national partnership for women & families

FACT SHEET

American Indian and Alaska Native Women's Maternal Health: Addressing the Crisis

OCTOBER 2019

American Indian and Alaska Native (AIAN) women[1] are experiencing an alarming rate of maternal mortality: they are three to four times more likely than white women to die of complications related to pregnancy and/or childbirth.[2] Moreover, AIAN women experience a higher rate of severe maternal morbidity, including a preterm labor rate and an obstetrical hemorrhage rate (bleeding that occurs before, during or after childbirth) that is more than twice that of white women.[3]

Context

Adverse maternal health outcomes are, in part, due to the historical trauma of systemic racism, colonization, genocide, forced migration, reproductive coercion and cultural erasure.[4] AIAN women also experience systemic barriers that create unequal social conditions relative to white women. For example, AIAN women are more likely than white women to experience high levels of poverty, live in hazardous conditions, experience food insecurity and lack access to health insurance. They are also more likely than white women to experience sexual and interpersonal violence, and the historical trauma of systemic racism is linked to the disproportionately high levels of behavioral health problems that many AIAN women experience.[5] Furthermore, the history of forced sterilization and infant separation policies has led to distrust between AIAN women and their care providers, making it hard to establish meaningful physician-patient relationships.

Drivers of Worse Outcomes

A number of factors interact simultaneously to affect the maternal health outcomes of AIAN women, including difficulty accessing insurance and health care services, both systemic and interpersonal discrimination and underlying health challenges. These barriers accumulate in ways that jeopardize the health and well-being of AIAN women.

Access to Insurance and Necessary Care

AIAN women are more likely than white women to face barriers to care. They are more likely to lack health insurance, and face difficulties accessing care, whether they live in rural or urban settings. For example, Alaska Native women may live hundreds of miles from the nearest hospital and in areas that are inaccessible by car for months each year. Even in cities, Native women may have challenges finding reliable, affordable transportation and accessing time away from work to seek care.[6] Additionally, high turnover rates of physicians and understaffing causes expectant mothers to see different providers at each visit, and visits are conducted under time constraints, making it difficult to build the patient-physician relationship.[7] The Indian Health Service, a major source of care for AIAN women, is chronically underfunded and may not provide needed services. As a result, AIAN women are more likely than white women to enter prenatal care later and receive less and lower-quality maternity care.[8]

- Twenty-one percent of AIAN women of reproductive age (15-44) are uninsured, compared to eight percent of white women.[9] Pregnant women without health insurance often delay or forgo prenatal care during the first trimester, which is associated with higher rates of maternal and infant mortality and increased risk of low birth weight.[10]
- AIAN women are 3 to 4 times more likely than white women to begin prenatal care in the third trimester. [11]
- 41 percent of AIAN women cite cost as a barrier to receiving the recommended number of prenatal visits.[12]
- AIAN women often have long waits to see a health care provider for prenatal care, sometimes up to two hours for a 15-minute appointment.[13]
- AIAN women receive a lower quality of care than white women, and care that is devoid of traditional cultural birth practices found in indigenous communities.[14]

Discrimination

AIAN women's maternal health is also negatively impacted by discrimination they experience, which can increase stress and cortisol levels, and have adverse effects on maternal and infant health.[15] New research demonstrates that the weathering hypothesis, which posits that chronic stress linked to socioeconomic disadvantage and discrimination over the life course causes pregnancy to be riskier at an earlier age, may also apply to AIAN women.[16]

AIAN mothers are more likely than white women to experience discrimination, delays in care and to see a different provider each time they attempt to access prenatal care. In

fact, 25 percent of AIAN women report experiencing discrimination when going to the doctor or a clinic.[17]

Health Conditions

Women who have poor health are more likely to have adverse maternal and infant health outcomes. Deleterious social conditions have led many AIAN women to have higher rates of many preventable diseases and chronic health conditions, including diabetes, obesity and cancer.

AIAN women also experience more maternal health complications during pregnancy and childbirth than white women. These complications are often inadequately addressed, and can reduce the quality of life, lead to weakness and fatigue, often require a long recovery period, and can sometimes result in death.

- AIAN women are 1.4 times more likely than white women to be diagnosed with gestational hypertension and pre-eclampsia. If not properly treated, pre-eclampsia can lead to severe maternal health complications and death.[18]
- AIAN women are 1.5-2 times more likely to be diagnosed with gestational diabetes than white women.[19] Gestational diabetes is the onset of diabetes during pregnancy. If left untreated, this condition can lead to severe maternal and infant health complications.

Policy Recommendations

Provide adequate and appropriate funding for the Indian Health Services. The IHS has been consistently underfunded, understaffed and under resourced from its inception. For example, between 1993 and 1998, IHS appropriations increased by 8%, while medical inflation increased by 20.6%.[20] To improve AIAN maternal health and fully meet the trust responsibility[21], Congress should increase the funds allocated to IHS.

Expand and maintain access to health coverage. AIAN women gained insurance as a result of the Affordable Care Act, primarily through the expansion of Medicaid, but 21 percent of all AIAN women (18-64) remain uninsured or underinsured. Due to historical patterns of forced migration, the majority of AIAN women are concentrated in eleven states, many of which did not expand Medicaid.[22] Congress should continue to protect and strengthen the ACA, and states that have not already done so should expand Medicaid to increase access to care and reduce the financial instability and stress associated with being uninsured. Congress should also ensure that AIAN women, whether they are covered through the ACA, Medicaid or Indian Health Services, have

access to comprehensive reproductive health care and other essential health care services.

Develop deeper knowledge about American Indian and Alaska Native women's maternal health outcomes through collaborations between AIAN communities and other stakeholders. Due to relatively small numbers of AIAN individuals, diverse geographic settings and challenges with proper racial categorization (i.e. ascertainment), data are limited on AIAN women. To adequately understand the depth of the maternal mortality crisis for AIAN women, it would be valuable to collect more granular and accurate data, with an emphasis on oversampling where necessary and accurate racial identification. At the same time, AIAN people have for too long been the subjects of research without their consent or their control over the resulting data, a legacy of racism and colonization that should not be repeated. Non-Native researchers and policymakers should consult with AIAN communities to develop collaborative, and ideally Native-led, efforts to collect additional data in ways that support AIAN women and advance the sovereignty of Native communities.

Address the social determinants of health. Social determinants of health are the conditions under which people live, work and play. Many AIAN women live in conditions that are deleterious in nature. For AIAN women who are affected by structural inequality and discrimination, the chronic stress of poverty and racism has been shown to have an adverse effect on health outcomes and is linked to their persistent maternal health disparities.[23] To improve AIAN maternal health outcomes, Congress should implement policies that raise incomes and build wealth; provide access to clean, safe and affordable housing; improve the quality of education; prioritize reliable public transportation and transport for medical appointments; and increase the availability of healthy, affordable food.

Support federal policies that that are responsive to the needs of AIAN women. AIAN women should receive health care that is respectful, culturally relevant and appropriate, safe and of the highest quality. To address the maternal health crisis for AIAN women, Congress should enact bold legislation that is respectful of tribal sovereignty and expansive enough to reach reservation-dwelling women.

Policy should incentivize providing patient-centered care that focuses on AIAN women's individualized needs, including non-clinical needs. Policies should also endeavor to eradicate cultural biases and discrimination in medical practice and medical education, increase provider diversity in maternity care and hold individual providers and hospital systems accountable if they fail to provide unbiased, high-quality, evidence-based care.

Likewise, greater support for proven safety and quality improvement initiatives should be a policy priority. For example, maternal mortality review committees increase understanding of the underlying and contributing causes of pregnancy-related deaths and a structured death review process can provide powerful data and information to facilitate change that improves the health of women before, during and after pregnancy. Similarly, leaders of state-level perinatal quality collaboratives and evidence-based national data-driven maternal safety and quality improvement initiatives should ensure that these initiatives reach AIAN-serving clinics and facilities.

Expand and protect access to trusted community-based health care models. AIAN communities are reviving birth practices that are rooted in the cultural traditions of indigenous communities. Many of these strengths-based services are provided through community-based care models (CBMs) that primarily service low-income and women of color, and offer access to midwives, doulas or birth companions and community (birth center or home) birth settings.[24] These models also provide care that is culturally relevant and appropriate, and have training programs for birth workers of color. Currently there are not enough CBMs nationwide to serve the number of low-income and at-risk women in need of prenatal through postpartum care and support services. Increasing the number of programs implementing CBMs and providing adequate funding for these programs would enhance AIAN women and families' ability to seek high quality maternal health care.[25]

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[1] We use the term "women" throughout this issue brief, but recognize that people of many gender identities – transgender, nonbinary and cisgender alike – need and receive maternity care.

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[14] See note 11.

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[20]Warne, D., Frizzell, L.B. (2014). American Indian Health Policy: Historical Trends and contemporary Issues. *American Journal of Public Health, 104*(3), 263-267.

[21] The trust responsibility refers to the legal and moral obligation to provide adequate quality health care to AIAN people.

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