



THE UNIVERSITY OF  
TENNESSEE  
HEALTH SCIENCE CENTER.

# Social Determinants of Health in the Obstetric Population

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No Disclosures

# Objectives

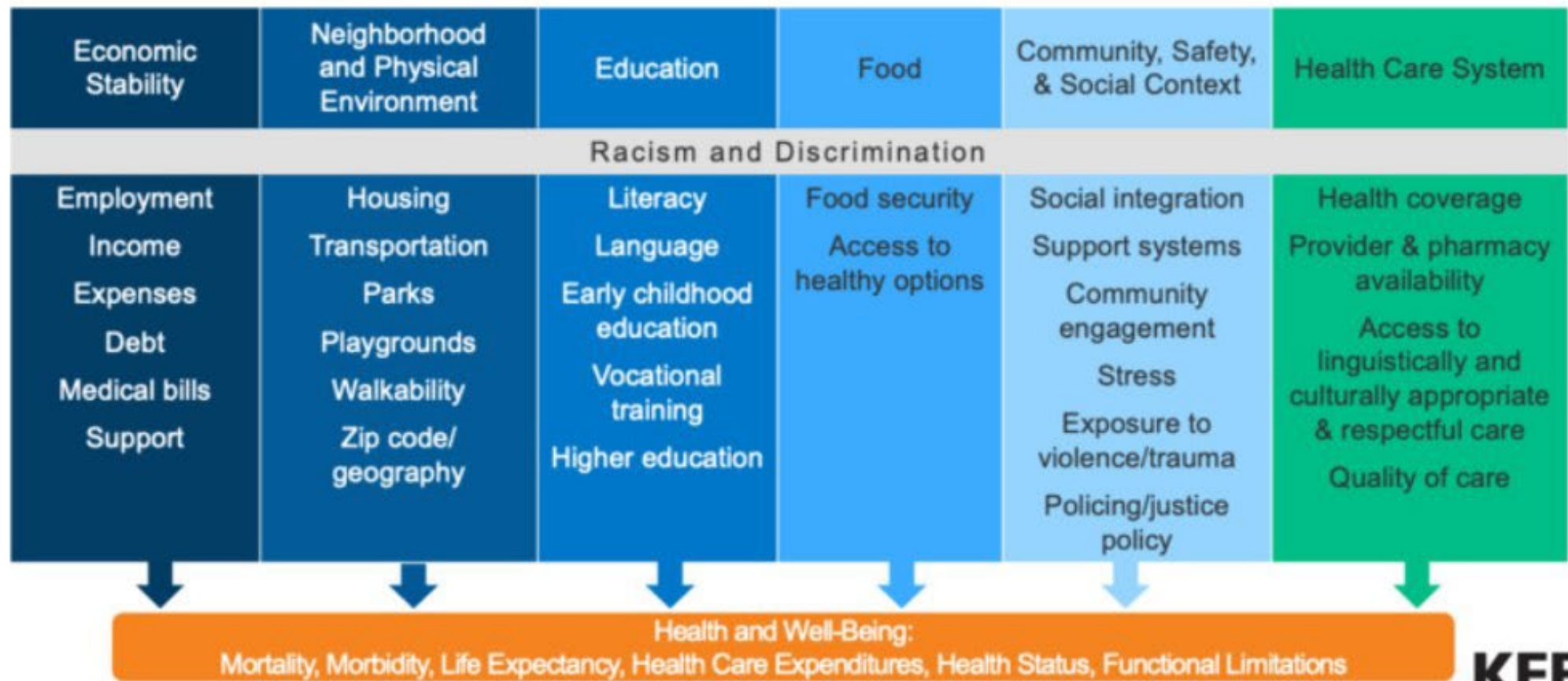
- Define social determinants of health (SDOH)
- Address SDOH in obstetric patients
- Discuss ways to reduce health care inequities

# How is social determinants of health defined?

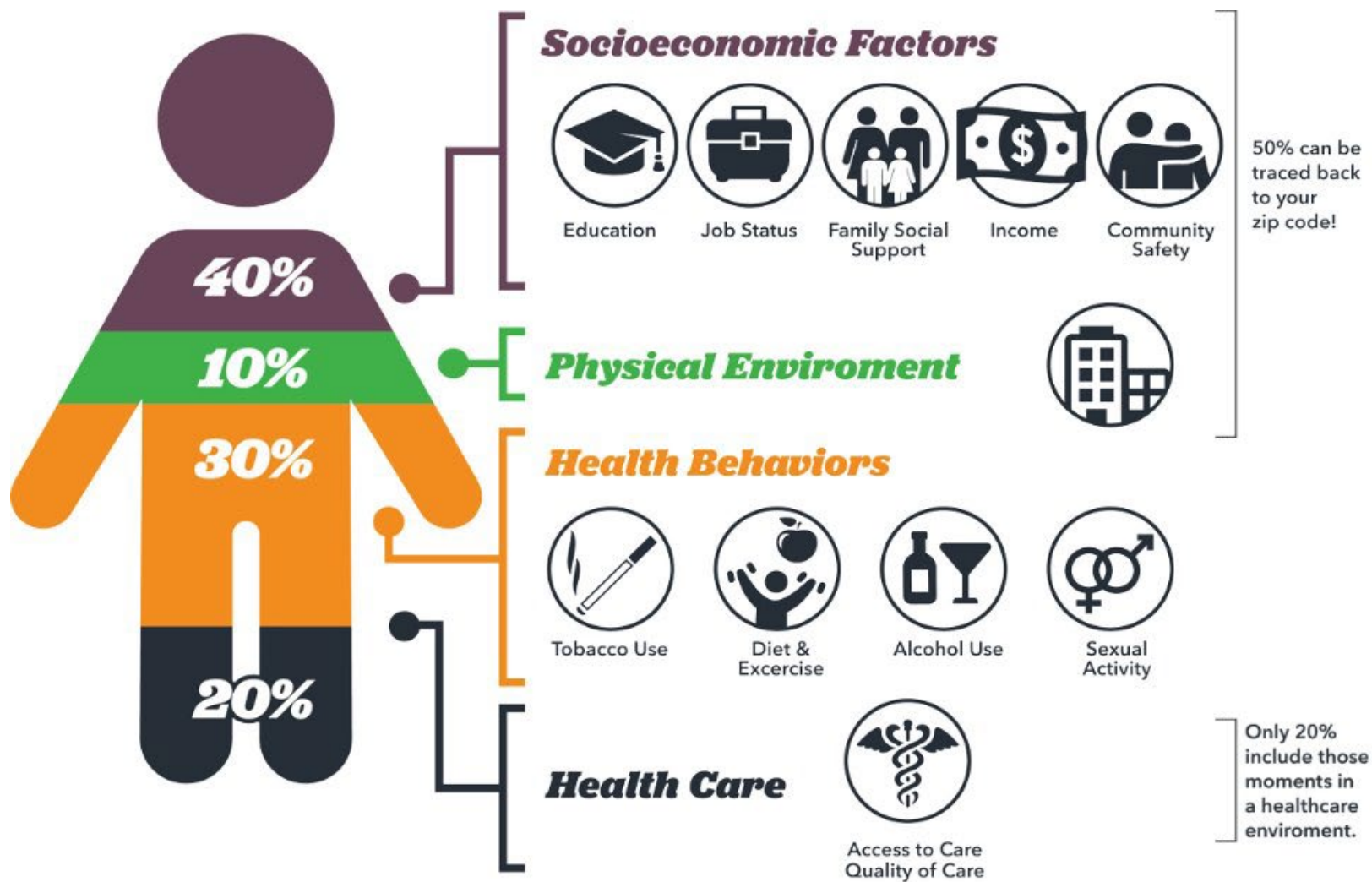
- World Health Organization
  - Non-medical factors that influence health outcomes
  - Conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life







**KFF**

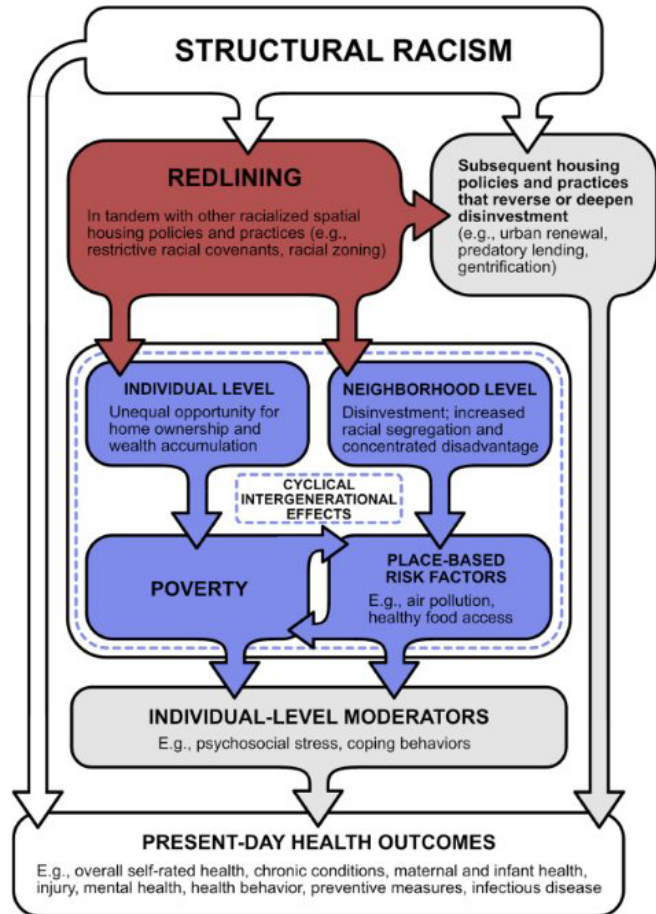


Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)





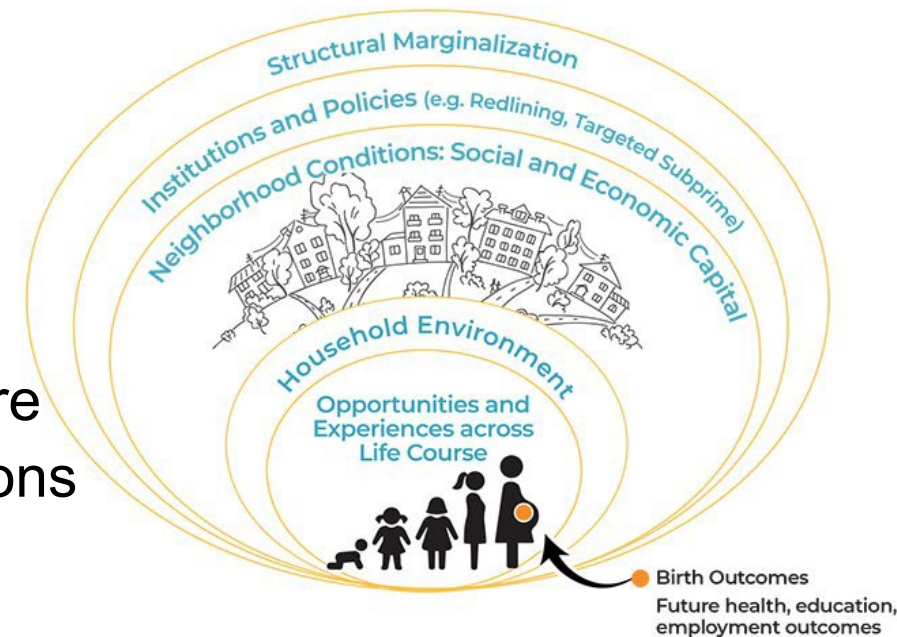
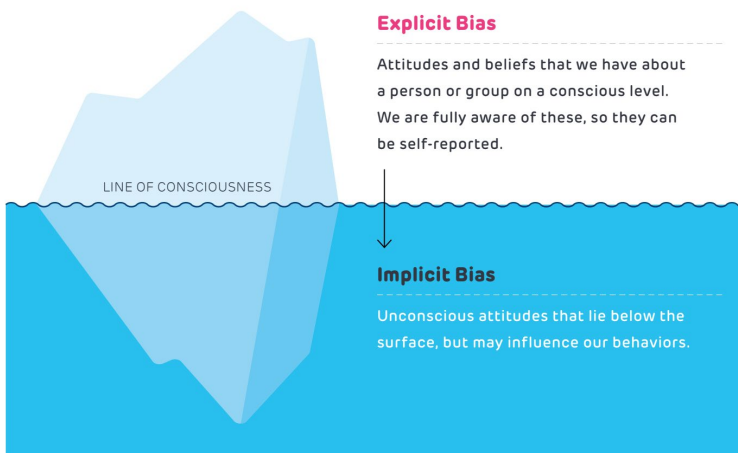
# Structural racism



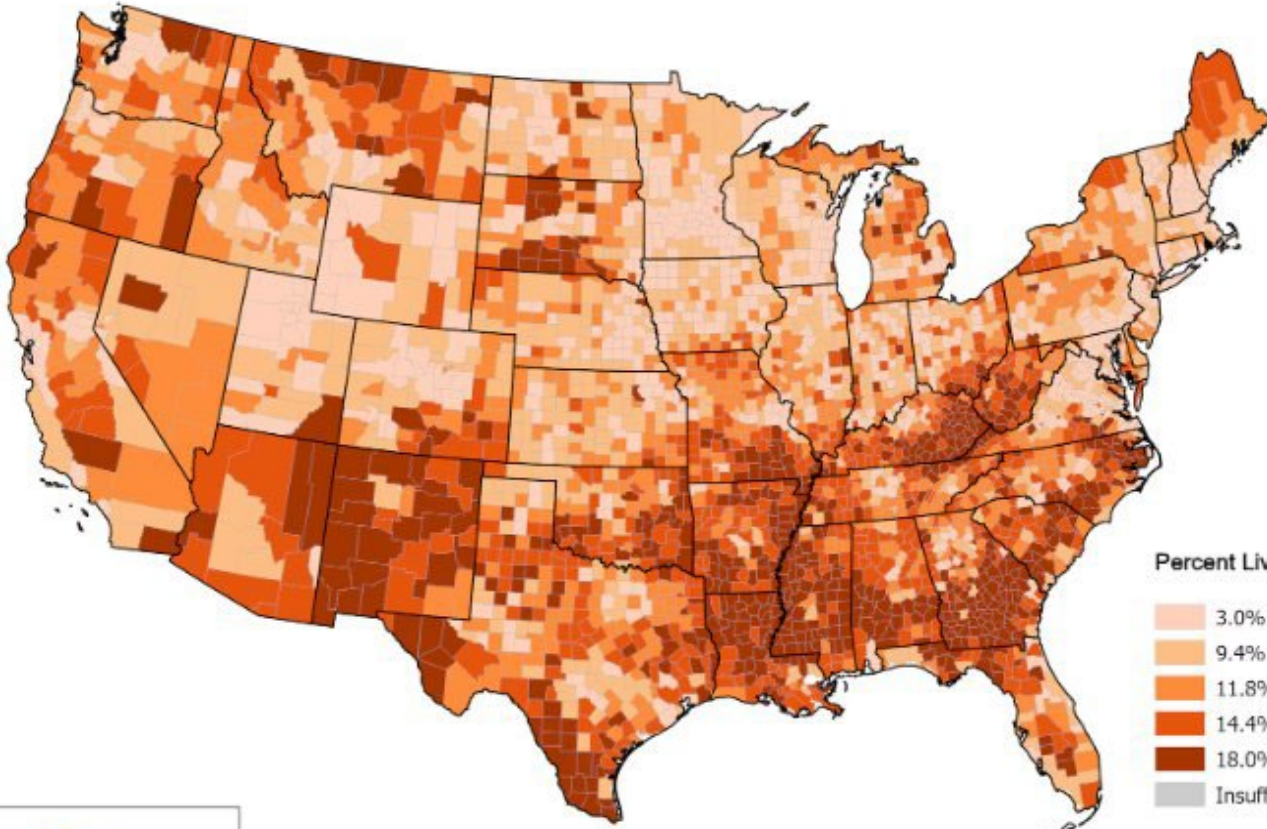
- The totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care and criminal justice.

# Structural racism in healthcare

- Reinforces discriminatory beliefs, values and distribution of resources
  - Affects health status
  - Cause of health disparities
  - Different treatment practices
  - Lack of culturally responsive care
  - Lower resourced hospital locations
  - Provider shortages
  - Biases



# Percent of Population Living in Poverty, 2020 by County



Data source and methodology found at: [www.cdc.gov/dhdsp/maps/atlas/statistical-methods](http://www.cdc.gov/dhdsp/maps/atlas/statistical-methods)



Alaska



Hawaii



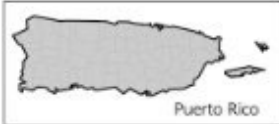
Guam



Northern Mariana Islands



American Samoa



Puerto Rico

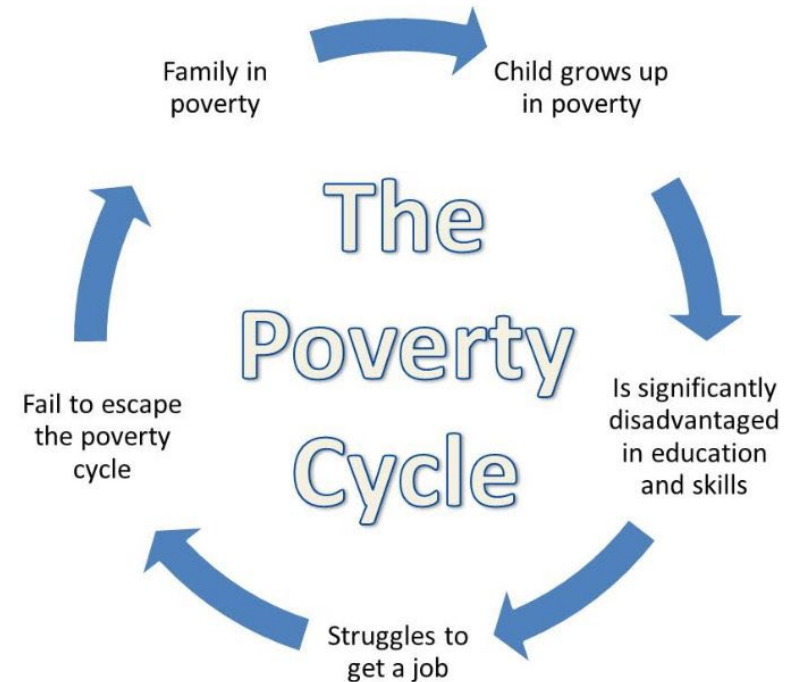


US Virgin Islands



# SDOH contribute to wide health disparities and inequities

- Social conditions influence individual health and work to create cycles that perpetuate intergenerational disadvantage.
- People who do not have access to grocery stores with healthy foods are less likely to have good nutrition. Lack of nutritious diet raises their risk of health conditions like heart disease, diabetes, and obesity, and lowers life expectancy.



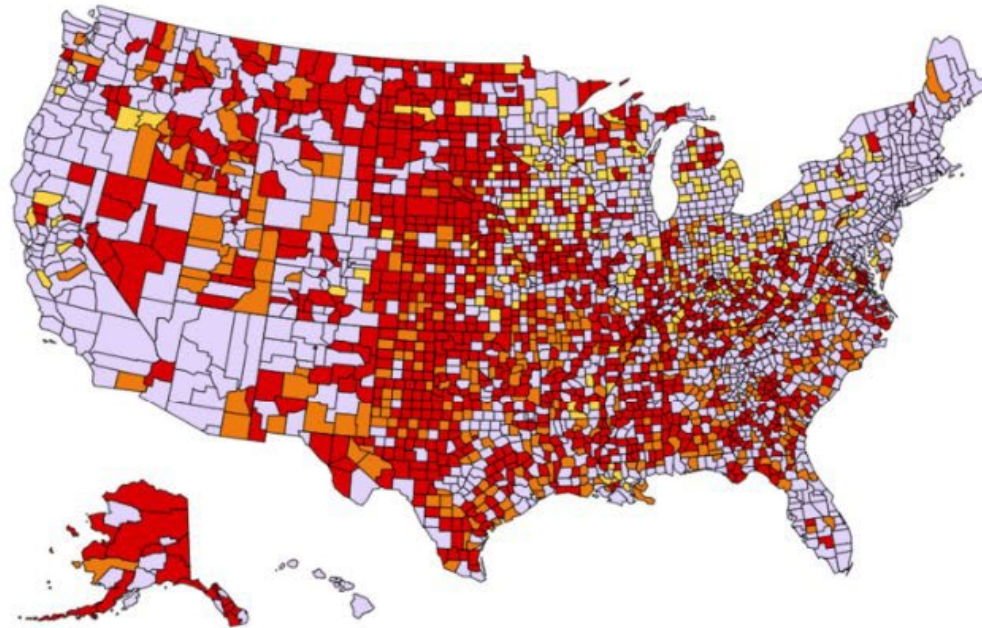
# Effect of adverse SDOH in Obstetrics

- Infertility
- Unintended pregnancy
- Preterm birth
- Low birth weight
- Infant mortality and morbidity
- Chronic and pregnancy-related diagnoses
- Maternal morbidity
- Maternal mortality



# ACCESS TO MATERNITY CARE

Maternity Care Deserts, 2020



■ Maternity Care Desert

■ Low Access to Care

■ Moderate Access to Care

■ Access to Maternity Care

## Maternity Care Deserts

- 36% of all U.S. counties are designated as maternity care desert.
- More than 2.2 million women of childbearing age live in maternity care deserts.
- In 2020, more than 146,000 babies were born in maternity care deserts.

## Limited Access to Care

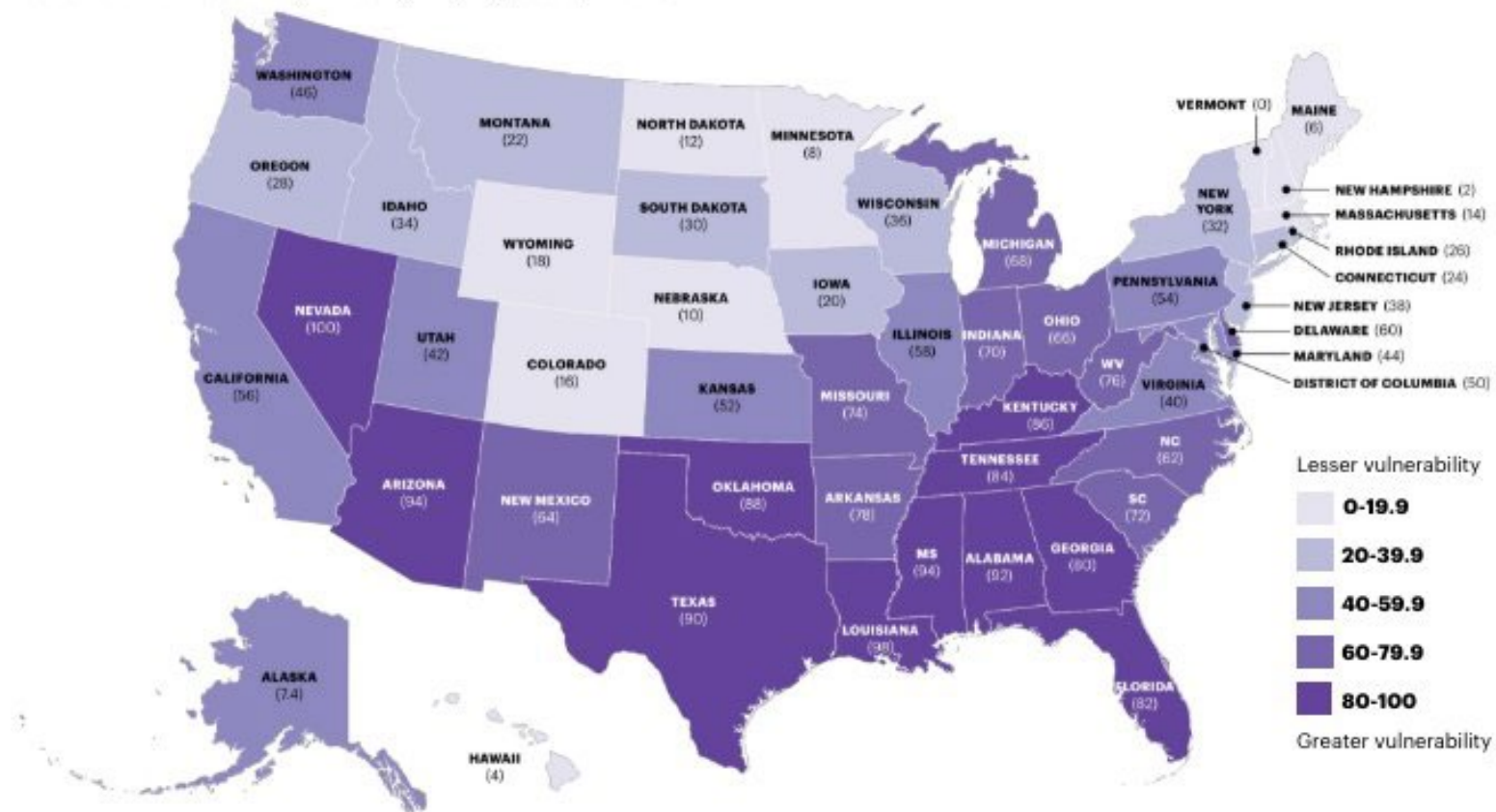
- Over 2.8 million women of childbearing age and nearly 160,000 babies were impacted by reduced access to maternity care.

Source: Nowhere to go: Maternity Care Deserts across the U.S. March of Dimes, September 2022.

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## Birthing people living in the darkest shaded states are most vulnerable to poor maternal health outcomes

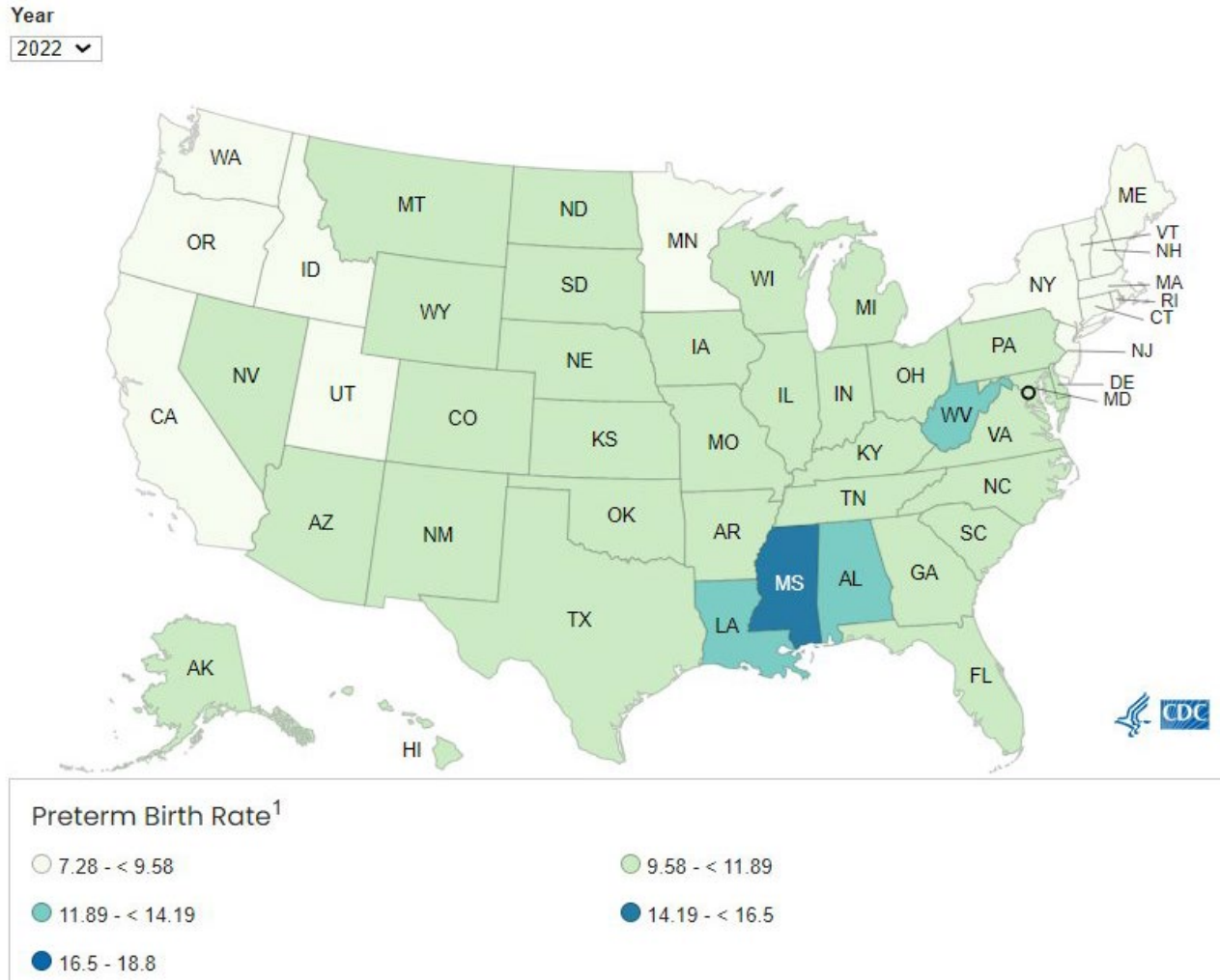
Maternal vulnerability index (MVI) by state, 2023



**Notes:** The Maternity Vulnerability Index (MVI) is a tool used to understand where birthing people in each state may be more likely to have poor outcomes, including preterm birth and maternal death, due to clinical risk factors and other social, contextual, and environmental factors.

**Source:** Surgo Health, Maternal Vulnerability Index, 2023.

# Preterm Birth Rates



## States with highest rates

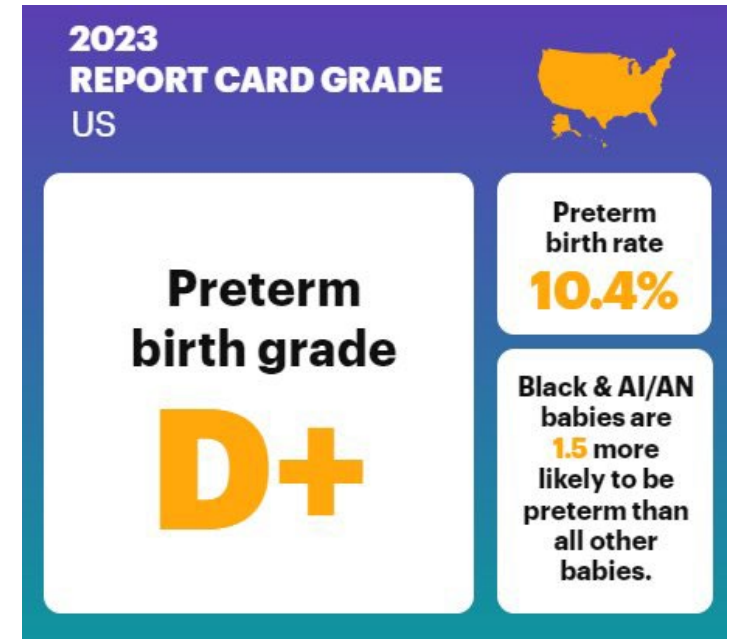
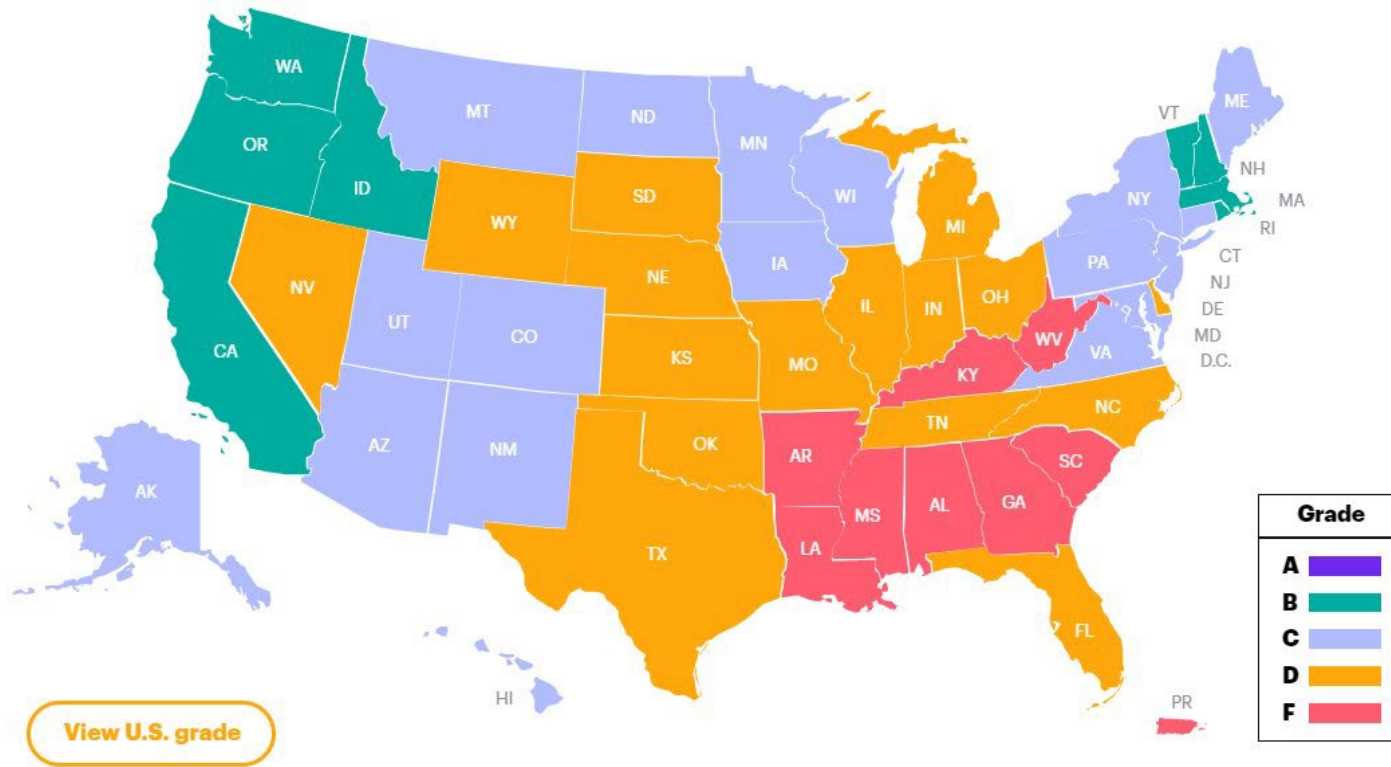
- Mississippi- 14.8
- Louisiana- 13.3
- Alabama- 12.8
- West Virginia- 12.98

## Demographic and social risks

- Teens, women >35
- Black, Native Hawaiian and Pacific Islander, and American Indian or Alaska Native
- Lower income
- Women experiencing stress
- Hypertensive disorders of pregnancy
- Tobacco or drug use

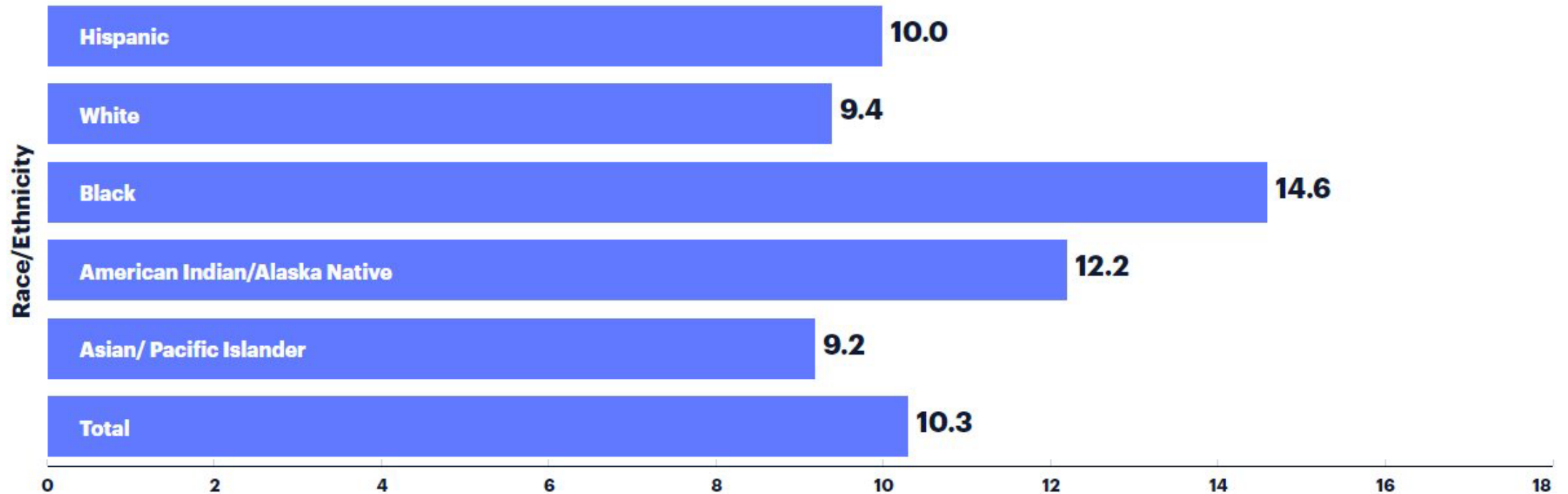


# March of Dimes Report Card



# Preterm birth

Percentage of live births in 2020-2022 Average that are preterm



- 36% of infant deaths are related to preterm birth
- Prematurity is the leading cause of newborn death and disability among infants (developmental delays, chronic respiratory problems, and vision and hearing impairment)
- Increased emotional and economic impact on families

# Goal of Healthy People 2030

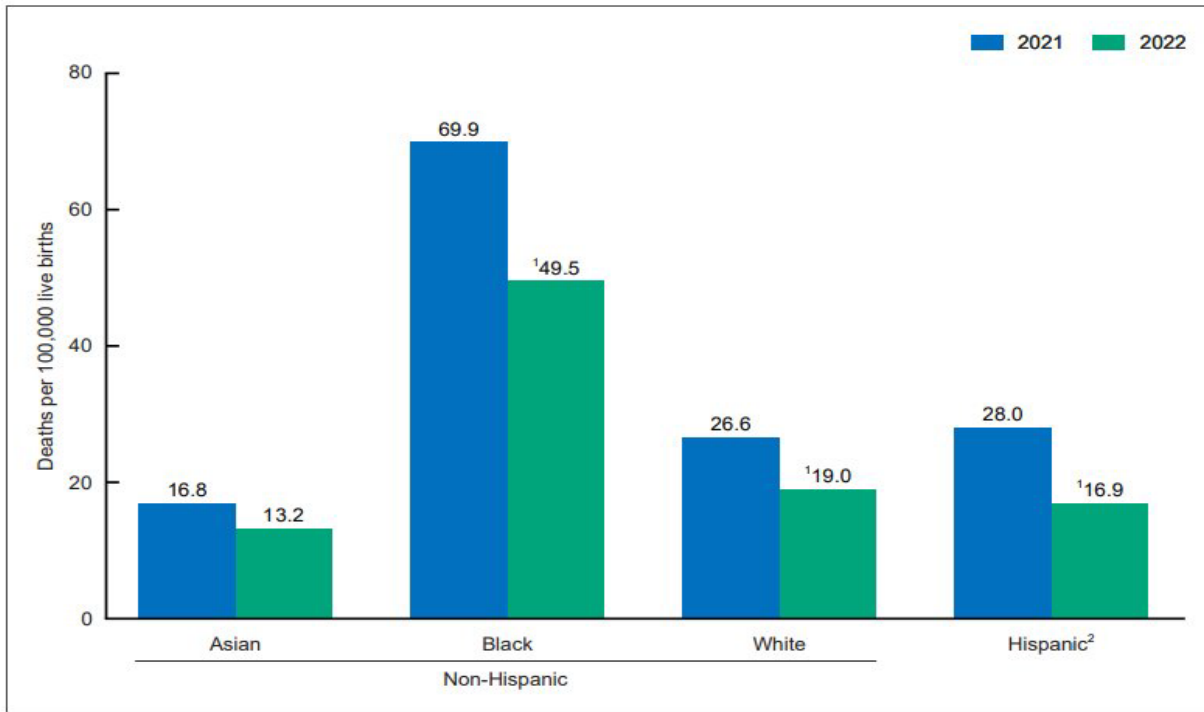
- Key focus of Healthy People 2030- Social determinants of health
- Goal: Prevent pregnancy complications and maternal deaths and improve women's health before, during, and after pregnancy.

The logo for Healthy People 2030 features the text "Healthy People 2030" in a bold, white, sans-serif font. Below it, the tagline "Building a healthier future for all" is written in a smaller, white, sans-serif font. The background of the logo is a blue, textured pattern with a hand holding a glowing blue sphere.

The Office of the Assistant Secretary of Health's (OASH) Office of Disease Prevention and Health Promotion (ODPHP) leads and manages the Healthy People initiative in collaboration with a diverse group of stakeholders, partners, and organizations.

# Maternal Mortality

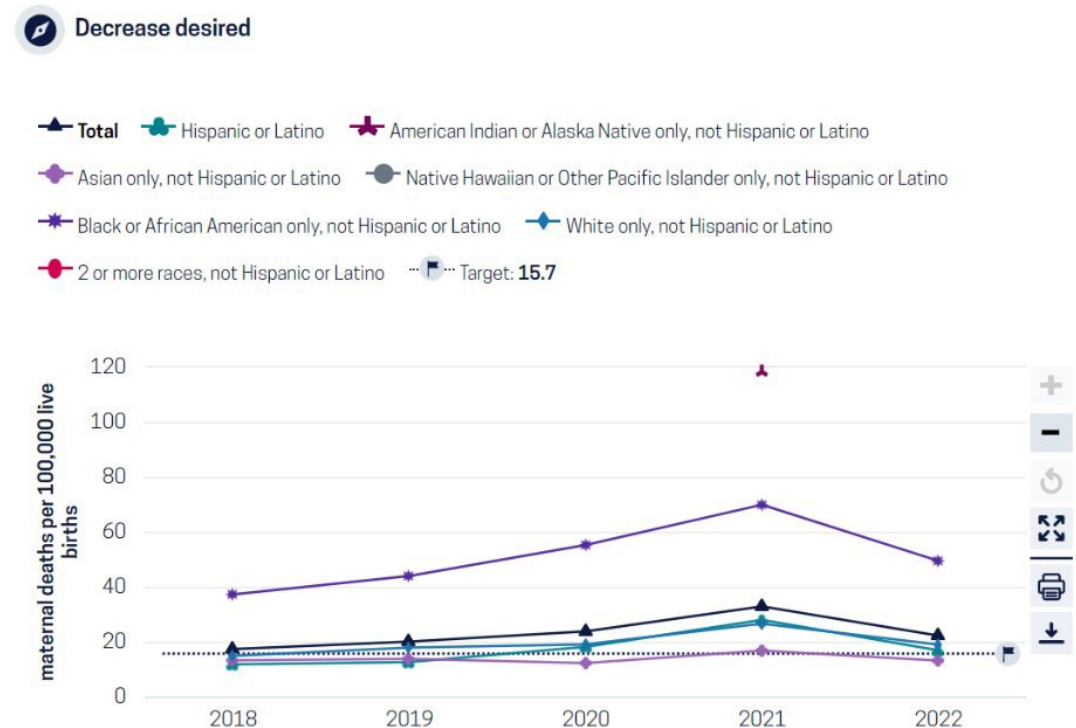
Figure 2. Maternal mortality rate, by race and Hispanic origin: United States, 2021 and 2022



<sup>1</sup>Statistically significant decrease from previous year ( $p < 0.05$ ).  
<sup>2</sup>Hispanic people may be of any race.  
 NOTE: Race groups are single race.  
 SOURCE: National Center for Health Statistics, National Vital Statistics System, mortality data files.

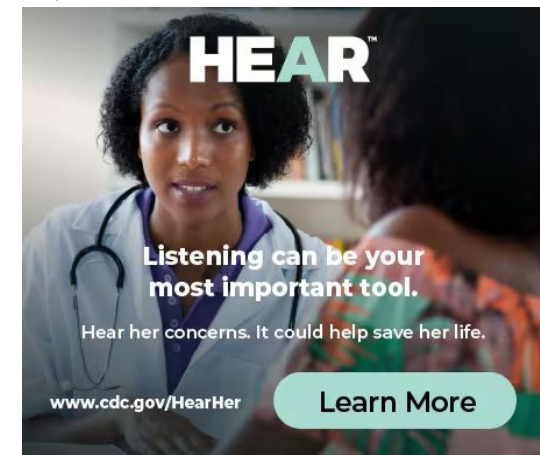
- Target Healthy People 2030-15.7/10000
- Average- 22.3/100,000 live births
- Black or African American- 49.5
- White- 19.0
- Hispanic or Latino- 16.9
- Asian- 13.2

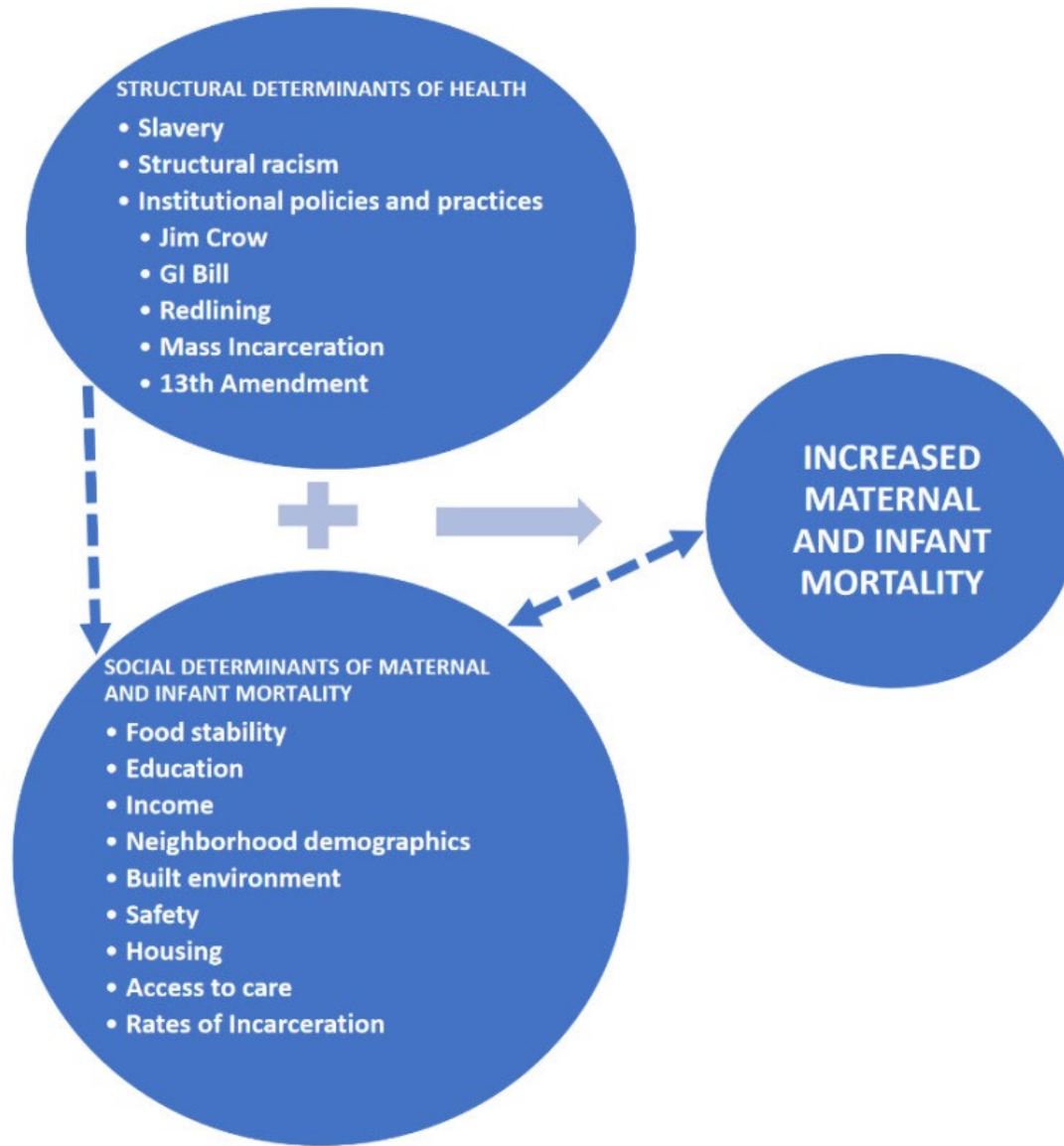
Maternal deaths by Race/Ethnicity, 2018-2022



# Black maternal health and mortality

"Black women are three times more likely to die from a pregnancy-related cause than White women. Multiple factors contribute to these disparities, such as variation in quality healthcare, underlying chronic conditions, structural racism, and implicit bias. Social determinants of health prevent many people from racial and ethnic minority groups from having fair opportunities for economic, physical, and emotional health."





# ACOG Recommendations

- Inquire about and document social and structural determinants of health
- Maximize referrals to social services
- Provide access to interpreter services for all patient interactions when patient language is not the clinician's language
- Acknowledge that race, institutionalized racism, and other forms of discrimination serve as social determinants of health
- Recognize that stereotyping patients based on presumed cultural beliefs can negatively affect patient interactions
- Advocate for policy changes that promote safe and healthy living environments



# Recognition of patient behaviors

- Providers should recognize social needs are just as important as medical needs
- A shared history and daily experiences of discrimination among patients of color might negatively influence their health outcomes and feelings about health care system
  - Avoiding care
  - Mistrusting health care providers
  - Not following recommended treatment
- Immigrants may not access care
  - Lack of coverage
  - Fear of deportation

**1 in 5**

About 20% of women reported mistreatment while receiving maternity care.

**1 in 3**

About 30% of Black, Hispanic, and multiracial women reported mistreatment.

**45%**

Almost half (45%) of women held back from asking questions or sharing concerns during their maternity care.

- Understand the patient's decision as the result of larger systems that create and maintain inequalities
  - Delve deeper to understand reasons for "non-compliance", missed appointments, other care challenges
- Recognizing SDOH will allow providers to better understand patients, effectively communicate about health-related issues, and improve health outcomes

- Poor weight gain- job instability with inability to afford adequate food for her family with the inability to maintain proper nutrition
- Increased weight and weight gain- access to healthy food options or walkable neighborhoods for physical activity
- Late or missed appointments- relying on public transportation
- Medical compliance- lack of health care coverage and inability to afford medication

# Practice Tools

- Screening for Social Determinants of Health
- Medical–Legal Partnerships
  - Obstetrician–gynecologist practices that are part of a community health care clinic or network should encourage the facility to establish medical–legal partnerships..
  - Liaisons with Community-Based Social Needs Programs
    - Develop partnerships with social workers and local community advocates who provide assistance with basic resources
  - Transportation and Logistics
    - Underserved populations often have difficulties obtaining transportation to health care facilities
    - Access to public transportation should be considered when planning office locations

**Table 1.** Sample Screening Tool for Social Determinants of Health ↵

Domain	Question
Food	In the last 12 months, did you ever eat less than you felt you should because there was not enough money for food?
Utility	In the last 12 months, has your utility company shut off your service for not paying your bills?
Housing	Are you worried that in the next 2 months, you may not have stable housing?
Child care	Do problems getting childcare make it difficult for you to work, study, or get to health care appointments?
Financial resources	In the last 12 months, have you needed to see a doctor but could not because of cost?

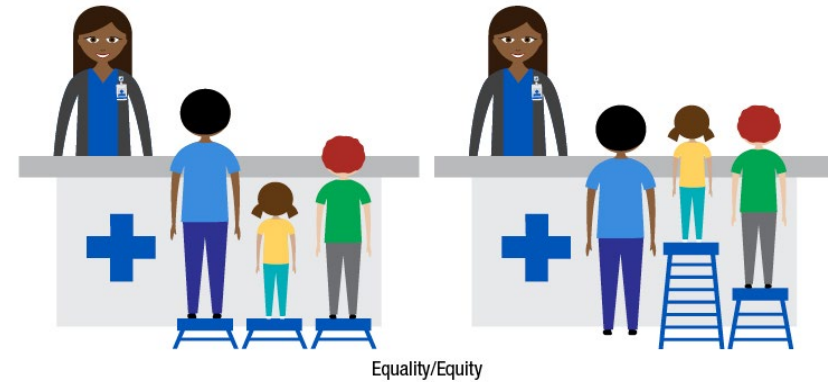
Transportation	In the last 12 months, have you ever had to go without health care because you did not have a way to get there?
Exposure to violence	Are you afraid you might be hurt in your apartment building, home, or neighborhood?
Education/health literacy	Do you ever need help reading materials you get from your doctor, clinic, or the hospital?
Legal status	Are you scared of getting in trouble because of your legal status? Have you ever been arrested or incarcerated?
Next steps	If you answered yes to any of these questions, would you like to receive assistance with any of those needs?

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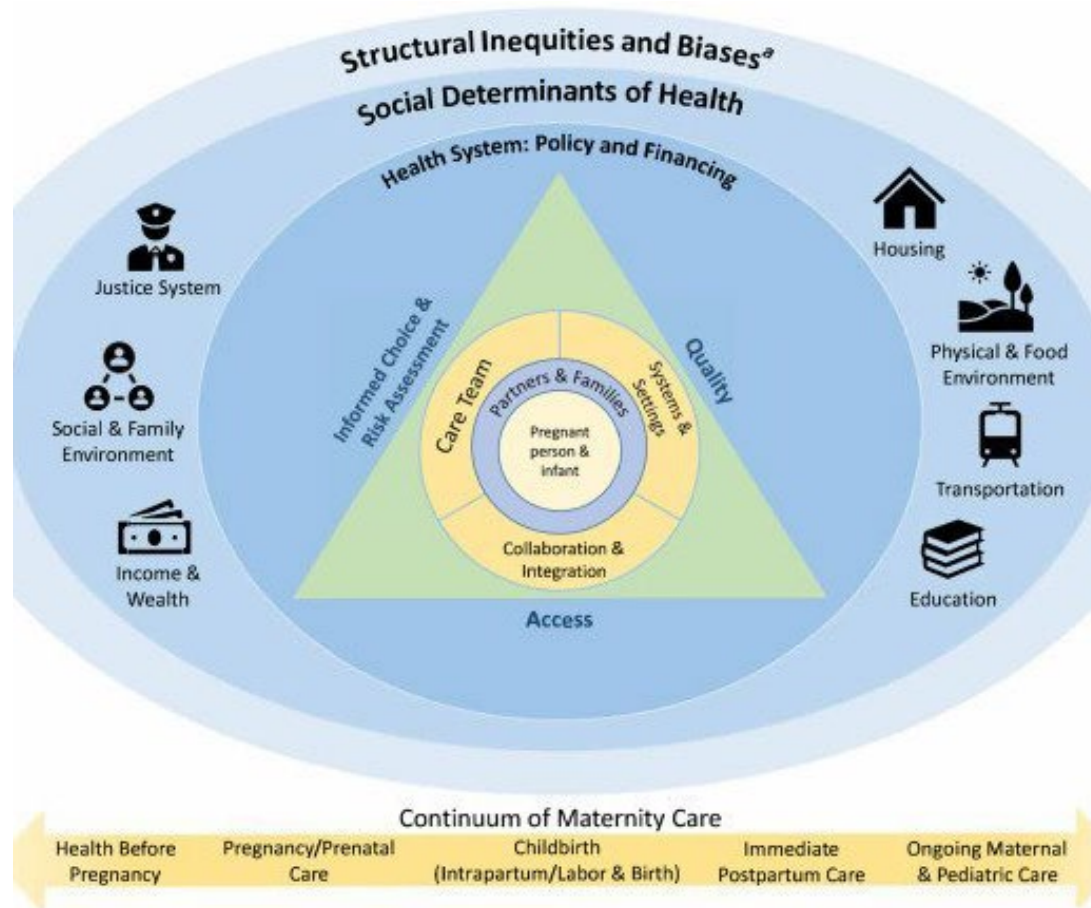
Modified from Health Leads. [Social needs screening toolkit](#). Boston (MA): Health Leads; 2016; *and* Bourgois P, Holmes SM, Sue K, Quesada J. Structural vulnerability: operationalizing the concept to address health disparities in clinical care. [Acad Med 2017;92:299–307](#).

# PAVING THE ROAD TO HEALTH EQUITY

**Health Equity**  
is when everyone has the opportunity  
to be as healthy as possible



- Inequities in health are socially determined, preventing poorer populations from moving up in society and making the most of their potential.
- Pursuing health equity means striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social conditions.
- Action requires not only equitable access to healthcare but also means working outside the healthcare system to address broader social well-being and development.



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Thank you!

