Maternity Care Coalition (MCC), founded in 1980, has for the past 26 years helped low income women in their childbearing years by addressing both personal and systemic barriers to receiving consistent perinatal care. MCC’s mission is to improve maternal and child health and well being through the collaborative efforts of individuals, families, providers and communities. The agency achieves its mission through outreach in high-risk neighborhoods and advocacy at the local, state and national levels.

MCC’s signature program, the MOMobile®, offers community-based outreach and support for pregnant women, new parents, infants, and their families in eight communities in Southeastern Pennsylvania. Our expertly trained community health workers provide links to prenatal care, pediatric and women’s healthcare, behavioral health services, nutrition programs, education and other community resources. The MOMobile® is widely known in neighborhoods throughout our region and is nationally recognized as a program model of excellence. Since 1989 we have served more than 60,000 families.

MCC is grateful for the support of the United Way of Southeastern Pennsylvania, the Samuel S. Fels Fund and the William Penn Foundation, which made this project possible.
It is hard to say precisely when the rumblings began – was it the fourth hospital closure or the sixth? Was it the growing number of reports of women waiting months for prenatal appointments or the rumors that obstetricians were “fleeing Pennsylvania” at record rates? Perhaps it was when we began to hear of women laboring in hospital hallways or when we learned of a hospital overwhelmed with deliveries lacking isolettes for newborns, while just a few miles away a recently closed hospital, complete with obstetrical unit and isolettes, sat empty and idle.

There were other disturbing reports: a health center that had been the primary source of care for undocumented pregnant women in a community outside of Philadelphia was no longer accepting patients. They could not find a physician for their midwifery practice. At the same time, the nearby community hospital maintained signage in English-only, despite having many Spanish speaking patients.

Whenever “it” began, we know that by spring 2004 consumers, providers and advocates were alarmed, fearing a health-care crisis for childbearing families. And as they have for over twenty-five years, members of the region’s maternal/child health community turned to Maternity Care Coalition (MCC) to seek help, to look for answers and to call for action. In March of that year, Brian Castrucci of the Philadelphia Health Department and Andrew Wigglesworth of the Delaware Valley Healthcare Council met with MCC’s Research and Public Policy Committee, and their insights helped confirm the need for this inquiry.

We all realized that before MCC could act, we had to move from rumors, anecdotal information and hearsay to a clear understanding. Using our unique ability to bring together and work with health-care providers, community organizations, city and state agencies, and pregnant women, we set out to answer the question: Is there a crisis for childbearing families?

We recognize that childbirth is not isolated from the full scope of women’s health, but for this investigation, we chose to focus on the health and policy issues related to childbearing – i.e. from pregnancy through the postpartum period. We also decided to study the experiences of all childbearing women in Southeastern Pennsylvania because it was clear that the problems we were hearing about were not confined to one income group or one geographic area. We enlisted Philadelphia Citizens for Children and Youth and the Women’s Law Project to help us define the issues, gather data, and develop a strategic plan for the project.

We conducted interviews with more than 70 key informants including hospital administrators, physicians, midwives, nurses, insurers, government officials, academics, and maternal/child health advocates. We identified current data available from the city and state health departments and the Philadelphia Health Management Corporation. We collected additional data from the Centers for Disease Control and the March of Dimes.

At the same time we identified information that was NOT there because it was never collected or not readily available. Just two examples: we were unable to determine the number of uninsured pregnant women in our region or to track postpartum visit rates. We also struggled with limitations within the data, finding we could not always get figures at the level we wanted or in comparable formats.
We brought in national experts, convened community dialogues and held roundtable discussions. We conducted focus groups with consumers, midwives and doulas, and collected birth stories. We advertised in popular parenting newspapers and interviewed mothers in our MOMobile®, Early Head Start, and Cribs for Kids programs and other consumers for their perspectives on prenatal and obstetric services. We asked a physician long-concerned about women’s health, Gene Bishop, to review, analyze and compile the information collected by our project team. And, as we suspected she would, Gene did this and more, extensively researching medical journals, collecting data, interviewing physicians, researchers and policy experts – expanding our knowledge and understanding of the issues and helping to identify potential solutions.

Finally, we asked a distinguished panel of reviewers to read the material and give us their feedback. This group, whose names appear at the end of this report, contributed additional data, insight and perspective.

From these rich and diverse sources, we formed a picture of the state of childbirth options and care in Southeastern Pennsylvania. And we learned that while it may be premature to say that we are in a healthcare crisis for childbearing families, we are indeed at a crossroads. At this critical juncture we as a community must decide the direction we will take.

If we continue along the present road, we will see a lack of appropriate care for our increasingly diverse population, inadequate healthcare for our neediest, a declining pool of providers, continued health inequities across the region and a continuing deterioration of birth choices for childbearing families at all income levels. If we choose to commit ourselves – and devote our resources to – another road, we have the opportunity to improve healthcare choices and outcomes for all childbearing families and for our community as a whole.

JoAnne Fischer
EXECUTIVE DIRECTOR
MATERNITY CARE COALITION
• In one out of five homes in Philadelphia, and one out of ten homes in the suburban counties, the primary language is not English.
• More than 1 out of 10 women in Southeastern Pennsylvania ages 18-39 lack health insurance.
• Since 1997, 13 hospitals in the area have discontinued obstetrics.
• African-American infants in Southeastern Pennsylvania are more than twice as likely to die in the first year of life.
• Philadelphia’s breastfeeding rate places it last among the 10 largest American cities.

...that led us to our five key findings:

DIVERSITY

The travelers along the childbearing “road” form a very diverse population, posing new challenges to a strained healthcare delivery complex.

Women from around the world reside in Southeastern Pennsylvania. Those giving birth here reflect the diversity of our region in ethnicity, culture, race, income, age, and healthcare status.

ACCESS

Access to adequate healthcare, beginning before conception, through pregnancy, and continuing postpartum, remains elusive for many women in our area.

Large numbers of women obtain health insurance only when they become pregnant, depriving them of preconception preventive care and delaying their entry into prenatal care. Many do not qualify for Medicaid. New high deductible insurance products add to the number of under-insured. At all income levels, health insurance status is a major determinant of reproductive healthcare and maternity care options.

We can choose to provide universal health insurance, guaranteeing every woman access to healthcare beginning before conception, through pregnancy, and postpartum. While supporting long-term city, state, and national efforts, we see the following interim goals:

- Expand healthcare coverage for the uninsured and under-insured.
- Improve current systems to facilitate easier access and coordinates services.

To reach these goals we need to have:

- Governments, insurers and advocacy organizations that seek to expand or improve coverage for all unemployed and low income employed people.
- Maternity care and reproductive services included as a benefit in all insurance policies in the Commonwealth that are marketed to women of childbearing age.
- A plan to address the need to care for undocumented residents.
- An extended Medicaid benefit period for women who give birth – ideally, an increase from 60 days postpartum to 12 months.
- Adequate diagnostic and treatment services for maternal depression in order to secure the mother-child bond.

CARE

A declining pool of practitioners, physicians, midwives, and nurses, is vulnerable to malpractice suits and faced with a healthcare framework where maternity care is considered unprofitable.

Constraints on practice structure forced by malpractice and reimbursement arrangements have left obstetricians and midwives frustrated, angry, and less satisfied professionally, leading to decreased patient satisfaction. Fewer students are
choosing the specialty. Choices in childbirth providers, both practitioners and hospitals, have declined for all women, regardless of income level, but these constraints are particularly acute for low income women. In both urban and suburban areas, safety net providers are overwhelmed and under-funded.

**We can choose** to make decisions on provision and location of services based on demonstrated regional healthcare needs. Let's consider innovative approaches to medical liability to better serve practitioners and childbearing families. Let's ensure an adequate supply and distribution of practitioners who welcome the opportunity to provide professional assistance and support to all families. Let's ensure an adequate supply and distribution of practitioners who will serve practitioners and childbearing families. Let's ensure an adequate supply and distribution of practitioners who will serve practitioners and childbearing families.

**To reach these goals we need:**
- Maternal/child health policy based on sound data, consistent data collection, and community input.
- A change in the climate that surrounds medical malpractice and obstetrics.
- Regional support of efforts to increase the supply of all childbirth practitioners and providers, especially those interested in serving low income or minority women.
- An improved work environment for current practitioners.

**EQUITY**

Marked healthcare inequities still exist across the region.

African-American infants are more than twice as likely to die as white infants in Southeastern Pennsylvania. Entry rates into prenatal care remain lower for teenagers, the uninsured, women on Medicaid, and African-American, Hispanic, and Asian women. Improvements in infant mortality have come from improved survival of prematurity and low birth-weight babies, not from a reduction in the number of these births. Breastfeeding rates are lower than most large cities in the U.S. We are not meeting national public health goals.

**We can choose** to narrow, rather than widen, the gap between rich and poor, between whites and all other racial and ethnic groups. This choice must involve conscious and active efforts to end inequities and reduce health outcome disparities based on race and income. This choice provides every mother and child with an equal chance for a healthy start and a healthy life.

**To reach this goal we need:**
- Region-wide efforts to achieve national public health goals.
- Programs, both educational and service, that confront racism and poverty at multiple levels.
- Research on healthcare inequities that seeks the most effective solutions.

**SUPPORT**

Women's active participation in defining their birth experience has declined.

Technological intervention in childbirth is increasing, even without medical evidence to recommend it. Midwifery options for full maternity care have decreased. Our culture romanticizes motherhood but does not offer women the knowledge and support required for self-confidence during pregnancy and birth. Too often, the voices of women are lost; the needs and interests of families of infants are ignored.

**We can choose** to see birth as a medical condition, separated from home and family, with many opportunities for a safe and healthy childbearing experience, and many technological advances.

**We can also choose** to emphasize the normal in childbirth, and place childbearing and new parenthood in their natural context of family and life cycle. Let's return birth to a family-centered event in a society that values pregnancy, childbirth, and infancy as the building blocks of a healthy life-long relationship.

**To reach these goals we need:**
- Birth environments that help women experience the joy and transforming power of childbirth as full participants, maximizing self-empowerment and minimizing fear.
- A culture that supports children and families and values parents.
- Public and private sector policies that recognize the importance of time for parental leave, flexible work schedules, and other family-friendly practices.
- An improved local environment for breastfeeding mothers and babies.

**Maternity care in Southeastern Pennsylvania stands at a crossroads.**

The road we're on leaves increasing numbers of women without access to care that meets their needs. It is time to choose a road that will reach every woman's door, providing her with access to quality healthcare services throughout her life cycle. Healthcare providers across our region must be prepared to serve our changing and ever more diverse population. Universal health insurance must be a short-term, not a long-term, goal. We must seek innovations in healthcare delivery, practice structures, and malpractice insurance to ensure a supply of enthusiastic practitioners. Our region needs a comprehensive approach – incorporating business, healthcare, government and philanthropy – to reduce the health inequities we have found.

Amidst all this, we must listen to women, respecting their needs, and offer them the opportunity for full participation in a wide range of childbirth options. We must welcome babies into our communities with the care and support they deserve.
MCC’s start was firmly rooted in a national movement for a woman’s control over her reproductive functions. This grassroots health movement supported “natural” or “prepared” childbirth – through Lamaze or other classes, fewer drugs, breastfeeding, and fathers and siblings in the delivery room. Homelike environments appeared in hospitals, with deliveries occurring in a labor room instead of an operating room. “Rooming-in” – allowing the newborn to sleep in the room with the mother – became commonplace.

These changes empowered women; more women entered medical school and the profession of obstetrics/gynecology. Interest in midwifery surged, and midwifery schools expanded. The medical profession took a new look at an old dictum, and a National Institutes of Health Consensus Conference concluded that VBAC – vaginal birth after Cesarean – was a safe procedure. NIH called for a national public health policy to reduce the number of Cesarean births.

In this social and political setting, MCC set out to inform the public and mobilize to prevent unnecessary infant deaths and get ALL families off to a healthy start. Southeastern Pennsylvania had rich healthcare resources. More than 40 hospitals had obstetrical units, and the region included Booth Maternity Center, a unique, free standing full-service maternity hospital. Additionally, there were two non-hospital birth centers, and a small number of women had home births.

Access to healthcare was a problem. Private health insurance allowed most women to choose any provider. HMOs, entering the market in the 1980s, required members to select from a list of doctors and hospitals. Medicaid was accepted by public and teaching hospital clinics and a few private providers, but many low income women were not eligible. Philadelphia and its suburbs no longer had any public hospitals. Although women presenting in labor could not be turned away, women who registered in advance had to pay admission deposits.

Healthcare quality – “doing the right thing at the right time in the right way for the right people and having the best possible results”1 – is by definition an ongoing issue. In the 1980s, delivering quality maternity care meant confronting

In 1980, more than 2 out of every 100 non-white children born in Philadelphia were dying before they reached the end of the first year. A group of professionals and lay people, seeking to change that number, founded the Maternity Care Coalition. Since that time, MCC has worked to chart and advocate an agenda to improve maternity care for all women in Southeastern Pennsylvania, and to work cooperatively with advocates to improve healthcare and to strengthen families, one baby at a time.

One of the most promising ways to improve care, make better use of existing monies, get people working with each other in more effective activities and ultimately, to impact on the politics of healthcare – is to organize around maternity service.

MCC FOUNDER, ED SPARER, ESQ. 1980

Looking Back

MCC FOUNDER, ED SPARER, ESQ. 1980
issues old and new. During that decade we continued to see unacceptable infant mortality rates, with a widening gap between black and white babies. Practitioners noted high rates of prematurity and low birth weight.

Crack cocaine and heroin use became critical maternal and child health issues. Warning labels regarding alcohol use in pregnancy arrived in 1989. HIV appeared and soon became a disease of pregnant women and babies. Domestic violence gained recognition as a special issue in pregnancy.

MCC’s childbirth agenda has sought to improve access and quality in the context of a women’s health culture that celebrated childbirth as part of the human life cycle and offered women increased choices in deciding when and whether to have a child, and what the experience would be like.

During the 1990s, MCC’s professional education series discussed these issues and others - healthcare reform, depression, teen pregnancy, patient rights and managed care. And we do have some cause for celebration. Both infant mortality and teen pregnancy rates have fallen, as have the numbers of women without any prenatal care. Yet there is still cause for concern.

MCC Believes That Our Priorities Over The Years –

• extending insurance so low income women can receive services available to the insured
• supporting pregnancy in the total context of a woman’s life
• decreasing infant mortality through improved access to prenatal care and support
• narrowing the racial disparities in outcomes

still stand as common goals around which to unite consumers, advocates, healthcare providers, and government agencies. We ask you to keep these goals in mind as you read our findings.

The first thing was making community people themselves become involved in [understanding] the very thing that was destroying them and they didn’t know what to do about it. The babies were dying and they didn’t know why.

MCC FOUNDER, LOUISE BROOKINS, PHILADELPHIA WELFARE RIGHTS ORGANIZATION 1983.
An increasingly diverse population meets a strained healthcare delivery complex

Who is having babies?

69,364 women became pregnant in the five Southeastern Pennsylvania counties in 2003 and 50,144 gave birth to live babies. These women represent a diverse population, whether we are looking at ethnic and cultural diversity, racial diversity, income diversity, age, or healthcare status.

8,202 of these births were to girls under 19, a steadily decreasing number, and 1,746 of these births were to women over 40, a steadily increasing number.

More women gave birth using assisted reproductive technology - and these women are disproportionately white, middle and upper income, and insured. However, much of this treatment is not covered by health insurance.

Birth statistics sorted by race or Hispanic origin do not begin to reflect the diversity of the area. Almost one out of 5 Philadelphia households and one out of 10 suburban households are homes where the primary language is not English. Pregnant women in our area may speak Spanish, Portuguese, Hungarian, Romanian, Arabic, Italian, Vietnamese, Korean, French, Tamil, Mandarin, Khmer, or one of numerous West African languages. One suburban Philadelphia midwifery practice sees women from Ecuador, Liberia, Ivory Coast, and Mexico. In fiscal year 2004-2005, Medicaid provided emergency insurance to cover the deliveries of 1,200 undocumented immigrants in Southeastern Pennsylvania.
Almost half of all births in Philadelphia are to low income women, yet few obstetricians outside teaching hospitals accept Medicaid. In all of Southeastern Pennsylvania, 28% of births in 2003 were to women insured by Medicaid, and that number rose steadily from 1999-2003. Across the state, approximately one out of three births is to a woman on Medicaid. The number of uninsured low income women who are not eligible for Medicaid is not known. Fifty percent of births at the Hospital of the University of Pennsylvania are to women who are on Medicaid or uninsured. In contrast, births to women who attended Abington Hospital’s prenatal clinic - accounting for a majority of the Medicaid or uninsured births at Abington - represented 15% of Abington’s 4849 deliveries in 2005.

Most childbearing women are young and healthy and are fortunate to have healthy pregnancies and healthy babies. However, the presence of chronic medical or social problems increases pregnancy risk. In our region, 15-20% of women of childbearing age indicate they have a chronic physical illness such as diabetes, hypertension, or HIV. Eighteen percent of white women, 13% of African American women, and 17.5% of Latina women indicate they have a chronic mental illness. Pennsylvania women report binge drinking and smoking at significantly higher rates than the national averages.

The wide diversity of socio-economic status and baseline health status presents a challenge to our community and to healthcare providers. However, whether a woman is educated, employed, well insured, and a recipient of ongoing preventive healthcare or whether she has limited English proficiency, little or no insurance and no ongoing healthcare, her questions are similar:

Do I want to have a baby?
Do I have insurance to pay for it?
Where can I go for prenatal care?
Who is available to assist at the birth – an obstetrician, a midwife, a family doctor?
Where will I have the baby?

For most women, insurance or its lack determines locations for prenatal care, delivery, and postpartum services. Not all practitioners take all plans, and insurer handbooks rapidly become outdated. Locations of offices and clinics, and the transportation needed to get to them are often a critical factor.

Women with underlying chronic mental and physical health problems require coordination of care among practitioners. Fewer hospitals now offer obstetrical services, leaving neighborhoods without a local option.

MCC STAFF MEMBERS HAVE TOLD US:

A client called MCC from a medical appointment to ask a staff member for help with translation. The doctor took the phone and said, “This isn’t my job; I don’t have time for it,” and hung up.

At one health center, a security guard who speaks multiple languages functions as a translator. Although this is contrary to accepted medical practice and to Federal law, it is better than nothing.

Clients often say they did not understand a word that was said at discharge.

At MCC Roundtables, practitioners reported women choosing to obtain prenatal care close to home, but then choosing to deliver at hospitals unaffiliated with the prenatal care provider. Women who seek care from providers who speak their language may encounter long waits for the few available appointments. Matching personal and practitioner philosophies - finding a practitioner who shares a woman’s preferences regarding childbirth choices - is difficult even for those women with adequate insurance.
Routes 202 and Ridge Pike: *Norristown, Pennsylvania – A Real Crossroads*

Right now, low income women in Norristown, county seat of Montgomery County, are at the crossroads of issues facing maternal and child health in our region:

- The infant mortality rate for Norristown is almost twice that of the rest of the county.
- Few private obstetricians in the area will see women insured by Medicaid.
- Many childbearing women are undocumented, uninsured and/or Spanish-speaking.
- The one Federally qualified health center stopped offering prenatal care in November 2005.
- The only two hospital clinics accepting Medicaid had extensive waits for prenatal visits, even for women at high risk.
- One hospital recently announced plans to relocate elsewhere in the county outside of downtown Norristown.
- The county’s use of Federal maternal/child health funds to pay for prenatal care for the uninsured is only able to cover 1/3 of more than 400 eligible women.
- 13% of African-Americans in Norristown and 8% of whites had low birth-weight and very low birth-weight babies in 2005.

Norristown is home to 15,000 to 30,000 persons of Mexican origin, many of them undocumented, accounting for 1/3 of Pennsylvania’s Mexican born population. The number of births there to African-Americans, Southeast Asians, and Latinos increased every year since 1990 by about 4% more than births of white children.

In the Borough of Norristown, per capita income in 2000 was $17,977 and the household median income was $35,714. Yet Montgomery County as a whole has one of the highest per capita incomes in the United States.

How will we respond?

Where is maternity care for these families headed?

we come to our first decision. We can proceed down a road that increasingly bypasses many women. Or...

We can choose a way that embraces and respects the diversity of our region, creating systems and resources to serve not only the well insured English speaking woman, but also the undocumented, the uninsured, and those with special needs:

> Women in all five counties will have access to physicians, midwives, and affiliated healthcare staff who treat them with respect and caring.

> Practitioners will meet "National Standards for Culturally and Linguistically Appropriate Services in Health Care".7

> Healthcare facilities will identify the predominant language needs of their communities and provide services, signage, and other simple amenities that help those with limited English proficiency to negotiate systems.

> More obstetricians, midwives and other healthcare providers, particularly in suburban areas, will be willing and committed to work with diverse populations and will have the support services they need to do this work well.
> Many women lack access to adequate healthcare

At our maternity care crossroads, we recognize that childbearing is only one part of a continuum of health and healthcare throughout a woman’s life. Pregnancy serves to focus us on the critical role that health insurance, or its lack, plays in a woman’s ability to obtain healthcare whether or not she is pregnant. We start by introducing three women who shared their stories during our Crossroads Project: Deirdre, Lina, and Susan.

**DEIRDRE**, a 35 year-old woman in her third pregnancy, visited an emergency room when she thought she was pregnant. They confirmed her pregnancy, and that meant she was eligible for Medicaid. She applied, and received a card in the mail 60 days later. Very soon, she tried to go to a City Health Center and to a prenatal clinic at a university hospital, but was dismayed to learn how long she would have to wait for an initial appointment. After contacting MCC, she got an appointment at a Health Center 6 weeks before her due date. She continued to get bills from the emergency room for her pregnancy test, despite the fact that it should have been covered retroactively. She said, in an interview with MCC: “Pregnant black women can’t get help. [You] go to a walk-in clinic, wait all day and are told at 3pm that there are no more available appointments; come back tomorrow. All “free clinics” have four to six month waiting lists for everything. You get tired waiting and just figure you will go back next week.”

**LINA**, a Brazilian born woman with a prior history of ruptured ectopic pregnancy became pregnant but had no health insurance. She had previously been insured, but lost her job and was unable to afford to continue the insurance. She tried to buy new insurance but was denied for a preexisting medical condition. At the time she became pregnant, she went to a City Health Center where the nurse arranged for an immediate ultrasound at a hospital to be sure there was no ectopic pregnancy. The nurse submitted a Medicaid application that was denied because Lina was not a citizen. The hospital sent her a bill for $359 for the ultrasound and offered her maternity care at a price she could not afford. A friend referred her to a reduced rate program at another hospital.

**SUSAN**, a 33 year-old woman, was actively trying to conceive. She and her husband did a home pregnancy test 10 days after she missed her period. On the recommendation of friends, she chose a Center City hospital with an excellent reputation, and a private practice at that hospital. She was offered an appointment in her 8th week, but because of her concerns about a thyroid condition, she was able to obtain an appointment immediately. She was seen monthly,
biweekly, and then weekly on standard prenatal care protocols, and attended childbirth and breastfeeding classes. Her prenatal care alleviated anxieties and gave her confidence in her healthy pregnancy. She hired a doula, a birth support attendant, who came to her home in early labor, stayed with her and helped determine when to go to the hospital. The doula then supported her through labor and a birth without complications.

WHAT ARE DEIRDRE, LINA, AND SUSAN TELLING US?

• Only Susan traveled a smooth road that included healthcare before pregnancy, an intended pregnancy, and a choice of healthcare providers who could see her promptly. Most private obstetrical practices in Southeastern Pennsylvania accept both of the dominant commercial insurers in this market, but only a few accept any of the Medicaid HMO plans. Although insurance covers prenatal care and delivery, it does not cover the services of a doula, and coverage for lactation consultants or home care is variable. Susan’s health insurance will continue to pay for well woman visits, contraception, and any acute medical problems she might develop.

• Deirdre traveled a road full of potholes. Without health insurance, she visited an emergency room to confirm her pregnancy. New state Medicaid programs have eliminated the 60 day wait for a card, but Deirdre’s story shows that health insurance by itself does not guarantee that a woman gets care. Race figures prominently in her thinking about the obstacles she faces, and in her distrust of the healthcare apparatus. Her patience is thin. As a woman without health insurance who became pregnant, Deirdre most likely had not been getting any regular medical care prior to the pregnancy. If she wanted to terminate the pregnancy, she would have to obtain the money, and would still be without health insurance or contraception. Studies have shown that women who are unhappy or ambivalent about a pregnancy delay obtaining prenatal care. Deirdre brings us face to face with health inequities and their consequences.

These stories highlight the critical importance of health insurance. National data show that fewer than half of low income women in Pennsylvania between 18 and 64 have private insurance, and 28% are uninsured. Local information, using Philadelphia Health Management Corporation household survey data, shows that 11.4% of women aged 18-39 were uninsured in Southeastern Pennsylvania in 2004, and that the uninsured live in all five counties.

Nationally and locally, Latina women are especially likely to be uninsured. More than half of the Latina women in Chester County between the ages of 18 and 45 are uninsured, and one out of four Latina women in Bucks and Philadelphia Counties are uninsured.

We do not know the exact number of women in our region who have no health insurance when they become pregnant. National data show that 22.4% of pregnant women were uninsured 12 months prior to delivery. For comparison, we looked at a survey of women at the Chester County Healthy Start Program, which provides prenatal home visiting. Among this group, 78% – clearly a much higher number – did not have health insurance at the time of enrollment.

The number of women who are uninsured – who have health insurance but discover that it provides inadequate coverage and financial protection – is growing with the advent of so-called “consumer directed health insurance.” New high-deductible plans can have a $2,000 deductible for maternity care plus require payment of 20% of hospital costs after the deductible is met. A woman with an unplanned pregnancy may have a policy that does not cover maternity at all. She would be at risk of serious indebtedness before her child is even born.

Many low income women are working at jobs that do not provide any health insurance or time off for medical appointments. Yet, a University of Pennsylvania School of Nursing study found that low income working women (italics ours) in one clinic spent an average of more than 3 ½ hours at each prenatal visit! MCC staff members repeatedly hear stories of employed uninsured women who leave their jobs to qualify for Medicaid.

There are few options for uninsured women, unless they are eligible for Medicaid. In Pennsylvania, pregnant women who are U.S. citizens with incomes up to 185% of the Federal Poverty Level can apply for Medicaid. A pilot program in Southeastern Pennsylvania has sought to decrease administrative barriers to care by allowing providers to enroll uninsured pregnant women in Medicaid and provide immediate care. Pennsylvania’s Medicaid income ceiling for pregnant women is higher than the Federal government requires, but 16 states have even higher income limits.

Uninsured women with income levels above 185% of the Federal Poverty Level are at risk for the entire cost of obstetric care. A very limited number of clinics in the five-county area will see these women for prenatal care and will aid them in making plans for delivery, either by helping them apply for emergency Medicaid (if they are eligible) or arranging extended payment plans for prenatal and hospital care. In many instances, families accrue large debts, or hospitals are left with unpaid bills.
CROSSROADS No. 2: ACCESS

UNEXPECTED ROADBLOCK: DISAPPEARING PROVIDERS
WHEN DOES 69 = 6?

In August 2005, MCC staff searched the websites of two Medicaid HMOs in Norristown. On one, we found 69 OB-GYN providers within a 5 mile radius of the Norristown zip code 19401. Further study revealed these 69 to be 38 individuals and 10 group practices. Of the 10 group practices listed, only 4 were still in existence and accepting patients. Of the 38 individuals, only six were still practicing in the Norristown community. Of these six, only two had correct contact information on the website. This exercise was repeated for the second Medicaid HMO with similar results.

Montgomery and Philadelphia counties use some Federal funds to pay for prenatal care for uninsurable/undocumented residents. Unfortunately, in both counties, these funds are inadequate to serve all the women in need of help. Last year, $175,000 was allocated in Philadelphia. In 2004, Montgomery County allocated $136,000, enabling an estimated 170 women (out of 440 eligible) to receive care.19

Insurance does not necessarily guarantee access. Although the payment rate for maternity services under Medicaid managed care does not differ substantially from the commercial rate, many private practices do not accept Medicaid. A few practices across our region have stopped participating in any insurance plan. Between 1999 and 2002, there was a net loss of almost one quarter of the sites accepting pregnant women with Medicaid.20

To serve women on Medicaid or uninsured:

- Philadelphia has a total of 25 free standing sites available, including City-run health centers and Federally Qualified Health Centers. The City also has ten hospital clinics that serve low income women.
- Montgomery County has three hospital clinics.
- Delaware County has two hospital clinics.
- Chester County has one hospital clinic. One social service agency and some private OB groups serve women on MA.
- Bucks County has four hospital clinics.

These limited options translate to long waiting times for appointments. MCC staff, sampling practices in the Norristown area in September 2005, found waiting times for initial prenatal appointments at clinics accepting Medicaid to be twice as long as in private offices. New patients would have to wait 4-6 weeks for a clinic appointment. Delay in recognition of pregnancy, combined with lack of available appointments, leads to delay in early prenatal care, including the initiation of folic acid and vitamins (supplements that require a physician prescription in the Medicaid program).

In Philadelphia, City Health Centers and Federally Qualified Health Centers struggle to meet their guidelines for scheduling new prenatal visits within two weeks, or sooner for women late in pregnancy. Actual waiting times varied by Health Center and showed significant improvement during 2005, decreasing from as long as 14 weeks in February 2005 to two weeks in September 2005. However, overburdened prenatal facilities find themselves forced to over-schedule, with women spending more time in the waiting room and less time face-to-face with their midwives. This naturally causes frustration all around. At one facility, in order to meet prompt scheduling guidelines, three midwives are frequently asked to see 65 women in one day, including 12 new prenatal patients, many of whom do not speak English.21

Along with a limited choice of providers, low income and uninsured pregnant women face other barriers to prenatal care. Many use public transportation, raising issues of cost, convenience, and time. Trips away from home may require childcare for older children. Spending 3 1/2 hours at a prenatal visit may not be possible if a school-age child has to be picked up or if work schedules are inflexible.

MATERNITY CARE IN THE CONTINUUM OF WOMEN’S HEALTHCARE

“Prevention measures to reduce maternal and infant mortality and to promote the health of all childbearing-aged women and their newborns should start before conception and continue through the postpartum period.

MORBIDITY AND MORTALITY WEEKLY REPORTS OCTOBER 1994

I can’t get follow-up medical care for an uninsured woman who gets emergency Medicaid just to pay for the delivery. I can’t follow up on her blood pressure or her positive TB test.

MIDWIFE PRACTICING IN PHILADELPHIA

> 14
Pregnancy and childbirth are only two possible events in the continuum of women’s healthcare during the childbearing years. Search “preconception counseling” on Google and 63,000 hits appear. Yet preconception healthcare is non-existent for many women. A recent article in the Journal of the American Medical Association noted that pregnancy presents an ideal time to screen young women for cardiovascular disease and diabetes, and to institute lifelong preventive measures. Unfortunately, few women without health insurance get regular healthcare prior to becoming pregnant, and they are unlikely to continue care following pregnancy.

Fifty percent of pregnancies are unintended, and, as discussed in the previous section, many pregnant women are uninsured in the year prior to becoming pregnant. At a time when they could really use routine health screening and information, these uninsured women rarely receive it. Prior to pregnancy, they need Pap smears, screening for sexually transmitted diseases, and preventive health counseling (e.g. risks of alcohol, tobacco and drug use). They may want advice about contraception or, if they are planning to conceive, they need to know the importance of taking vitamins and that folic acid helps prevent birth defects. Although family planning programs have filled some gaps in preventive care, future funding for this resource is uncertain.

Philadelphia Health Management Corporation data indicate that over 90% of women aged 18-39 in Southeastern Pennsylvania reported a Pap smear in the prior two years. For uninsured women of any age, this number drops to 81% in Philadelphia, Delaware, and Montgomery Counties and even lower, to 77% in Chester County and 68% in Bucks County.24

The Pennsylvania Department of Health reports that 53% of women aged 18-44 reported taking folic acid, but that percentages were higher (65%) for women with household incomes >$75,000 and lower (45%) for those with incomes between $15,000 and $25,000. Lack of health insurance means that women with chronic conditions – diabetes, high blood pressure, epilepsy, asthma, or lupus – already suffering medical consequences of being uninsured, find themselves subject to a higher risk of maternal death because of lack of access to care prior to becoming pregnant.25

Lack of health insurance also decreases a woman’s ability to continue to care for herself following the pregnancy. Failure to return for postpartum visits was reported by practitioners, MCC clients and managed care companies, although we have no local statistics to assess the seriousness of the problem or whether it is worsening.

To accommodate women in a timely fashion, we are double and triple booking. Women are waiting in the clinic to see us all afternoon.

MIDWIFE IN A COMMUNITY HEALTH CENTER

The high-risk clinic I had to go to was two bus rides from my house. That is hard when you have your kids with you.

ROUNDTABLE PARTICIPANT

Barriers to postpartum follow-up identified by our clients included lack of practitioner support during the birth. One MCC client said, after her birth experience, “Why would you go back to see someone who made you feel you had boxing gloves on?”

The same barriers that exist for prenatal care - lack of transportation, need for childcare, rigid work schedules - remain for postpartum visits. In addition, many women believe that prenatal care is only for the baby. They appreciate the importance of check-ups for the infant, but neglect their own postpartum care. If forced to choose between visits to a pediatrician, to the WIC office, or to their own provider, these women choose to get care for their children.

Postpartum visits are traditionally scheduled 42 days after childbirth. Women who receive Medicaid only because of the pregnancy lose their health insurance at 60 days postpartum. It’s often difficult to schedule an appointment within this time and there’s little chance to re-schedule a missed appointment.

Opportunities presented by the postpartum visit to engage and educate women in lifelong healthy behaviors, including diet/nutrition, exercise, maintaining a smoke-free home, safe sex, and contraception, are therefore lost. Comprehensive healthcare services – following up on high blood pressure, or pregnancy related diabetes – are completely out of reach. Although free family planning services are available, they may be offered at a different location from the family’s healthcare providers, necessitating yet another difficult-to-schedule appointment.
A Special Case: Depression

Over the past few years, high-profile cases have brought postpartum depression to the front page. For new mothers, for their friends, and for their midwives and physicians, it is not news that postpartum depression is real, and common.

“Not until I left the abusive relationship did I realize my depression was from the relationship, not the baby. The birth made me sad, and I thought it was the baby, but it was me feeling helpless.”

MCC STAFF MEMBER

For many women, the stress of the postpartum period serves to emphasize depression or anxieties that often existed before or during the pregnancy. And antepartum depression, while less well known, can be equally debilitating.

National studies have found an incidence of major postpartum depression from 8 - 20% (We don’t have local data.) Postpartum depression was originally a national health benchmark for Healthy People 2010. It was removed during the midpoint review in 2005 because there were few reliable data sources. Risk factors for depression include stressful life events during the pregnancy and low levels of social support.

Obstetricians and midwives have an increasing awareness of depression both during and after pregnancy. Some have begun to more closely monitor mental health factors, especially during postpartum care. Unfortunately, as noted above, many women do not return for postpartum care.

In MCC roundtables, women from all five counties and from all socio-economic levels noted the lack of adequate resources and insurance coverage for perinatal depression. They cited fragmentation – both private and Medicaid insurance systems separate physical and mental healthcare. And they found poor or no communication between physical and mental health practitioners.

Accessing services through either insurance system is difficult. With an overstressed community mental health system, women experience long waits for new appointments. Commercial managed care systems require a mother to call an 800-number to get an appointment, and the provider she’s referred to may not be trained or proficient in working with perinatal depression. While Southeastern Pennsylvania has many private practitioners specializing in this field, only a limited number of women can afford private treatment not covered by health insurance. Resources are especially limited for non-English speaking women.
we are faced with a critical decision. We can proceed down the road on which we now travel, with large numbers of women uninsured, and without secure access to lifelong health services, dependent on “safety net” providers whose funding sources are also insecure. Or...

We can choose to provide universal health insurance, guaranteeing every woman access to healthcare beginning before conception, through pregnancy, and postpartum.

WHILE SUPPORTING CITY, STATE, AND NATIONAL EFFORTS, WE SEE THE FOLLOWING INTERIM GOALS:

> Expand healthcare coverage for those who are currently uninsured or under-insured

**Action Steps:**
- Encourage support for governments, insurers and advocacy organizations that seek to expand or improve coverage for all unemployed and low income employed. Current efforts include the City of Philadelphia’s “Decent Health Care for All” project and the expansion of Adult Basic Coverage at the state level.
- Advocate to ensure that maternity care and reproductive services are included benefits in all insurance policies that are marketed in PA to women of childbearing age.
- Encourage Pennsylvania to develop ways of caring for undocumented residents. This includes looking at other state models like Illinois and California; using state Medicaid funds; maximizing the use of Federal Maternal and Child Health grants; and exploring the use of CHIP and/or State funds as a last resort.
- Support immigrant aid organizations that are educating the public and helping immigrants to achieve legal status and successfully integrate into our communities.
- Promote the establishment of adequate diagnostic and treatment services for maternal depression in order to secure the mother-child bond. Goals include improving recognition by healthcare practitioners, expanding multi-lingual and multi-cultural treatment services, and attracting funds for research to document prevalence and best practices.

> Improve the current systems to facilitate easier access and coordinated services

**Action Steps:**
- Encourage PA to extend the benefit period for Medicaid for pregnant women from 60 days postpartum to 12 months.
- Publicize the successful Medicaid presumptive eligibility program for pregnant women where entry into prenatal care is not delayed.
- Support the creation of a non-commercial guide to be maintained by the Department of Health’s Healthy Babies hotline listing maternity services statewide. Each entry will include insurance plans accepted, language capabilities, practitioners and disciplines, and hospital affiliations.
- Ensure that the Commonwealth’s Healthy Beginnings Plus program (a comprehensive package offered to eligible pregnant women under Medicaid that requires best practices and a standard of care) delivers the expected level of service.
- Ask the Department of Public Welfare to: Monitor Medicaid managed care contractors quarterly and confirm practices’ timely acceptance of new prenatal patients.
- Publish this information at least annually.
- Support efforts to improve communication between physical and behavioral health systems in commercially insured and Medicaid populations.
Our Region Suffers a Loss of Practitioners and Hospitals

Since 1997, although births in the five-county area have remained steady at approximately 50,000 per year, 13 Philadelphia and suburban hospitals have discontinued obstetric services.

This change is directly attributable to the new economics of healthcare and hospital services. Over the same period, additional forces, including malpractice insurance rates and changing workplace conditions, contributed to a perceived but difficult-to-document decrease in the number of physicians and midwives available to provide prenatal care and attend at births, as well as a decline in work satisfaction among these providers. We’ll take a closer look at these trends.

A LOSS OF OBSTETRICAL BEDS

From the perspective of health insurers, the Philadelphia metropolitan area in 1990 had an excess of hospital beds. Since then, many medical beds, and whole hospitals, have closed as numerous services moved to out-of-hospital settings. Labor and delivery, however, have largely remained hospital based. (A small number of women continue to have home births.)

Currently, women can deliver in one of 29 hospitals in the five-county area or at one of the two birth centers that are not within hospitals. But options for low income women are limited. For example, a major hospital system recently acquired a community hospital in Norristown, and plans are underway to move from downtown to a more suburban location. Poor families in Norristown will then have even fewer choices for care.

Obstetrics is no longer the gateway to lifelong loyalty to a hospital. Today’s referral patterns are determined by insurance contract agreements. Hospitals are confronted with the difficulty of meeting
I loved the doctor who was with me when I delivered my first baby. When I became pregnant again, I called her office and discovered she had limited her practice to gynecology.

PHILADELPHIA MOTHER, MCC FOCUS GROUP

There was consensus among our practitioner informants – physicians and midwives – that the number of obstetric practitioners in our area has decreased. However, this has been surprisingly hard to confirm. Professional organizations and state licensing agencies have accurate lists of members and licenses, but do not differentiate between practitioners who currently limit their work to teaching, or to outpatient gynecology, or to gynecology only. Our efforts to obtain accurate data indicate that the number of obstetrician-gynecologists who include childbirth in their practice in the five-county area is unknown. Indirect evidence gives cause for concern.

Pennsylvania started to collect this information with physician license renewals in 2005. Data from that effort show that 70% of Pennsylvania obstetricians and gynecologists practice obstetrics, and 7.3% planned to stop within 12 months. Statewide only 133 family practitioners include obstetrics in their practice, and 12% planned to stop within 12 months. It is not known how this compares to prior years because information was not available from either the state or professional societies.31

The number of graduating United States medical students choosing obstetrics and gynecology as a specialty has dropped by almost 50% since 1980. The number of residency training slots has declined slightly, but a higher proportion of these positions are filled by international medical graduates. Additionally, a higher percentage of ob-gyn residents are choosing to do sub-speciality fellowships in oncology or maternal-fetal medicine, contributing to an overall decline in the number of general obstetricians. The number of midwifery schools is declining nationwide, and midwifery training continues to face significant obstacles. There are 118 practicing certified nurse midwives in the five-county area. Of these, 85 are childbirth practitioners. Only 4.5% of local births are attended by midwives, compared to 9% nationally. Family medicine training programs in the five-county area continue to offer obstetrical experience, but few family physicians outside of teaching facilities include childbirth in their practice.

The effect of malpractice insurance rates is equally difficult to quantify. The Commonwealth of Pennsylvania, via the Mcare (Medical Care Availability and Reduction of Error) Abatement program designed to keep healthcare providers practicing in the state, is subsidizing malpractice coverage for physicians, obstetricians and midwives. MDs, OB/GYNs and midwives whose work includes childbirth receive 100% abatement. According to the 2003 American College of Obstetricians and Gynecologists Survey on Medical Liability, 12.5 percent of obstetricians and gynecologists in Pennsylvania have stopped practicing obstetrics and 57.5 percent have made some change in their practice because of issues with affordability or availability of liability coverage.34 However, we found conflicting estimates of the number of physicians who stop the practice of obstetrics as they move through their careers, irrespective of malpractice

...when [a nearby] hospital closed in 2004, women were laboring in our hospital halls.

HOSPITAL OFFICIAL, IN A KEY INFORMANT INTERVIEW

We have sometimes had to close our emergency room to pregnant women, diverting them to other hospitals, because our obstetrics and labor units were filled to capacity.

HOSPITAL PHYSICIAN, IN KEY INFORMANT INTERVIEW AFTER THE LARGE NUMBER OF ABRUPT OBSTETRICAL UNIT CLOSINGS IN 2004.

Patient volume has increased to out-of-control proportions, and our back-up hospital is not enthusiastic about taking new patients.

PRENATAL PROVIDER IN A NEIGHBORHOOD WHERE A HOSPITAL ANNOUNCED THE CLOSING OF ITS OBSTETRICAL UNIT

...when [a nearby] hospital closed in 2004, women were laboring in our hospital halls.
concerns. Malpractice coverage is also a concern of midwives because rates for their malpractice insurance (unlike those for physicians) do not change if the midwife eliminates childbirth from her practice. 35

In an effort to look at this issue in a balanced fashion, the Pew Charitable Trusts funded The Project on Medical Liability in Pennsylvania. 36 This research confirmed that malpractice insurance rates for obstetricians rose from $68,916 in 2000 to $134,335 in 2003 and have continued to rise. In addition, there is widespread discontent among Pennsylvania obstetricians - much more than in a national sample. Pew found that claims of a "physician exodus" from Pennsylvania due to rising liability costs are overstated, but the malpractice situation is having demonstrable effects on the supply of specialist physicians, which likely impinges upon patients’ access to care. The perception of malpractice as an issue does influence physician behavior. One third of Pennsylvania ob-gyn residents plan to leave the state after completing training because of malpractice insurance costs and the "litigation lottery." 37

The impact of a decreasing supply of practitioners and decreasing economic rewards for hospitals is greatest in areas of low income and high medical need. The City of Philadelphia has had difficulty attracting staff to its health clinics to offer patients a broader choice of practitioners and available appointments. Similarly, a health center in Norristown had to discontinue obstetrics when it had no physician back-up for its midwives.

CHANGING CONDITIONS FOR THE OBSTETRICAL WORKFORCE

It is no secret to policymakers or news media that there is widespread dissatisfaction among practitioners and patients with many aspects of our healthcare structure. Satisfied physicians have been shown to be more attentive to patients, to have patients who adhere to treatment better, and to have more satisfied patients. 38 The MCC Roundtables and interviews with key informants support findings of practitioner frustration. The combination of relatively low reimbursement for outpatient obstetrics and gynecology, combined with high malpractice insurance rates, has led most obstetricians in Southeastern Pennsylvania to become employees of hospitals or health systems. 39 These factors also create pressure to see more patients more quickly, leaving practitioners with less autonomy, less freedom to manage their own time, and less ability to plan day-to-day interactions - all factors closely related to physician job satisfaction. 40 Added to this, administrative burdens accompany the inevitability of seeing patients from multiple insurers, each with its own rules, paper-work, and billing and coding requirements. Covered services and ease of billing become determinants of care provided.

A second critical change in the obstetrical work environment has been the increase in women in the field. In 1999, 67% of residents in obstetrics and gynecology were female. Soon an overwhelming majority of practicing obstetricians will be female, and most midwives are female.

Women’s health activists in the 1970s did not foresee that the humanizing influence of women in medicine would lead to reluctance to embrace work hours that left them with less time for their own families. Residents in training now have an 80-hour work week requirement - considerably less than in the past. This combination of feminist values and more reasonable work expectations during training has led today’s medical students and residents to be less interested than their predecessors in becoming the workaholics 41 required to attend births 24/7, or to be on-call many nights and weekends. Many physicians, especially women, are choosing to work part-time, but are limited in their ability to do so because most malpractice insurance rates are not proportionally decreased.

Hospitals are looking for new models of care to accommodate the needs of obstetrics practitioners and the women for whom they care. One local hospital now employs midwives (who have not provided the prenatal care) solely to see and evaluate women who arrive in labor.
we see one route where decisions on provision and location of services are based on profitability; the malpractice insurance system fails to serve the needs of practitioners or childbearing families.

Another way considers regional healthcare needs, collecting statistics, assessing community needs and then providing services to meet those needs. This road has an adequate supply and distribution of practitioners who welcome the opportunity to provide professional assistance and support to all women preparing for and giving birth.

TO REACH THIS GOAL WE NEED:

> Maternal and child health policy based on sound data: consistent data collection, community input, and analysis in each county that allows all stakeholders to assess changing community needs.

**Action Steps:**
- Ask Pennsylvania to adopt and implement the National Model Birth Certificate that will establish consistent birth certificate data across the United States.
- Encourage Commonwealth and practitioner association efforts to accurately determine the number of active practitioners, their scope of practice, and their locations to facilitate obstetric services planning.
- Support Pennsylvania’s continued use of PRAMS, Pregnancy Risk Assessment Monitoring system, a national CDC surveillance project, to collect state specific information on maternal attitudes and experiences before, during, and shortly after pregnancy.
- Advocate that hospitals planning to relocate or close obstetric units be required to give 90-day notification to the PA Health Department and hold community hearings to provide sufficient time for families to make alternative care plans and to redistribute resources.

> A change in the climate that surrounds medical malpractice and obstetrics, including:

- Innovative approaches to medical liability that protect the consumer from serious medical mistakes but allow the resumption of trust in the practitioner/patient relationship.
- Availability of pro-rated malpractice insurance for physicians and midwives whose childbirth practice is only part-time.
- A no-fault way to secure lifelong healthcare for neurologically impaired infants (e.g. government funded pensions, or alternative solutions proposed in other states).

> Regional support of efforts to increase the supply of all childbirth practitioners and providers, especially those interested in serving low income or minority women.

**Action Steps:**
- Encourage racial and ethnic diversity in medicine, nursing, and midwifery to reflect the racial, cultural, and linguistic diversity of our population and offer positive internship and community service experiences in maternal and child health in multiple disciplines through mentoring programs and community organizations.
- Promote midwifery care.
- Train nursing assistants and other health workers as childbirth assistants/doulas.
- Include doulas and lactation consultants in health insurance coverage.
- Expand current statewide economic development/healthcare reform efforts to recruit nurses and nurse practitioners.
The Emergence of the *Doula*

More than many other developments, the emergence of doulas in the American birth experience speaks to the lack of support available from other caregivers. A birth doula is a trained labor support person who provides physical and emotional support to a woman and her partner.

Doulas are not new, but their numbers and roles have increased in proportion to the changing and more limited clinical roles of midwives and obstetricians in the delivery room. The only intervention that has consistently reduced rates of cesarean delivery in randomized controlled trials is the one-on-one support of a woman by a nurse, nurse-midwife, or doula, yet no health insurer pays the $200-$800 fee for doula services, including:

- explanation of medical procedures
- emotional support
- advice during pregnancy
- exercise and physical suggestions to make pregnancy more comfortable
- help with preparation of a birth plan
- massage and other non-pharmacological pain relief measures
- suggestions for labor and birth positions
- support that helps the partner to care for and encourage the laboring woman
- discouraging unnecessary interventions
- help with breastfeeding preparation and initiation
- written record of the birth

[www.childbirth.org/faq.html](http://www.childbirth.org/faq.html)

Women giving birth 25 years ago asked their obstetricians to provide supportive services like these (with the exception of the massage and the written record of the birth). Midwives have always offered them routinely as part of their job.
> Healthcare Inequities Persist Across the Region

Despite advances in improving the survival of premature babies, and despite excellent hospitals across our region, major maternal and child health inequities continue to exist. Using the goals of Healthy People 2010, “a statement of national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce these threats,” 42 we find that in our region, pregnant women are on different roads to those goals, and many are lagging far behind.

In the following section, we examine seven key indicators that we selected from the 29 maternal and child health objectives in Healthy People 2010. We use county level data when available, because statewide or regional data obscure key findings.

- Infant mortality
- Maternal mortality
- Early and adequate prenatal care
- Percent of low-birth-weight births
- Teen pregnancies
- Percent of low risk women having initial or repeat Cesarean sections
- Initiation and maintenance of breastfeeding
Nationally, Pennsylvania ranks 35th in infant mortality. Other comparable populous states, including New York, 13th, California, 7th, Illinois, 30th, and New Jersey, 10th, all do better. The inequities are flashing signs that command our attention: Black infant mortality is twice that of whites.

MATERNAL MORTALITY

HEALTHY PEOPLE 2010 GOAL: 3.3/100,000 live births

All Pennsylvania women: 9.6 /100,000 live births
Black Pennsylvania women: 25.1/100,000 live births
White Pennsylvania women: 6.3/100,000 live births

In the United States, in Pennsylvania, and in Southeastern Pennsylvania, the absolute numbers of maternal deaths are low. For the state as a whole, between 1999 and 2003, thankfully only 64 women’s deaths were classified as “maternal death.” Looking at Healthy People 2010 numbers, expressed as rates, it is important to remember that while disparities are present, the overall numbers are small.

Pregnancy related death shows the greatest racial disparity of all maternal and child health indicators, with mortality among African-American women 3-4 times that of white women. Twenty-nine developed nations have lower maternal mortality rates. Maternal mortality in Pennsylvania has increased among all women from the five-year period 1995-1999 to 1999-2003. The rate in black women rose from 19.5 to 25.1/100,000 women, and the rate in white women rose from 5.1 to 6.3/100,000 women. The absolute numbers during those five-year periods rose from 31 whites and 21 blacks to 37 whites and 25 blacks.

PRENATAL CARE

Healthy People 2010 has two goals for prenatal care: entering care in the first trimester and receiving care that is adequate.

GOAL FOR ENTRY IN THE FIRST TRIMESTER: 90%

Counties meeting/close to goal: Bucks 90.2%
Montgomery 88%

Counties not meeting goal: Chester, Delaware, Philadelphia

GOAL: Adequate prenatal care: 90%

Counties meeting goal: None

Range in 5-Counties: 56% to 69%

Assessing prenatal care is especially problematic. Looking at Medicaid births, we find discrepancies by data source. Information collected from birth certificates by Healthier Babies, Healthier Futures, a non-profit organization pooling data from Medicaid managed care (HealthChoices) in Southeastern Pennsylvania, found that between 65% and 73% of HealthChoices women received first trimester prenatal care. However, information collected by the same organization from intake forms completed at the time of visit and submitted by physicians to the managed

% PRENATAL CARE ENTRY IN 1ST TRIMESTER

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DEATHS PER 100,000

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RATE PER 1000 LIVE BIRTHS

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care plans indicated that only 38% of all HealthChoices women in the five counties had prenatal care in the first trimester. 48

A final source of information about the HealthChoices plans in Southeastern Pennsylvania is the HEDIS data available via the Commonwealth’s Office of Medicaid Programs. This data reports two other benchmarks: regular prenatal care and early prenatal care. The three Southeastern PA plans report regular prenatal care rates of between 39.7% and 58.6%. Unfortunately, two of the three plans’ rates are worse than half of the Medicaid managed care plans in the country, and the third is just above the 50th percentile mark.

At first glance, the numbers for “early” prenatal care appear better. However, the benchmark is either a prenatal visit in the first trimester or a visit within 42 days of enrolling in the managed care organization. Thus, a woman who does not obtain insurance or enroll until her 2nd or 3rd trimester will appear, by this standard, to have received “early” prenatal care. Even by this standard:

• Two of the three Southeastern PA plans, reporting rates of 63.5% and 68.5%, are worse than half of the Medicaid managed care plans in the country.

• The third plan, at 85.1%, is still below the 75th percentile of national plans.

In contrast, all three Medicaid managed care plans in the Pittsburgh area are above the 75th percentile.

The multiple methods of collecting and presenting the information - by county, by age, by insurance, by enrollment in health plans, by trimester, and by the definition of “adequate” care - can make the data seem confusing or contradictory. However, the conclusions are not confusing.

• Privately insured women are more likely to get prenatal care in the first trimester. The increasing numbers of uninsured women in the suburbs may explain the slight increase, between 1997 and 2003, in women who did not receive adequate prenatal care in Bucks, Chester, and Montgomery Counties.

• Teens have the lowest rates of entry into early prenatal care. (Many are not aware that they are pregnant until well into the second trimester).

• The racial differences are marked. In Philadelphia, Delaware, and Montgomery counties we find inadequate prenatal care among 18-22% of Asian and Hispanic women, 26% of African-American women, and 8-12% of white women.50

By whatever measures are used, we are not meeting Healthy People 2010 guidelines. Lack of insurance, ambivalence about the pregnancy, lack of timely appointments at available sites, and problems with transportation and childcare were all noted by Maternity Care Coalition consumers and staff members as reasons for delayed prenatal care.

In a study done through MCC, women reported a mean awareness of their own pregnancies of 1.9 months, and then faced waits of between 3 weeks and 14 weeks to obtain prenatal appointments.51 Under these conditions, even a woman who seeks early care can easily be in her second trimester before she receives it.

A SUBSET OF INADEQUATE CARE: NO PRENATAL CARE

“All unregistered births” - the number of women who give birth at a hospital without having previously registered and received prenatal care from an affiliated provider - are a marker of problems in the delivery of care to pregnant women.

• From 2001-2004, unregistered births at one university hospital rose from 8.6% of all births to 14% of all births.52

• At two other major hospitals, absolute numbers of women with either no prenatal care, or prenatal care elsewhere have risen, resulting in women delivering babies with no prenatal care records available.53

• 0.4% to 2.5% of women giving birth in the five-county area received no prenatal care in 2002 and 0.7 to 4.2% of all births in 2003 were to women who did not receive prenatal care.54

LOW BIRTH WEIGHT BABIES

Low birth weight is defined as under 5 pounds 8 ounces (2500 grams). Babies born under five pounds are often preterm and have a greater likelihood of serious medical problems.

HEALTHY PEOPLE 2010 GOAL: 5%

Counties in Southeastern Pennsylvania meeting goal: None55
In Pennsylvania, in Southeastern Pennsylvania, and nationally, low birth weight and preterm births have increased in the last ten years, with marked racial inequities in the distribution of these births.

- In all five counties, African-American women are twice as likely to give birth to low birth weight babies as white or Hispanic women.
- Age of the mother is a risk factor for low birth weight. Teen moms are at special risk of having a low birth weight baby: 1 out of 6 births to Asian teens in Philadelphia is LBW; 1 out of 8 births to Hispanic teens is LBW. In addition, women over 40 are at high risk. One out of 5 black women over 40 giving birth in Montgomery County has a low birth weight baby.

Racial differences in birth outcomes between black and white women persist even when socio-economic status is equivalent, and when education is equivalent. To look at causes of low birth weight, researchers have examined poverty, education, underlying health problems, healthcare delivery factors, individual health behaviors, the role of stress, and the impact of racism, but no definitive conclusions have emerged that would lead to corrective measures.

Advances in medical care have led to declining infant mortality due to improved survival of low birth weight and premature babies. Yet preterm and low birth weight babies who survive often have complex medical problems and developmental disabilities throughout childhood and adulthood. To address these challenges, parents must identify and mobilize extensive medical, educational, and especially financial resources.

**TEENAGE PREGNANCIES**

Healthy People 2010 defines teen pregnancies as those in girls between 15 and 17 years of age.

HEALTHY PEOPLE 2010 GOAL: 43/1000 pregnancies in females age 15-17

- Bucks County: 12.8/1000
- Chester County: 12.4/1000
- Delaware County: 20.2/1000
- Montgomery County: 12.2/1000
- Philadelphia County: 59.4/1000

Despite overall achievement, racial disparities persist:

- In Philadelphia, 9% of black mothers were under 18 and 4.5% of white mothers.
- In Montgomery County, 4.1% of black mothers and <1% of white mothers were under 18.
- In Delaware County, 8.6% of black mothers and 1.1% of white mothers were under 18.
- In Chester County, 7.2% of black mothers and 1.1% of white mothers were under 18.
- Bucks County does not report teen pregnancy statistics by race.

**CESAREAN BIRTHS**

Surgical/Cesarean birth, rather than normal vaginal delivery, increases risks to both the mother and child. Cesarean rates have been rising locally and nationally and are the subject of controversy in the medical, public health, and women’s health advocacy communities.

HEALTHY PEOPLE 2010 GOAL: Cesareans when women give birth the first time: 15%

Counties meeting goal: None

HEALTHY PEOPLE 2010 GOAL: Repeat Cesareans: 63%

Counties meeting goal: None

The numbers for the five Southeastern Pennsylvania counties are essentially the same as the statewide numbers:

- Cesareans for Pennsylvania women at first birth in 2003: 24%
- Repeat Cesareans for Pennsylvania women at subsequent births in 2003: 78.5%

While the number of births in our region has remained constant from 1990-2003:

- From 1990 to 1995 C-sections in all 5 counties declined and vaginal deliveries increased.
- From 1996 to 2003 C-sections in all 5 counties increased; vaginal deliveries decreased.
The Cesarean section rate continues to climb dramatically in our region and elsewhere, a consequence of social and medico-legal forces, including:

- Physicians hoping to reduce the risk of malpractice suits.
- Confusing debates about studies discussing complications of VBAC.
- Assertions subsequently refuted in the medical literature, that Cesarean sections have fewer overall lifelong complications than vaginal delivery.

In addition, the desire to plan the date and time of birth has led to more inductions, which in turn lead to more Cesarean sections than natural labor.

Yet a recent study using a new analytic approach confirmed that across the United States, there is enormous geographic variation in rates of Cesarean delivery, and that this variation is greatly influenced by non-medical factors such as the number of providers, the number of hospitals, and malpractice pressures. The study noted that regions with higher Cesarean rates perform these procedures in medically less-appropriate women – without seeing any improvement in maternal or neonatal mortality.

**BREASTFEEDING**

Although health benefits to both the mother and baby are well documented, and the American Academy of Pediatrics recommends exclusive breastfeeding for three months, nursing a baby is not the “default mode” of American mothers. Healthy People 2010 goals reflect three different indicators for the initiation and maintenance of breast-feeding:

**HEALTHY PEOPLE 2010 GOALS:**
- Breastfeeding initiated at birth: 75%
- Breastfeed exclusively for 3 months: 60%
- Breastfeeding at one year: 25%

For this goal, data is available for Philadelphia and for all other parts of Pennsylvania combined. We do not have county-level data for the other counties in our region.

**PHILADELPHIA:**
- Breastfeeding initiated at birth: 51%
- Breastfeed exclusively for 3 months: 24%
- Breastfeeding at one year: 10.5%

**PENNSYLVANIA EXCEPT PHILADELPHIA:**
- Breastfeeding initiated at birth: 61%
- Breastfeed exclusively for 3 months: 34.3%
- Breastfeeding at one year: 17.9%

Despite improved public education efforts by advocacy and professional groups, we are far from the Healthy People 2010 goals and have insufficient community support and education to move closer to the goal.

Philadelphia has a high percentage of African-American women, who have significantly lower rates of breastfeeding. But this does not completely explain the Philadelphia rate. Eight out of the ten U.S. cities with the highest African-American populations all have higher rates of breastfeeding than Philadelphia.

Improving breastfeeding rates requires support in hospitals at the time of birth, and ongoing support once the mother is home. Seven out of ten Philadelphia hospitals now have lactation consultants, an increase from four out of seventeen in 1998 and one of 19 in 1985. However, the number of staffed hours varies widely, and no hospital is able to meet the 24/7 needs of new mothers and their babies.
MCC clients reported getting varied, and different, advice regarding breastfeeding from the multitude of staff they met on an obstetrics floor, including nurses, nurses’ aides, physicians, physicians-in-training, and social workers.

All area hospitals offer free company-provided formula to each new mother before discharge. (At hospitals where this practice was eliminated, breastfeeding rates increased dramatically.)

Clients are looking for information on breastfeeding. Many of them want to breastfeed, but don’t know how. The ones that do, it’s because their mind was already made up. Younger clients are “not having it.” Their friends tell them it hurts, but often that was because they weren’t doing it right themselves.

Following discharge, many private health insurers cover postpartum home visits from a nurse, breast pumps, and phone consultations on lactation. The WIC program - Women, Infants, and Children - is a Federal nutritional supplement program for income eligible families administered by contracts with local agencies. In Southeastern Pennsylvania, the percentage of women eligible for the WIC program who initiate nursing in hospital has steadily risen in all five counties in the last 10 years, but the duration of nursing in weeks has not improved equally during the same period. WIC program data show that in Philadelphia, and statewide, breastfeeding initiation is well below the Healthy People 2010 goal of 75%.

Data from the WIC program is reflected in initiation rate and duration of breastfeeding by number of weeks. We do not have sufficient successes to report breastfeeding for three months or longer.

Breastfeeding, if initiated, is difficult to sustain for many mothers. Multiple economic and cultural influences in American society combine to produce low breastfeeding rates, especially among poor and minority women.

- Strong family supports and a tradition of breastfeeding encourage breastfeeding. Grandmothers and mothers who never breastfed discourage it. MCC staff members report that teenagers, particularly young African-American teenagers, find breastfeeding incompatible with their sexual self-image.

- Women who return to work early have difficulty maintaining breastfeeding. Few workplaces, even at high professional levels, provide private space and time to pump breast milk multiple times per day and then arrange a safe refrigerated location for storage. Juggling pumping and nursing requires a skilled and determined mother. She and her baby must be able to switch easily between bottles and breast. Maternity leave standards that require return to work at six weeks postpartum are almost incompatible with continuing to nurse unless the mother is very committed to breastfeeding.

- Lactation consultants, nurses, and midwives at multiple Philadelphia hospitals report that women uncomfortable with the physical aspects of nursing, or with initial difficulties in nursing, are using new highly effective breast pumps to pump breast milk but are not actually nursing their babies.
the choices are clear. One road veers off, widening the gap between rich and poor, and between whites and other racial groups. Without conscious intervention and change, this is the path of least resistance. The medical literature is full of research documenting how unconscious racist attitudes affect medical decision making every day.

The other way chooses to narrow and close this gap with active efforts to end inequities and reduce health outcome disparities based on race and income.

It provides every mother and child with an equal chance for a healthy start and a healthy life.

TO REACH THIS GOAL WE NEED:

- Recognition and heightened public awareness of Healthy People 2010 goals so that efforts to achieve these goals involve all sectors of our community.
  - Sufficient resources to develop solutions to Pennsylvania’s wide inequities in maternal and child health through the Office of Health Equity established by the Secretary of Health to improve the health status of disparate populations; statewide results evaluated and published annually.
  - Commitment by local leaders from the public and private sectors to address the social determinants of health – housing, employment, income, and education – recognizing that health disparities are rooted in societal inequities.
  - A reinvigorated statewide Healthy Mothers/Healthy Babies Coalition that will develop and implement a broad maternal and child health agenda. This group will evaluate the Commonwealth’s progress annually in meeting Healthy People goals.
  - Programs, both educational and service, that confront racism and poverty at multiple levels.
    - Community and advocacy groups working together to address knowledge and beliefs about health and illness as well as mistrust of the healthcare realm that is more prevalent in poor and minority communities.
  - Partnerships uniting health insurers, local healthcare institutions, and community service/advocacy agencies to develop innovative community based programs that will reach the most vulnerable pregnant women: those who are homeless, who are victims of domestic violence, or who have a mental illness or substance dependence.

- Research on healthcare inequities that seeks the most effective solutions
  - County and local officials taking responsibility for identifying “pockets of need” (geographic, cultural or medical) that may be missed by state or even county level statistics.
  - Further research to assess the quality of cultural competence training and more fully examine the biases that health professionals bring to their work.
  - A maternal and child health institute to engage researchers across a variety of disciplines including clinical medicine, public health, sociology, public policy, and gender studies to address the many unanswered questions regarding best practices in the field.
21st Century Medicine and Culture Shape the Childbirth Experience

We turn now from looking at the hard numbers of public health goals to examining the childbirth experience in 2006 and listening to the voices of women who attended our roundtables, who work with us in family advocacy, and who come to us for help. Discussions that began more than twenty-five years ago regarding the proper balance between technological innovation and excessive intervention into a natural process continue. Medical advances offer some women previously unavailable opportunities to bear healthy children, yet these advances have also led to a re-medicalization of childbirth.

The childbearing culture of the baby boomers may seem dated to young women today. The loud voices that equated power and control over women’s bodies with an emphasis on natural processes have quieted. Today some women equate control with the option to pick the date and time of birth by induction or Cesarean and seem to place no intrinsic value on a “natural” childbirth experience.

Advertising and commercialization have reached into medical and personal worlds in unforeseen ways. A Southeastern Pennsylvania woman offered her newborn son as a human billboard at auction on eBay. She agreed to make advertising “space” available on her child and accepted the bid to clad him in clothes advertising a casino. Welcome to childbirth in the modern marketplace.

How do women in our area describe their experience of pregnancy and childbirth? In the passages below, we focus on prenatal care and management of labor and delivery. We listened to women who spoke at our roundtables and to MCC’s MOMobile® staff, and we have placed their voices in a national context of maternity care practices and culture. Finally, we examine childbirth and the early stages of parenthood through the lens of early 21st century cultural trends.

WHY GET PRENATAL CARE?
To find out if there’s anything wrong with you or your baby, if there’s anything they could catch early they could help you with, help your baby with. It’s really more beneficial to your child than to you....
MCC CLIENT

The need for prenatal care, i.e. medical assessment during pregnancy, is probably one of the most widely known and accepted public health recommendations. Prenatal care has traditionally had three components:
• Assessment of the medical condition of mother and baby.

• Health promotion and education.

• Medical and psychological interventions to ensure a healthy mother and baby.

The fundamental structure of initial visit, monthly visits, and more frequent visits at the end of pregnancy have changed very little in the last 50 years, although procedures and testing have been added to incorporate new technology such as ultrasound, or the ability to test for diseases of the mother, such as diabetes or hepatitis. Recently, in the public and community health fields, researchers are asking new questions about prenatal care:

• Is the traditional approach to prenatal care the best way to improve outcomes?


• How can prenatal care be tailored to meet the different needs of individuals as well as diverse populations of women?

Given the multiple demands on prenatal care, our Crossroads participants’ diverse views are not surprising. Midwives at our roundtables spoke of frustration at decreased time for education and counseling, and an inability to impact the societal problems affecting their patients. Prenatal programs that provide comprehensive social service supports, such as Healthy Beginnings Plus, no longer function as they were intended because of lack of time, personnel, and sufficient reimbursement.

Healthy Start, a Federal program, has been beneficial in supplying funds to educate the community about maternal and child health, but does not reach all eligible women. There are four Healthy Start programs in our region, and each is limited to a specific geographic area. While this effort has enabled some women to receive intensive case management, the needs of mothers and babies in many communities are still unmet.

Time constraints and care fragmentation weaken the bond between a pregnant woman and her practitioner, and consequently decrease the power of that bond to help a woman care for herself in pregnancy and labor. The prenatal care clinic at a major university hospital in Philadelphia has recently abandoned its routine of providers seeing the same patients throughout pregnancy, and replaced it with an assembly-line approach, in order to improve the efficiency of providers’ time. This discounts the most powerful therapy that physicians and midwives have – the power of their relationship with patients.

Maternity Care Coalition’s clients overwhelmingly view the purpose of prenatal care as ensuring the health of the baby, rather than supporting the health of the mother. This makes sense in the context of repeated messages in the media that discount the health of the mother and view her as a vehicle for carrying the unborn child.

Unfortunately, this view may make women less interested in prenatal care as preparation for the birth experience, or less receptive to prenatal care as a foundation for lifelong healthcare. The medical model convinces them from the start that technology is the answer to prenatal health, rather than attention to their own health and behaviors. And increased use of technology has become the gold standard. MCC staffers report that clients often think a friend who has had more ultrasounds is getting better care - not considering that the friend might be having a more difficult pregnancy.

Insured women seeing private practitioners view prenatal care as an opportunity to get answers to questions regarding pregnancy and birth, and to be reassured about the healthy progress of the pregnancy. For many women with access to the Internet, online information and bulletin boards supply an extensive catalog of information and anecdotes supplanting some of the functions previously served by prenatal care education.

Seeking to change the low rates of entry into early prenatal care, and the low rates of adequate prenatal care described in the previous section, local healthcare providers and insurers have tried different approaches. One Medicaid Managed Care company, using a standard disease-management approach, contracted with out-of-state nurses to provide case management by telephone. Not surprisingly, they had difficulty engaging high risk women, many of whom move frequently or are without telephone service. Other cities have had success with alternative models, using existing community organizations to provide peer support and outreach.

Simply getting a woman to prenatal care may not be enough, unless the care is focused on the needs of the specific woman and her prenatal risk factors. The American College of Obstetrics & Gynecology (ACOG) recently issued a Committee Opinion recommending that physicians conduct psychosocial screening of all women. “Because problems may arise during the pregnancy that were not present at the initial visit, it is best to perform psychosocial screening at least once each trimester to increase the likelihood of identifying important issues (e.g. barriers to care, unstable housing, unintended pregnancy, communication barriers, poor nutrition, tobacco use, substance use, depression, lack of safety, intimate partner violence and stress) and reducing poor birth outcomes.”

In addition, several area health centers have initiated “Centering Pregnancy,” a new model of prenatal care based on group participation and empowerment, in an effort to more fully involve women in their care and to better use the time available to midwives and mothers.
NATURE VERSUS INTERVENTION: FINDING THE PROPER BALANCE

Women don’t know about their bodies or the birth process, but they do know the word epidural.

ROUNDTABLE PARTICIPANT

I do birth plans with my clients. Most want a natural birth but don’t have enough support in the delivery room.

MCC STAFF MEMBER

I’m seeing women who are scheduling a Cesarean section so they can have a baby the week their mother can take off and help them. They don’t really understand what they are agreeing to, and they are not fully informed about the possibility, that they won’t be able to have future vaginal births.

MCC STAFF MEMBER

I’ve counseled women who were afraid to deliver in the hospital. [In the past] they had been left alone, without support. Doctors talked about them as if they were not there. These clients were scared that if they spoke up, treatment would get worse. But overall the speaking up made it better.

MCC STAFF MEMBER

Despite the fact that the vast majority of pregnancies and births are healthy events, trends in medicine and technology have once again propelled us to a model of labor and birth as a sickness needing medical intervention. Valuable new medical techniques, including those for treating infertility, for diagnosing fetal malformations during pregnancy, and for managing complicated pregnancies in women with underlying illnesses, represent significant advances. They also contribute to a healthcare climate that considers all pregnancies and deliveries as complex medical problems. This disease model, in contrast to a wellness model, has consequences for the labor and delivery experience.

If childbirth is a medical event, practitioners and women look toward medical solutions for management of labor, even if non-medical solutions may offer a chance for equal or better outcomes. In obstetrics as in many other medical fields, physicians do not always use the best available evidence, or, if the best practice is not clear, they do not always offer women objective discussions of all available options. Examples in the following passages examine three aspects of labor and delivery: pain management, electronic fetal monitoring, and episiotomy.

Pain In Labor

In the United States, anesthesiologists—doctors who put people to sleep during surgery—have become our experts in pain control. In my hospital, the first doctor a woman in labor meets is the anesthesiologist, who gives her a warm welcome and assures her she’ll be back soon to take away the pain. Anesthesiologists are not interested in, and do not profit from, non-drug means of pain control.

OBSTETRICIAN, SPEAKING ABOUT CURRENT CHILDBIRTH PRACTICE

Women now demand to have multiple choices in their childbirth experiences, and have the right to choose a pain-free birth. Also, in this society, people now clamor for a pain-free existence and are seduced by the wonders of technology.

BILL MCCOOL, CNM, AT MCC CONFERENCE STAKEHOLDERS SPEAK, MARCH 8 2005

The natural/prepared childbirth movement in the 1960s and 1970s was in part a reaction to an earlier practice—the use of scopolamine. This drug, a type of anesthesia, was known as “twilight sleep.” Women who took it felt pain during labor, but didn’t remember it, and maternity hospitals were filled with sedated women screaming in pain.

Lamaze and other breathing techniques, and childbirth preparation classes allowed women to give birth fully awake, conscious, and in control—but not pain free. Childbirth was hard, but women met the challenge. Managing labor pain with breathing, massage, and support from family and midwives/doctor/nurses resulted in a birth that was both natural and triumphant. Although birth was difficult, a woman could overcome fear, manage pain and go home with a child born without pre-birth exposure to medication. Many women describe childbirth like this as a profound physical and emotional experience.

In 2006, an epidural—a mode of anesthesia where medication is injected into a space around the spinal cord—has become the default option for pain control in labor. The pendulum has swung away from natural/prepared childbirth and toward epidurals as the answer to the understandable fear of pain during labor and delivery.

In this country, most physicians and nurses are not trained in non-medical approaches to labor pain. Epidurals require the presence of an anesthesiologist, they require specific monitoring during labor, and they immediately transfer the control of pain, and much of labor, to the physician and away from the woman. Epidurals are very effective. Women have less pain, but they also have a more “medical” experience.
It has been clearly shown that the main determinants of the kind of pain relief offered to women are the professional training of the principal caregiver (midwife, family physician, obstetrician), the practices and beliefs of other healthcare personnel (nurses, anesthesia department), and the size of the hospital and whether or not it is a tertiary care center.79

Childbirth Connection, an advocacy group in New York (formerly known as the Maternity Center Association) looked at the issue of pain control in labor as part of its larger project to promote evidence-based practice in maternity care. An extensive discussion of this topic, along with references, is available on their website.80 Their research indicates that in the United States, pregnant women in labor have more restricted choices for pain control than women in Europe.81 Proponents of epidurals acknowledge that they may lengthen the pushing phase of labor, but are still there, as we heard in our Roundtables.

Electronic Fetal Monitoring

Electronic fetal monitoring (EFM) is a prime example of a technology that came into almost universal use, and stayed, despite its unproven benefits and known side effects. Its presence has contributed greatly to the view of labor and childbirth as processes that require technology.

EFM was introduced in the 1970s without scientific validation. All good medical studies of EFM show that it leads to a higher rate of interventions into the natural birth process and to increased Cesarean sections. It has not been shown to change perinatal deaths, Apgar scores (a measure of infant health immediately after birth), admission of infants to intensive care units, or incidence of cerebral palsy.83 On all these measures, it has not been shown to be better than intermittently listening with a stethoscope to the fetal heart.

The increased use of electronic fetal monitoring and the false belief that it can prevent the problems of neurologically impaired newborns has actually increased the number of malpractice suits.84 EFM is one of several labor practices in frequent use in American hospitals, despite World Health Organization recommendations against them, and medical evidence that most mothers do not need them.85

Episiotomy

Episiotomy is a surgical incision made to widen the vaginal opening for delivery. It was rarely used when most deliveries were done by midwives at home, but two prominent obstetricians, writing between 1918-1920, touted its necessity to preserve the pelvic floor functions. It then became widely used by obstetricians in hospitals.86 The unproven scientific belief that it improved sexual function, urinary function, and delivery remained unchallenged, although midwives continued to use natural stretching, oils, and massage to ease the path of the oncoming head.

In the early 1980s a study appeared questioning whether scientific evidence existed to support the practice of episiotomy, and its use declined. In 1979, the episiotomy rate in the United States was 65.3%; it decreased to 38.6% by 1997, with higher rates among white women and women with private insurance.87

In a recent study from a large teaching hospital in Pittsburgh, 55% of women who delivered between 1995 and 2000 received episiotomies. Confirming other data, the study found that white educated women with private insurance were more likely to get an episiotomy.

What are the lessons of this story?

Episiotomies were performed for many years without adequate medical evidence to support their use. A combination of pressure from women’s health advocates, an increase in female obstetricians, and medical studies demonstrating lack of benefit and potential harm has brought the rate of episiotomies down. Their disproportionate use in white insured women shows that unconscious physician beliefs and attitudes play a role in the care patients receive. In this case black uninsured women (often treated by residents in training) received better care as supported by medical evidence.88 These conclusions offer the possibility that newer, younger physicians will no longer consider episiotomies a standard of practice. Just this year, the American College of Obstetricians and Gynecologists issued an official recommendation against episiotomies.89
The episiotomy story demonstrates the difficulties of changing physician beliefs and practice even in the face of evidence. Many women’s health advocates are concerned that similar patterns of belief unsubstantiated by evidence are being followed with regard to indications for Cesarean section and electronic fetal monitoring. Childbirth Connection, in New York, has taken the lead in promoting evidence based childbirth.90

OVERALL IMPACT OF “MEDICALIZATION”

The medicalization of childbirth has had many consequences for the birth experience.

Although hospitals now have some “home-like” birth environments, these cosmetic changes obscure the continuing emphasis on technology. Twenty-five years ago, childbirth advocates and midwives called for out-of-hospital birth centers. Medical studies and reviews continue to show that out-of-hospital birth centers are associated with lower rates of intervention and complications.91 And these results are not all due to selection bias (the idea that only lower risk women go to birth centers). Over the years, a number of birth centers have opened and closed in our region. The two that remain are closely connected with hospitals and are able to accommodate only a limited number of births.

Of course out-of-hospital birth centers will never be appropriate for all women. But the promotion of worry, the emphasis on catastrophes, and the fear of malpractice has served to limit their availability as a choice to women in our area.

Midwifery care, standard for low risk women in many European countries, is misunderstood or falsely perceived to be second-class care here in the United States. Midwives, highly trained professionals who offer individualized care within a model that views childbirth as a normal process, face opposition to their practice from obstetricians and hospitals. Many women reject midwifery care without a full understanding of its standards and benefits. Ironically, in Southeastern Pennsylvania and nationally, two very different populations receive midwifery care: low income women at community health centers, where midwives are often caring for high risk women, and high income well-educated women actively seeking a powerful birth experience with limited intervention.

WHERE ARE THE VOICES OF WOMEN?

Over and over, as we listened to women, they asked to be respected for who they are and the choices they need to make.

Our Roundtables told us:

Today’s pregnant woman wants a place to give birth that is safe and welcoming. She wants to be treated with respect, to know what is happening with her body and what her options are in terms of care. But we have also learned that conditions of economics, of racism, of language and culture bring different expectations and yield different experiences.

Women want to be involved in decision making, and we believe this is an important component of patient satisfaction. For women who have had few choices in their lives, the ability to learn about their pregnancy and make decisions about the birth can be an empowering experience. Decreased time for education at prenatal visits keeps a woman from fully understanding her choices, such as ultrasound, genetic testing, type of anesthesia, and consequences of a Cesarean section. Further “efficiency” moves each choice in the direction of the healthcare provider. A mother asking to be free from pain does not necessarily mean she wants an epidural, but a physician with no training in other approaches interprets her request as such.

Women want explanations in language they can understand. Consumers consistently noted that “procedures were not explained well,” and there was “not enough communication in laymen’s terms.” Childbirth classes, held separately from prenatal appointments, are not available to all women because of time and transportation constraints, and are more likely to be attended by white middle class women than by black or poor women.92

Women want, and need, support that goes beyond traditional healthcare concerns. MCC staffers report that clients routinely request many kinds of help, including locating housing, transportation, dental care, and food stamps.

Women want to see the same practitioner at each prenatal visit, “so she would know my history and come to understand me.”93 Yet changes in the structure of medicine now favor large practices and less personal care, even for more affluent women with excellent insurance coverage. A woman today is less likely to have a personal relationship with her obstetrician or midwife, and less likely to know the person who assists in the delivery of her baby, than 20 years ago. This is a result both of dissociation of prenatal care from delivery, but also of larger on-call groups that offer midwives and physicians a more sane life, but make it less likely that the person on duty when a woman goes into labor is someone with whom she has an ongoing relationship.

Women want support from caregivers, including office staff, and commented on the lack of it. They noted “nasty” billing personnel, and rude staff who intimidated non-native English speakers.

It is clear that the strain of medical practice today is felt by healthcare providers and support personnel. Receptionists, billing staff, nursing assistants and others often find it impossible to function as the friendly supporters to pregnant women that they would like to be.
THE CULTURE OF CHILDBIRTH

Families, friends, ethnic traditions, the medical world, and cultural trends in society all contribute to the experience of childbirth. Many women report childbirth as a peak emotional experience, using words like awe-inspiring, a true miracle. Yet in addition to the medical forces described above, cultural forces in our society may be dampening the joys of the experience.

Today, we are far removed from the consumer-driven women’s health movement of the 1970s and 80s. Women seem resigned to choosing among existing alternatives – community hospitals or university hospitals; midwives or obstetricians; early or late epidurals – rather than trying to change the choices available.

A generation of women raised with ubiquitous electronics – from computers to cell phones to assisted reproductive technology – accepts modern medical procedures with less skepticism than their mothers 25 - 30 years ago. Women today than those that confronted their mothers 25 - 30 years ago. Challenges and decisions for childbearing have been redefined by some women to mean their attempt at total control over the birth process, including choosing the timing of delivery and the right to choose a Cesarean section. There is active debate in the medical literature over 1) the ethical implications of performing an operation that is not medically indicated, simply because a woman requests it and 2) how practitioners should counsel women about a medically unnecessary surgical delivery. One physician has asked whether informed consent for such a procedure truly discusses the “joy, power, and transformative nature of vaginal birth.”

Breastfeeding is still not the norm in our culture, but rather something that must be actively chosen. The dismal Healthy People 2010 numbers must be seen in the context of culture and society. Women have been slow to accept the recommendation to breastfeed. Families, cities and workplaces do not view nursing a child as an integral part of life.

It is clear that cultural changes have led to a far different set of influences, challenges and decisions for childbearing women today than those that confronted their mothers 25 - 30 years ago.

The concept of reproductive choice has been redefined by some women to mean their attempt at total control over the birth process, including choosing the timing of delivery and the right to choose a Cesarean section. There is active debate in the medical literature over 1) the ethical implications of performing an operation that is not medically indicated, simply because a woman requests it and 2) how practitioners should counsel women about a medically unnecessary surgical delivery. One physician has asked whether informed consent for such a procedure truly discusses the “joy, power, and transformative nature of vaginal birth.”

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It is clear that cultural changes have led to a far different set of influences, challenges and decisions for childbearing women today than those that confronted their mothers 25 - 30 years ago.
we echo this young student’s voice - “if they don’t feel comfortable, they are not going to want the help.” Here, several routes intersect and diverge. We can choose the thoroughfare where birth is seen as a medical condition, separated from home and family. On this road, there are many opportunities for women to have a safe and healthy childbearing experience, and many technological advances.

But we can also choose a way that intersects the first, appreciating its safety, yet taking a turn that emphasizes the normal in childbirth, and places childbearing in its natural context of family and life cycle. We can continue to learn what makes different women comfortable. We can use that understanding to help create a society that values pregnancy, childbirth, and the bonds formed in infancy as the building blocks of a healthy lifelong relationship.

TO REACH OUR GOAL WE NEED:

- Birth environments that help women experience the joy and transforming power of childbirth as “full participants within a climate of confidence that reinforces strength and power and minimizes fear.”
  - A full range of “high tech and high touch” options, following the best medical evidence about safety and effectiveness, available to all women.
  - Birth plans with goals, offering comprehensive options and designed to engage women and their families, as a standard of care for all.

- A culture that supports children and families and values parents.
  - Access for all families to parent education and support, especially in early infancy, a critical period for attachment and child development.
  - Communities that acknowledge and celebrate every new child in a variety of ways: family-centered and culturally sensitive approaches to birthing and infant care that include mothers, fathers, grandparents, aunts, uncles, siblings, cousins, and friends as networks of support.

- Public and private sector policies that recognize the importance of time for parental leave, flexible work schedules, and other family-friendly practices.
  - Sufficient financial support for adequate childcare in all communities.
  - Special support for families of premature babies immediately after the birth and during the first several years.

- An improved local environment for breastfeeding mothers and babies.
  - Widely available support that includes an adequate number of lactation consultants at hospitals, in-home visits after discharge and continuing education programs for practitioners.
  - Increased emphasis on breastfeeding by WIC, with sufficient funding to serve all eligible families in each county and new approaches for mothers who are difficult to reach.
  - Regional support for programs that highlight breastfeeding-friendly communities and workplaces.
  - The World Health Organization “Baby Friendly Hospital” designation as a model of care for hospitals in our region.
  - Workplace policies that provide time and space for nursing mothers to use breast pumps and store milk.
Conclusion

This report has looked at maternity care in our region from the perspective of pregnant women and advocates, doctors and hospitals, nurses and midwives, doulas and lactation consultants, and local and state government agencies. Based on what we’ve learned, we certainly agree that there are widely differing practices for care during childbirth and widely different experiences for different women.

But we cannot agree that paying attention to each woman’s personal childbirth experience, seeking to minimize negative health consequences, and recognizing that costs and resources must always play a role, will naturally lead to conflicts.

We see many areas for common ground, requiring collaborative efforts among healthcare providers, community organizations, philanthropic institutions, health insurers, all levels of government, and the business community. We can agree that addressing health disparities and social inequities will result in an improved experience for all. We can agree that every person should have health insurance, and we can work together to achieve that in a manner that efficiently uses available resources.

We can agree that every pregnant woman deserves to be treated with respect, and work to achieve that throughout the healthcare universe. We can agree that just because a woman looks different, speaks a different language, or has more or less money is not a reason that she and her child should be at higher risk for death, injury or illness. We can agree that our region needs an adequate number and distribution of obstetrical providers. And we can agree that a positive childbirth experience, when parents first see a new baby and fall in love, is a desirable goal.

As we stand at the crossroads, we believe that our region has the resources to choose a new way ahead, based on the wisdom and vision collected in this report. We look forward to working with those who join us on the journey.

FROM THE PENNSYLVANIA HEALTHCARE COST CONTAINMENT COUNCIL:

Delivery of appropriate maternity care is a very complex issue. Women who receive care, professionals who provide care and those who pay for care all want that care to be safe, effective and cost efficient. But, there is much less agreement about how best to deliver appropriate care.

While some stakeholders give priority to each woman’s personal childbirth experience, others aim to minimize the occurrence of negative health consequences in the baby despite a potential increase in the mother’s risk or discomfort. Still others, concerned with rising costs of care and the limited resources available, consider efficiency to be the most important objective. The diversity of goals and priorities results in widely differing practices for care during childbirth.
Notes


2 2003 represents latest available data for this section.

3 Personal communication to Gene Bishop MD from Office of Medical Assistance Programs

4 Low income is <200% of Federal Poverty Level

5 Philadelphia Health Management Corporation

6 Information accessed at www.marchofdimes.com/peristats


9 Kaiser Family Foundation Women’s Health Policy Fact Sheet November 2004. Available at http://www.kff.org

10 Philadelphia Health Management Corporation 2004 Household Survey

11 Philadelphia Health Management Corporation 2004 Household Survey


13 Bryer, Pamela letter to the editor, Philadelphia Inquirer July 20, 2005

14 www.aetna.com accessed August 2005

15 United Health Group Golden Rule plan; no maternity coverage www.ehealthinsurance.com accessed August 2005


17 Or those who fall into some special immigration categories

18 In 2006, for a pregnant woman without children, annual income ceiling is $24,420

19 Personal communication to MCC, from Montgomery County Health Department

20 Data from Healthier Babies Healthier Futures, Inc. summer update 2003 - most recent available. Healthier Babies has since disbanded. Medicaid HMO websites are not accurate sources for tabulating actual sites because of duplications and inaccuracies.

21 Key informant interview

22 Kaaja RJ, Greer I. Manifestations of chronic disease during pregnancy. JAMA 2005; 294: 2751-2757


24 Philadelphia Health Management Corporation 2004 Household Health Survey


29 Key informant interview, Hospital administrator

30 Guadagnino, C. Obstetrician scarcity in Pennsylvania Physicians News Digest May 2004

31 If we look at the 5-county hospitals by this standard, no hospital in Bucks County has 2000 deliveries; no hospital in Chester County has 2000 deliveries. In Delaware County, one hospital has almost 2000 deliveries. In Montgomery County, 4 hospitals have close to or more than 2000 deliveries but four others have <1000. In Philadelphia, four hospitals had fewer than 2000 deliveries in 2003-04. One of these closed June 2006. Source: http://www.dsf.health.state.pa.us/health/health/facilities/hosambl/2003-2004/REP1A.PDF

32 Phone calls were made to the local chapters of the American College of Obstetrics and Gynecology, to the Pennsylvania Medical Society, the Pennsylvania Association of Family Physicians, and to the PA Department of State, Bureau of Professional and Occupational Affairs.

33 Data from 2005 license renewals obtained by personal communication with Ann Honebrink, MD. This data is only recently available. During initial data collection for this project, phone calls were made to potential local and state sources of information. (See note 32.) None of these organizations had accurate information.

34 Guadagnino, C. Obstetrician scarcity in Pennsylvania Physicians News Digest May 2004

35 Midwife data obtained from Vivian Lowenstein, CNM, President Southeastern Pennsylvania chapter American College of Nurse-Midwives Fall 2005

36 This project and its papers can be accessed at http://www.pewtrusts.org Conclusions mentioned here are from papers available at this site, and published as part of this project unless otherwise cited.


39 Key informant interview

40 Mello M. et al. See citation 37.

41 Friedman, Alexander MD. Wanted: Workaholics to become Obstetricians. New York Times August 9, 2005

42 http://www.cdc.gov/nchs/aboutotheract/hpdata2010/abouthp.htm

43 As noted elsewhere in this report, from 18.1/1000 in 1980 to 10.5 in 2002

44 Annie E. Casey Foundation state level data. Accessed at http://www.aecf.org/kidscoun/sid/compare_results.jsp?is=70

45 The definition of maternal mortality is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes. Maternal mortality numbers are statewide because smaller numbers preclude meaningful data analysis by counties.

As determined by the Kotelchuck index, an accepted standard that combines early entry and continued participation.

Data received by MCC request from Healthier Babies Healthier Futures, November 2004.

Health Plan Employer Data and Information Set, a national managed care standard. Information available at http://www.dpw.state.pa.us/omap/hcnc/omaphcmci.asp.

All data from www.marchofdimes.com/peristats. Numbers are averaged among counties and may be slightly higher or lower for each group in each county.

Wieder, Devorah, Documenting obstacles to obstetric care utilization among Medicaid recipients in Southeastern Pennsylvania: A Patient Centered Perspective. MPH candidate student project done in conjunction with Maternity Care Coalition.

Data presented by Ann Honebrink, MD at MCC Childbirth at a Crossroads conference March 8, 2005.

Data presented by Ann Honebrink, MD at MCC Childbirth at a Crossroads conference March 8, 2005.

Bureau of Health Statistics and Research, PA Department of Health, PA Birth Certificate Dataset.

Bucks County does not have sufficient African-American population to make statistical comparisons valid.

Quoting national statistics and definitions. Low birth weight babies are defined as less than 2500 grams, and preterm infants are defined as those born at less than 37 weeks gestation. The terms are not interchangeable. It is possible to have a preterm baby with adequate weight, or a term baby of low weight. However, there is a great deal of overlap, and for the purposes of this report, similar known (or unknown) causes. Definitions from Iams, J. Preterm Birth. In: Gabbe: Obstetrics - Normal and Problem Pregnancies, 4th ed., 2002 Churchill Livingstone, Inc. Pages 755-757 Pennsylvania statistics available at http://www.dsfs.state.pa.us/health/cwp/view.asp?a=1758Q=228721&healthRN=rad2F756=1.


Data from 2004 national immunization survey www.cdc.gov/breastfeeding.

Philadelphia is not one of the top ten cities in percentage of African-American population. But seven of those ten cities have higher breast feeding initiation rates than Philadelphia.

Data from 2004 national immunization survey www.cdc.gov/breastfeeding.

WIC data supplied by Cindy Maki of PA Department of Health.

Key informant interview.

Data from PA Department of Health correspondence, 2005 to MCC.


Reports to MCC from lactation consultants at area hospitals.


“Newborn to be a casino billboard” Philadelphia Inquirer June 1, 2005. written by Amy S. Rosenberg.

Key informant interview.

Center for Health Care Strategies conference call transcript 6/27/2005. Joseph Stankaitis, MD, Chief Medical Officer of Monroe Plan for Medical Care in Rochester NY. Dr. Stankaitis noted that the multiple risk factors identified by his plan included lack of a high school education, poverty, frequent moves including at least once in the prior year to pregnancy, inability to afford needed food, needing transportation but inability to get it, and chronic medical conditions. Link: CHCS Network Exchange call Summary: Strategies for Improving Birth Outcomes in Medicaid Managed Care.


Marmor T, Krol D, op.cit.
86 The episiotomy story is well summarized in Scott JR. Episiotomy and Vaginal Trauma. Obstetrics and Gynecology clinics 32(2) June 2005.


90 www.childbirthconnection.org


93 MCC Women’s Voices


98 For a fuller discussion of a recent NIH conference on this topic, see the website, www.childbirthconnection.org

Key Informants

We are grateful to the many individuals and groups that enriched our understanding of issues. Informants are identified by their organizational affiliations at the time of the interview.

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- MCC’s Breastfeeding Advisory Committee
- Attendees at MCC’s March 2005 Conference, Childbirth at a Crossroads
- La Leche League Members
- Nurses, Doulas and Midwives
- Pregnant and Postpartum Women

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- Philadelphia Interdisciplinary Mortality Review
- PA Child Death Review
- PA Welfare Coalition
- Montgomery County Infant Health Advisory Board
- Covering Kids and Families Coalition

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