare provider plays a key role in promoting perinatal health equity. Acknowledging the role of racism and other systems of oppression in shaping the structural and social determinants of health as well as reflecting on one's own biases and prejudices is an important first step in taking ownership of one's role in promoting health equity. In the exam room, the healthcare provider should prioritize relationship-building, person-centered care, listening, and believing the client, honoring them as the expert of their experience and partnering with them in identifying and achieving the health goals that matter to them. The clinical encounter is also a unique opportunity to identify how social needs may impact client health and to address those needs. A familiarity with local community, state, and federal agencies that exist to provide aid to individuals in vulnerable circumstances is essential. Finally, the healthcare provider can also be an advocate for policies needed to make structural changes. Sexual and reproductive health providers and people with privilege need to join with people of color and with other groups that continue to be marginalized in fighting for social justice.

Resources for Clients and their Families

Disabled Parenting Project: An online space for sharing experiences, advice, and conversations among disabled parents as well as those considering parenthood. https://disabledparenting.com

How to obtain child support: Child support handbook. https://www.acf.hhs.gov/css/outreach-material/handbook-child-support-enforcement

Local food pantries. Assist people in locating local food banks or pantries using the link: http://feedingamerica.org/foodbank-results.aspx

Medicaid. Learn how to apply for coverage. https://www.medicaid.gov/about-us/beneficiary-resources/index.html

Temporary Assistance for Needy Families (TANF). A program that helps families transition from public assistance to work by providing financial support, work opportunities, and childcare assistance. For details about the program and eligibility, visit: http://www.acf.hhs.gov/programs/ofa/programs/tanf

Child Care Aware America. Find a Child Care Resource & Referral Agency (CCR&R). https://www.childcareaware.org/

The National Association of Free and Charitable Clinics. Organization for clinics providing free healthcare for uninsured or underinsured individuals across the country. https://www.nafcclinics.org/

The Special Supplemental Nutrition Program for WIC. https://www.fns.usda.gov/wic

US Department of Housing and Urban Development. public housing assistance is offered in the form of public housing or housing choice vouchers (section 8). https://www.hud.gov/topics/rental_assistance

Resources for Healthcare Providers

American Association of Family Physician. Social determinants of health: Guide to social needs screening. https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/hops19-physician-guide-sdoh.pdf

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American College of Obstetricians and Gynecologists. Committee opinion: Optimizing postpartum care. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care

Black Mamas Matter Alliance. Issue Briefs, Reports, and Publications. https://blackmamasmatter.org/literature

National Association to Advance Black Birth. The Black Birthing Bill of Rights. https://thenaabb.org/black-birthing-bill-of-rights

National Commission on Correctional Health Care. Women's Health Care in Correctional Settings (Position Statements on Breastfeeding in Correctional Settings, Transgender and Gender Diverse Health Care in Correctional Settings, and Women's Health Care in

Correctional Settings). https://www.ncchc.org/position-statements

National Health Care for the Homeless Council. Reproductive Health Care for Homeless Patients: Summary of Recommended Practice Adaptations: https://nhchc.org/wp-content/uploads/2019/08/Reproductive-Health-Care.pdf

Project Implicit. Implicit Association Tests: https://implicit.harvard.edu/implicit/index.jsp

Women's Prison Association. A summary of jail and prison nursery programs: https://www.prisonpolicy.org/scans/wpa/Mothers_Infants_and_Imprisonment_2009.pdf

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