Early Prenatal Care is one of twelve Maternal and Child Health (MCH) **Standardized Measures (SMs)** for the Title V MCH Services Block Grant to States Program. This SM is focused on increasing the percent of pregnant women* who receive prenatal care beginning in the first trimester.

For Early Prenatal Care there are 15 evidence-based strategies from MCHbest and 3 field-based practices from Innovation Hub (see page 3)

The **What Works Evidence Accelerators** provide background information and a summary of effective strategies to advance each of the SM topic areas. These strategies support increased access to and utilization of early and adequate prenatal care beginning in the first trimester to improve pregnancy outcomes.

Overview.

Early and regular prenatal care is important for preventing and responding to health concerns and delivering healthy infants. Prenatal care, or the health care received during pregnancy, should start as early as possible, and ideally within the first trimester or first 12 weeks of pregnancy.[1] Prenatal care consists of regular checkups, screening, and monitoring for pregnancy risks.[1] Health care providers should also offer counseling and education for healthy pregnancy and postpartum behaviors and manage any illnesses or complications that may arise.

Prenatal care can help prevent or minimize complications from pregnancy risks, such as hypertension, anemia, infections, depression, and gestational diabetes, which can lead to preterm birth, low birthweight infants, malnutrition, and even death.[1] Improved birth weight and decreased preterm delivery are two of the most significant benefits of early and ongoing utilization of prenatal care.[2] Research has found that infants whose mothers had no prenatal care are three times more likely to be born with a low birth weight and five times more likely to die than infants born to mothers who had early prenatal care.[2,3]

In 2021, 78.3% of all pregnant women in the U.S. initiated prenatal care in the first trimester;[4] however, these rates vary by race, ethnicity, age, geographic location, and insurance status.[5] Barriers to accessing care, such as finding a trusted provider, accessing a location where maternity services are offered, and having insurance coverage, affect women's ability to receive timely and adequate prenatal care.[1] With nearly a quarter of U.S. women not receiving early prenatal care often due to unequal access and utilization across different populations, effective state- and jurisdiction-level solutions, such as support for Home Visitors or Community Health Workers to improve access to health care services, and Medicaid Expansion or Medicaid Presumptive Eligibility allowing women to obtain Medicaid-covered prenatal care immediately, are needed to eliminate disparities and improve outcomes.[1]

Prenatal Care Guidelines. The ACOG Guidelines for Perinatal Care 8th Edition states that prenatal care should include comprehensive health care services that are patient-and family-centered, culturally and linguistically appropriate, risk-appropriate, and aligned with the specific needs of the pregnant woman. An appropriate level of care is facilitated by early and ongoing risk assessment to prevent, recognize, and treat conditions associated with maternal and neonatal morbidity and mortality.

- All pregnant women should be screened and tested for medical and chronic health conditions, such as diabetes, hypertension, anemia, and obesity during the prenatal care period.
- Pregnant women with chronic health conditions or complex pregnancies will need more frequent visits and monitoring compared to those with low-risk pregnancies.

Data Sources.

This SM is measured through data collected from the National Vital Statistics System (NVSS). Among women who gave birth in 2021, 78.3% began prenatal care in the first trimester, up from 77.7% in 2020.[4] In 2021, Native Hawaiian or Other Pacific Islanders were the least likely to have access to prenatal care in the first trimester (51.5%) followed by American Indian or Alaska Native (65.8%), Non-Hispanic Black (69.7%), and Hispanic (72.5%) women. Non-Hispanic White women had the highest rate (83.2%) of access to prenatal care.[4]

Social Determinants of Health (SDOH).

There are numerous societal and health system factors that affect the ability of pregnant women to access prenatal care in the first trimester.[1] Many of these factors also contribute to high rates of poor health outcomes and maternal mortality for Black women, who are more likely to experience barriers to obtaining quality care, including early prenatal care, and face racial discrimination and differential treatment from health care providers.[1]

The Maternal Vulnerability Index (MVI) examines determinants of maternal health and is the first county-level, national scale that helps to identify where and why pregnant women may be vulnerable to poor birth outcomes.[6] The MVI assigns scores from 0 (lowest) to 100 (highest). The southern part of the U.S. has some of the highest maternal vulnerability scores based on six domains: reproductive health care, physical health, mental and substance abuse, general health care, socioeconomic determinants, and physical environment. Addressing maternal vulnerability is crucial to ensuring equitable access to early prenatal care for pregnant women with the most need.[7]

Health Equity.

Disparities in access to early prenatal care are apparent by race/ethnicity, geography, insurance status, education, and socioeconomic status.[1]

- Native Hawaiian or Other Pacific Islander, American Indian or Alaska Native, Non-Hispanic Black, and Hispanic women are less likely than Non-Hispanic White and Asian women to initiate prenatal care in the first trimester.[4]
- Women with higher educational attainment are more likely to initiate prenatal care during the first trimester and less likely to start as late as the third trimester or forego care altogether.[1]
- Women in rural areas face challenges accessing prenatal care due to transportation, provider shortages, and lack of specialty care services.[1,8]

Health equity-centered, community-based models of care, such as group prenatal care and pregnancy medical homes, could improve access to and utilization of early prenatal care, and may help reduce the rate of maternal and infant mortality and morbidity, particularly among women of color.[9,10]

Pregnant Women and Lack of Access to Maternity Care.

More than 2.2 million women of childbearing age live in a maternity care desert. In the U.S., there are more than 1,095 (34.9%) counties that are identified as maternity care deserts and 359 (11.4%) counties with low access to maternity care.[11] Between 2004–2017, more than 179 rural counties lost or closed their hospital obstetric services leaving more than 50% of rural women having to commute more than 30 minutes to a prenatal appointment and more than 10% commuting up to 100 miles.[12] Low level access and barriers to care make it difficult for women in underserved areas to seek prenatal care early and routinely. To implement systemic changes, it is important to understand barriers and facilitators to accessing early prenatal care.[13]

Key Resources.

Access to early prenatal care is a key strategy for achieving a healthy birth outcome for pregnant women and infants.[1] Research also acknowledges the importance of preconception care as an integral part of improving outcomes.[14]

Search the Established Evidence database for peer-reviewed research articles related to strategies for improving access to early prenatal care.

Find field-based resources focused on improving access to early prenatal care relevant to Title V programs in the MCH Digital Library.

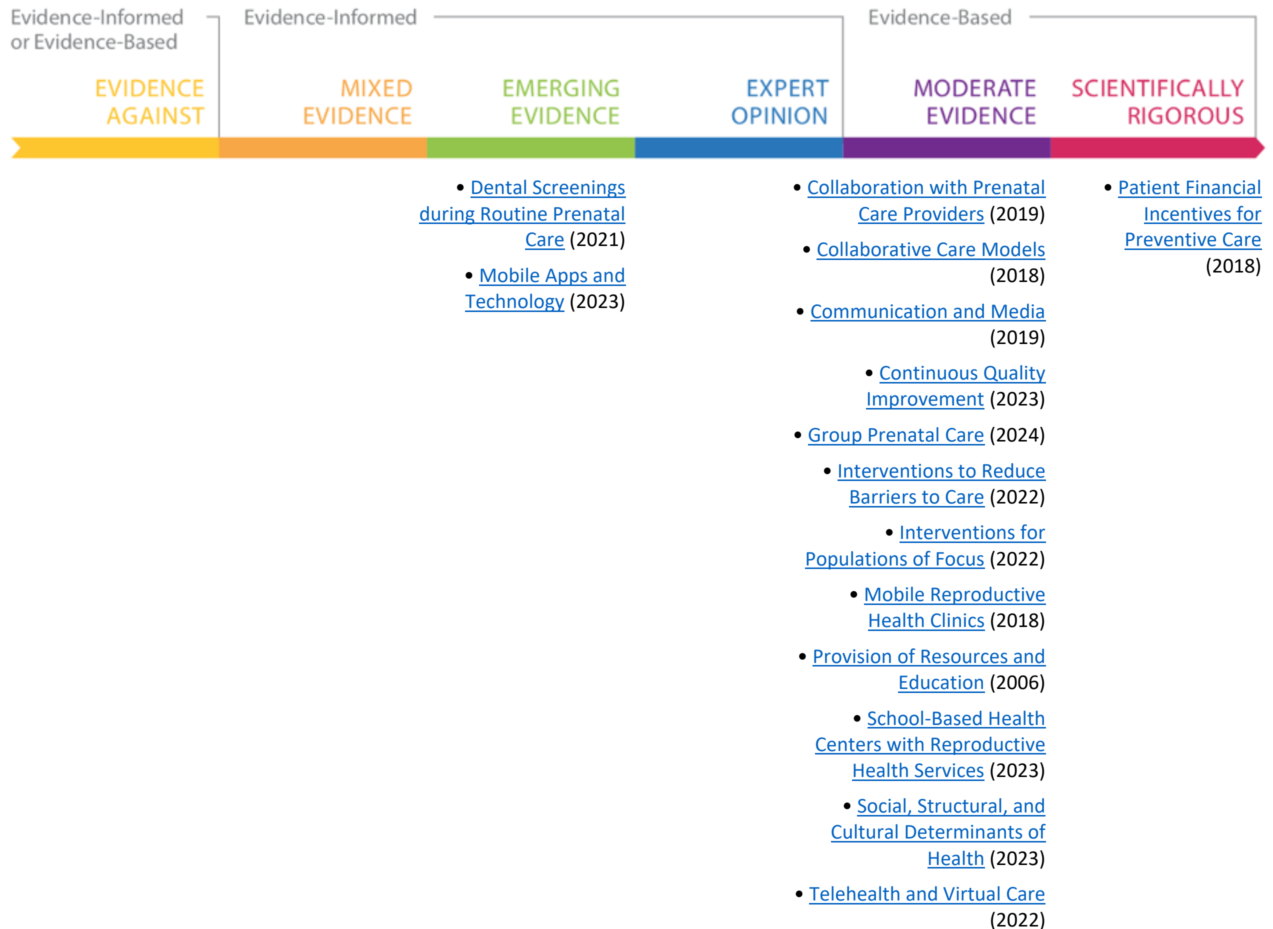
Partnership and the Role of Title V.

Title V agencies can support early prenatal care by:

- Exploring needs assessment data to prioritize where and with whom it is most necessary to support the implementation of evidence-based/informed initiatives to increase access to first trimester prenatal care.
- Collaborating with their Perinatal Quality Collaboratives and Maternal Mortality Review Committees to examine data on the lack of access to prenatal care to inform interventions.[15]
- Promoting Medicaid Expansion and the Postpartum Medicaid Extension to support timely and adequate prenatal care as well as reproductive health.[16,17]
- Supporting the utilization of midwives to address provider shortages and the needs of pregnant and postpartum women.[18]

Early Prenatal Care Strategies. This evidence accelerator summarizes the latest strategies and practices that have emerged as potential approaches for increasing the percent of pregnant women who receive prenatal care beginning in the first trimester. It provides a framework to identify, understand, and implement "what works" in creating new Evidence-based/informed Strategy Measures (ESMs). Use the links below to access strategy and practice details, approaches, supporting evidence, outcomes, and examples of how Title V agencies are either using these strategies directly or adopting components of the intervention that address this SM.

Evidence-Based/Informed Strategies. 15 strategies have emerged from studies in the scientific literature as being effective in advancing the SM. They can be adopted or adapted to meet your program needs. More information on these strategies can be found in the MCH Evidence Center's MCHbest database.



Field-Based Practices. 3 practices from state-/community-based programs have emerged as potential approaches for advancing the SM for specific communities or populations. They can be used as models to meet your program needs. More information can be found in the Association of Maternal and Child Health Program's (AMCHP's) Innovation Hub.

- Preconception Health Program (NE; 2009)
- Midwifery-Based Model that is Culturally Relevant and Accessible (FL; 2020)
- Universal One-Time Nurse Home Visit (MA; 2018)

Key Findings.
The following are key findings emerging from the literature:

1. Medicaid Expansion as allowed by the Affordable Care Act consistently increases access to insurance before pregnancy and has been found to improve rates of early prenatal care access.[19]
2. Patient, provider, system, and structural barriers result in delayed entry into prenatal care[20-22] for women who are single, non-Hispanic Black, non-Hispanic American Indian/ Alaska Native, Hispanic, utilize Medicaid insurance, have education at or below a high school level, and are from rural and/or frontier geographic locations.[13,23]
3. Addressing the intersectionality of race, ethnicity, and social and structural determinants of health can increase early access to prenatal care.[24]
4. Accessing health care prior to pregnancy has been found to improve early access to prenatal care, as well as maternal and infant outcomes.[25]
5. The most impactful interventions incorporate a focus on improving the quality of care, including racial congruence between patients and providers;[26] and comprehensive and inclusive services that address the structural and social determinants of health.[27-31]

Discussion: Research, Practice, Partnership.

Research. Multiple strategies are emerging as potential approaches to advance this SM, but they have not been studied with enough rigor to be included in the evidence-based continuum. Additional research is needed to verify outcomes, but initial studies have shown promise of these strategies in MCH settings:

- Deploying mobile applications (apps) to increase a family' knowledge and access to perinatal information in a culturally appropriate and innovative manner.[32,33]
- Offering group prenatal care, particularly for high-risk groups, to increase attendance at prenatal care visits and improve birth outcomes.[34]
- Establishing a dedicated prenatal care hotline that pregnant women can call for information, support, and guidance.[35]
- Implementing mobile clinics that can travel to remote or inaccessible areas to provide prenatal care services.[36]
- Collaborating with schools and educational institutions to incorporate prenatal care education into their curricula.[37]

Practice. The following tools can be used to translate evidence to action to advance this SM:

- Early Entry into Prenatal Care: Overcoming barriers and improving access to care (March of Dimes). This tool provides case studies and strategies to increase access to prenatal care.
- Pre-Pregnancy and Prenatal Care (NIH). These factsheets provide guidance on preconception care and early and regular prenatal visits to promote a healthy pregnancy.

Partnership. The following organizations focus efforts on advancing early prenatal care:

- Maternal Health Learning and Innovation Center. Provides resources and technical assistance.
- Maternal Health Task Force at the Harvard Chan School. Provides a listing of maternal health organizations.

Frameworks and Tools for "What Works."

Use this accelerator to strengthen current or new programs that align with multiple MCH frameworks across domains and settings. Access toolkits related to these frameworks for additional resources:

- MCH Evidence Framework
- Blueprint for Change for CYSHCN
- Maternal Health Toolkit
- Life Course and Social Determinants Brief

Need More Help?
Contact us for training and technical assistance customized to your needs.

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* Note. Throughout this document, we use terms such as woman, women, and mother to describe people who have the biological capacity to become pregnant. We acknowledge that some pregnant and/or birthing people do not identify with these terms. However, we use these terms as a reflection of language used in the peer-reviewed research that predominantly refers to study participants as "women." Our findings are not meant to be exclusive of individuals who do not identify as female. Read more in NCEMCH's Gender Identity Statement.

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