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Achieving Safe Motherhood Addressing the Healthcare and Education Needs of the Mothers with Comorbidities; Reenvisioning Prenatal Care and Education

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Introduction

The health and wellness of mothers has been identified as the cornerstone of public health, and it is well documented in the literature that mothers define the health of the family [1-3]. Safe Motherhood has been described as practices, and guidelines that ensure all women receive the care they need for a safe and healthy pregnancy and childbirth (World Health Organization [4]. The safe motherhood initiative begun with discussions in the 1980s in order to address the growing need for women to progress through pregnancy and childbirth ensuring with little health risks and little to no short-term and long-term morbidities [5,6]. Historically safe motherhood was thought to be a public health concern in developing nations, however the United States ranks well below many developed nations [3]. The current rate of maternal and infant mortality is abysmal, with national rates greater than 27 other developed nations. The latest 2014 data reported that the infant mortality rates stood at 6.1 per 1,000 live births. An infant born in Hungary, Poland, Slovakia, and Cuba has a greater chance of surviving past the first year of life than an infant born in the United States. More disconcerting is the fact that an infant born in Mississippi has the same chance of survival as an infant born in Bahrain or Botswana [7,8].

Given our vast wealth as a nation and access to advanced healthcare technologies, it is a disgrace that women who birth in the United States continue to have poor maternal health outcomes [9]. While a few nations have made progress in maternal and infant outcomes, the United States has only invested in the Safe Motherhood Initiative from an intrapartum perspective and has failed to address the importance of a life-course perspective, addressing the health of the woman before she becomes pregnant [10,11]. While the American Congress of Obstetrics and Gynecology (ACOG) is instituting the Safe Motherhood Initiative in tertiary care facilities around the country, little has be done to re-envision prenatal care and education [10]. What is well documented in the maternal-child literature is the concept that the health of the mother at time of conception is critical to the course of the pregnancy, the birth and the outcome of the fetus. Healthy mothers for the most part have healthy babies and we as a national have not developed substantial and sustainable programs to improve the way prenatal care and education is delivered [1,2,3,12,13].

Maternal mortality is defined as the death of a women while pregnant or within 42 days post partum up to one year following childbirth [14]. The leading causes of maternal morbidity and mortality care primarily vascular in origin: 1. postpartum hemorrhage, 2. hypertension, preeclampsia and ecclampsia, and 3. cardiovascular disease [15]. The etiology for the rates of maternal and infant mortality throughout the United States is poorly understood and complications have been found to be multifactorial. Socioeconomic factors, ethnicity, and comorbidities such as obesity, diabetes, hypertension, and mental illness influence the course and outcomes of a woman's pregnancy. According to the WHO (2014), 1 in 4 maternal deaths are due to comorbidities that pre-existed the pregnancy (i.e. obesity, hypertension, diabetes) and most maternal morbidity is related to vascular events that may or may not have preceded the pregnancy. Additionally, maternal age at onset of pregnancy is increasing and more mothers enter into pregnancy older and with greater rates of health issues and health issues that have existed for longer [5,11].

While many countries aim to improve prenatal care and education, the United States has not changed the practice and components of prenatal care and education is delivered to address the changing demographic. For example, lower income mothers have greater rates of maternal and infant morbidity and mortality, yet access to prenatal care and prenatal education has not been addressed by our health systems [8,11]. Maternal-child healthcare providers and public health experts, are well aware of this phenomenon, however little has changed in the way prenatal care and education is delivered in and throughout the United States and addressing the delivery of maternal-child healthcare that is tailored to specific populations is poor or non-existent. We are failing as a country to protect our mothers and their infants and delinquent in addressing sizable disparities in race, ethnicity, and socioeconomic status when it comes to prenatal care and education [7].

In 2007 the safe motherhood initiative celebrated its 20th anniversary, and while many countries have made progress in the millennium development goal five, reducing maternal mortality much work is still needed and rates are still at unacceptable levels [4,7]. Recognizing that healthy mothers have healthy babies and while we know the positive impact of prenatal care and education, barriers to care and health disparities continue to permeate obstetrical care in the United States. Effective interventions must be tailored to the changing demographic of women living and birthing in the United States. Re envisioning the components and the way prenatal care and education is delivered must be a priority. Reevaluating practice guidelines for prenatal care templates and revamping components of prenatal education particularly for marginalized women must be a priority. Availability of local, national and international resources are necessary along with the awareness campaigning and recruitment of policy-makers to implement the Safe Motherhood Initiative is critical to improving maternal health [12,14-16].

Addressing prenatal care and education from a lifespan approach utilizing the concept that preconception and interconceptual health should change based upon the changing demographic of women

seeking pregnancy. Using a framework that understanding that women enter into pregnancy with longstanding or recent comorbidities that complicate pregnancy and childbirth, have negative impacts to the growing fetus, and may cause lifelong health sequelae has to begin [5,17,18]. Rates of maternal morbidity and mortality are decreased if women's health problems are addressed during the preconception period, and clinical practice guidelines at the point of care during preconception and interconception are written about, but are not being implemented on a wide scale or being implemented based upon the interpretation of the healthcare provider. The importance of preconception care and pre-existing health issues influencing maternal and infant outcomes has been well-documented in theory in the literature, however, gaps in the delivery of tailored care and the tailoring prenatal care guidelines based upon the mothers pre-existing morbidities must be addressed through the lens of the life course perspective of women's health. Educating women on the benefits of managing maternal health using life course framework must starting in young girls and adolescent females who begin to menstruate [19]. Most women understand that being healthy in pregnancy helps to ensure the health of the baby, yet for the most part women do not understand factors that cause considerable risk in pregnancy and how to minimize them. A life course perspective of reproductive health identifies the physical and psychosocial needs of an individual depending upon where in the life course she is planning pregnancy. The life course perspective plans in accordance preconception, conception, and interconception. While some states have developed and implemented this model of care, national efforts to develop and implement guidelines and standard of care as well as models of the delivery of care do not exist. While any new and identified model of care is tedious to implement, health systems and health providers need to recognize that the future health and wellness of America's future generation lies in the hands of healthcare providers and healthcare systems of care [14,16,19].

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