12-21-2022

Medical Racism: Comparing Prenatal Care Across Races in the United States

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December 2022

Abstract

Prenatal care describes any care a woman receives during her pregnancy. It is intended to keep both the mother and the child healthy and also to reduce the risk of complications during and after birth. This care is especially important for women with high-risk factors so that doctors and nurses are able to monitor their health and the health of their baby during the duration of their pregnancy. For prenatal care to be most effective, it is imperative to begin prenatal care within the first trimester of a woman's pregnancy. However, in the United States, medical racism creates a major barrier for women of color in receiving prenatal care. Oftentimes, marginalized women receive prenatal care too late or not at all. As a result, the rates of maternal mortality and fetal mortality are higher for marginalized women than for their white counterparts. Barriers such as financial barriers, transportation barriers, inhospitable institutional practices (i.e. medical racism), general dislike or fear of prenatal services, and many other factors, contribute to the disparities marginalized women face within the American healthcare system. This research project aims to compare the percentage of mothers receiving early prenatal care across races as well as compare the percentage of women of reproductive age that are insured across races to understand if these variables contribute to poor prenatal care amongst marginalized women. Data indicates that there is in fact a correlation between the percentage of women who are uninsured and those who received early prenatal care, by race and ethnicity. These results illustrate that there is an intersectionality of many barriers that continue to perpetuate the issues of medical racism that need to be addressed in order for maternal and fetal health of marginalized identities to increase.

Objective

The objective of this project is to analyze the prevalence of prenatal care amongst marginalized women and compare it to their white counterparts in different regions of the United States. Prenatal care ensures that a mother and her baby are healthy before, during, and after the pregnancy to ensure that the next generation is healthy. This is especially true for marginalized women in the American healthcare system. Medical racism is very prominent in the medical system of the united states making this population much more vulnerable to health problems than their white counterparts.

Introduction

The United States has one of the most diverse populations in the world. Yet, our healthcare system is still catered to the white cis male individual. This leaves out women, persons of varying races and ethnicities, persons of varying sexual identities, and many more. Healthcare should be a universal human right, but so many are still fighting to fight for the bare minimum when it comes to accessing adequate healthcare. Why does this still exist? These issues are caused by the intersectionality of many identities that cannot be ignored.

Moreover, women’s health is especially important because, for years, women’s issues have been belittled as women’s hysteria instead of being taken seriously. Women have never been taken seriously in the highly patriarchal society that we currently live in. Even going into the highly advanced 21st century, these inadequacies still exist. More importantly, women are especially important because they are where life begins. They are the reason we are able to create families and generations of legacies. Without women, life as we know it today, would not exist. If we do not give proper attention to the

healthcare issues of women, we will never advance as a society because we are not supporting the sustenance of life.

One major issue within women's health care is prenatal care. Prenatal care refers to any care women receive while pregnant. It allows doctors and nurses to check in on the mother and their baby periodically throughout the pregnancy to ensure there are no major health issues. This care is extremely important to make sure the next generation is healthy. In addition, during these visits, doctors are available as resources for mothers during the length of pregnancies for any discomfort they are experiencing and how they can best alleviate it. Prenatal care is generally begun as soon as a mother realizes she is pregnant. For healthy mothers with a low-risk pregnancy, this means that they visit their doctor every 4 to 6 weeks for the first 32 weeks, every 2 to 3 weeks from weeks 32 to 37, and every week from week 37 until the delivery. If the mother or baby presents with other health issues or if the pregnancy is deemed as a high-risk pregnancy, the frequency of these visits may be altered.

Many barriers exist which prevent women from receiving proper prenatal care. However, there is a lack of focus on fixing these barriers in the system. Examples of such barriers include financial barriers, transportation barriers, inhospitable institutional practices (i.e. medical racism), and general dislike or fear of prenatal services. Furthermore, a mother's demographic risk factors, such as their minority status, age, education, marital status, income, and geographic location, are also contributors to poor prenatal care. Many programs have been designed to improve women's participation in prenatal care but these programs pay little attention to the reasons why poor prenatal care existed in the first place and how these issues can be fixed.

This study takes a particular focus on the issue of medical racism and its effect on prenatal in the past few years. The variables studied in this study are the percentage of mothers receiving early prenatal care, and the percentage of women of reproductive age that are insured. These factors were chosen because of their intersectionality between prenatal care and racial/ethnic background. The prevalence of early prenatal care amongst varying races and ethnicities can show the differences in how people perceive care, which is important in order to dismantle any dislike or fear of prenatal care that may exist. The insurance status of mothers across races and ethnicities can point towards medical racism creating financial barriers for mothers to receive prenatal care. While these two variables do not highlight all of the issues of medical racism within maternal and fetal care, they are large contributors to the poor care mothers have and continue to receive. Programs have been implemented to remove disparities due to race and ethnicity in maternal care but more work is needed to further remove these inadequacies.

The March of Dimes Peristats database allows one to make comparisons between national data or state data for different factors affecting maternal and infant health. The data can further be separated by age, race, and ethnicity. This project will be looking at the data that has been collected by state for mothers receiving early prenatal care and about uninsured mothers before pregnancy that is further organized by race and ethnicity. Prenatal care is any care that is pregnancy-related. This can include things such as screening and treatment for medical conditions, and identification and interventions for possible poor birth outcomes that may result from smoking or poor nutrition. Peristats data is collected by looking at the timing of the first prenatal care visit. Early prenatal care as defined by the March of Dimes refers to mothers who seek out prenatal care in the first trimester of pregnancy. It does not include mothers who seek out care in the second or third trimester or receive no prenatal care. The data was collected from the period of 2018-2020. Health insurance is extremely important because it determines whether individuals seek out the care they need to prevent health problems. By studying

disparities in health insurance, we can why certain demographics have poorer health conditions than others. This is especially true for uninsured mothers who have a hard time getting care before, during, and after their pregnancy. As a result, the health of the mothers and their babies is negatively impacted, pointing to the severity of the issue.

The National Vital Statistics Reports were used for their collection of data in 2004/ 2005 and 2016 on prenatal care utilization in the United States. Prenatal care utilization was assessed based on the trimester in which prenatal care was begun and by also using the Adequacy of Prenatal Care Utilization (APNCU) Index for selected maternal characteristics. The data was obtained from the national birth files of their respective years and was based on 100% of the births that were registered in all 50 states for those respective years. Moreover, the data was based on the revisions made in 2003 to the U.S. Standard Certificate of Live Birth. The data collected from this study for the purpose of this project was the percentage of women who began receiving prenatal care in the first trimester based on race and ethnicity for comparison purposes.

The book titled *Prenatal Care: Reaching Mothers, Reaching Infants* was obtained from the National Library of Medicine. The first chapter of this book, titled *Who Obtains Insufficient Prenatal Care?* was used to gather data for this project. It is known that ¼ to ⅓ of all pregnant women in the US do not obtain any early, continuous prenatal care. Moreover, depending on a woman's sociodemographic group and demographic area, certain women are less likely than others to seek out early prenatal care. As time has passed, trends have indicated a decline in women seeking prenatal care. This specific source looks at the birth certificate data for 50 states and the District of Columbia for the year 1985 to understand the trends in early prenatal care for women of varying sociodemographic and geographic backgrounds.

Kids Data, powered by the Population Reference Bureau, provides data on the percentage of mothers receiving early prenatal care in the entire nation, the state of California, and in every county of California. The state of California is particularly interesting for prenatal research as this is the state with the most mothers receiving early prenatal care across all races in the United States. The data from 2020 presented on the Kids Data website was gathered from the CDC Wonder Online Database Natality data in May of 2022. Furthermore, this website is particularly interesting as it talks about current policies that have been put in place to improve maternal and infant outcomes as well as future policies that can be implemented to better maternal and infant health.

In *Closing the Coverage Gap Would Improve Black Maternal Health*, Judith Solomon studies the effect of the Medicard “coverage gap” on the black maternal health crisis. In the coverage gap, adults with low incomes are facing difficulties accessing coverage because they live in one of twelve states that did not expand their Medicaid coverage. As a result, more than 800,000 women of reproductive age are denied access to continuous health coverage which is instrumental in ensuring the health and safety of a mother and her baby during pregnancy. The focus of this article looks at the poor outcomes for black mothers within the United States. It was found that Medicaid expansion has positive impacts on reducing rates of maternal mortality and morbidity for black mothers. There was also an increase in prenatal and preconception care for mothers in the states that had expanded Medicaid coverage. Data was collected on the twelve states that did not expand Medicaid coverage and how this affected the women of reproductive age of varying races from accessing affordable health coverage.

The National Partnership of Women & Families published a fact sheet in April of 2019 titled: *Despite Significant Gains, Women of Color Have Lower Rates of Health Insurance Than White Women*. Their research points to coverage disparities for women of color in the United States healthcare system. These disparities persist despite significant gains in health insurance due to the Affordable Care Health. Among women of color, there is a higher prevalence of preventable diseases and chronic health conditions (i.e. maternal mortality, diabetes, viral hepatitis). These disparities continue to persist due to a poor focus on ensuring all women have affordable health care. Proper healthcare ensures women of color get the care they need in order to stay healthy such as preventative care, screenings, and chronic disease management. This project looks at the data provided in this fact sheet to show the disparities between women of color and white women regarding healthcare coverage.

Georgetown Universities Health Policy Institute discusses barriers to health care for women in *Georgia's Women of Reproductive Age Face Many Barriers to Health Care.* Georgia was one of the states that did not expand Medicaid. As a result, Georgia has seen the highest rates of uninsured women of reproductive age in the United States. Reproductive age is defined as ages 18 - 44 for the purpose of this study. Almost one in every five women in Georgia is without health insurance. These disparities in access exist across all races and ethnicities in Georgia. The current Medicaid program in Georgia is poorly performing as it concerns prenatal care, postpartum care, and prevalence of babies with low birth weight. Their research looks at the uninsurance rates across races and ethnicities in Georgia for women of reproductive age and compares it to that of the entire nation. This project looks specifically at the data provided for the uninsurance rates of women of reproductive ages in the entire nation.

In the Assistant Secretary for Planning and Evaluation, an issue brief titled, *Health Coverage for Women Under the Affordable Care Act*, examines the various factors due to which women experience disparities in health care. The Affordable Care Act has increased women's access to comprehensive health care since its launch. The Affordable Care Act specifically affects women of reproductive age as it allowed for an increase in maternity care, birth control access, and breastfeeding supply and support. For this brief, reproductive age is defined as ages 15 - 44. The data collected in this brief was gathered from the American Community Service Public Use Microdata Sample 1-Year Estimates from 2010-2019. The data was then used to calculate the number of uninsured women of reproductive age by race and ethnicity. For this project, data was extracted from Table 4 which looked at race and ethnicity among women of reproductive age.

The Guttmacher Institute looks at recent changes in insurance for women of reproductive age in *Uninsured Rate Among Women of Reproductive Age Has Fallen More Than One-Third Under the Affordable Care Act*. It was found that within the first two years of the implementation of the Affordable Care Act, there was a 36% decrease in the proportion of women of reproductive age without insurance. In the case of this article, reproductive age is defined as ages 15 - 44. The data was gathered from the U.S. Census Bureau's American Community Survey and then analyzed to understand trends. However, even with the implementation of the Affordable Care Act and its positive benefits of increasing insurance access, significant disparities still exist based on the income, race or ethnicity, citizenship status, and state of residency of a woman. Data that was gathered on a women's insurance status and race were used for the purpose of this project.

In looking at the prevalence of prenatal care in the United States amongst marginalized women compared to their white counterparts, this project will explore two variables: the prevalence of early prenatal care and the prevalence of insurance for women of reproductive age. The previously

summarized articles will be used to collect and create data tables and graphs for the purpose of this project. In looking at these two variables, this project aims to understand the intersectionality which continues to perpetuate disparities that exist due to a long history of both medical hysteria and medical racism. By studying the prevalence of early prenatal care along with the prevalence of insurance, comparisons can be made across races to understand where disparities are highest. These comparisons and conclusions can be used by lawmakers to create positive changes to dismantle years of disparities to create a more equitable healthcare system.

Methods

This research will be done by conducting searches on trusted and highly used platforms. Some examples include PUBMED, Google Scholar, Web of Science, JASTOR archives, etc. So far, the sources that have been used are the March of Dimes and the National Library of Medicine. Using these platforms ensures data validity and avoids additional screenings that may otherwise be needed. The data collected from the sources will then be extracted and visualized to be analyzed quantitatively and qualitatively as it pertains to this research question. All of the data will be collected by systematically assessing previous data from older studies, no new studies will be conducted at this time.

This project was done at DePauw University as the final project for the class titled *Datafication of Society*. As such, it is important to acknowledge that this study presents limitations that may hinder its validity. It is important to acknowledge that this project was done at the undergraduate level where research was limited to a database of only 25 articles. A more official and in-depth analysis of medical racism and its prevalence in prenatal care would look at many more sources and articles to obtain more holistic and accurate results. It is also important to acknowledge that this project was carried out by an undergraduate who does not have a vast skill set or degree in prenatal care or statistics.

Results

Early prenatal care refers to any pregnancy-related care that is begun in the first trimester of pregnancy. This care is the most adequate care mothers can receive to ensure quality care before, during, and after pregnancy which can improve maternal and infant mortality, preterm births, and low birth weight. Inadequate care can be delayed if begun in the second trimester, or late if begun in the third trimester. There are many determinants to whether women seek out early prenatal care. Such factors include socioeconomic or insurance status, social acceptance of prenatal care, general fear of healthcare providers, racial barriers, and many others. While improvements have been made to the current healthcare system, the United States still trails behind other countries in maternal and infant mortality rates. One of the biggest reasons these high mortality rates continue to exist is the high levels of medical racism within the American healthcare system. To this day, Black and American Indian/ Alaska Native mothers continue to experience high rates of adverse pregnancy and birth outcomes.

Over the recent years, due to the changes in the Affordable Care Act and Medicaid policies, access to insurance for women has increased. However, barriers to access still exist based on income, race and ethnicity, citizenship status, and many other factors affecting a woman. Of these categories, women of color persistently experience the biggest disparities in health care coverage (8). Without access to comprehensive and continuous health coverage, especially for women of reproductive health, maternal and fetal health outcomes will not see any improvement (9). This access also allows women to

access preventative care such as birth control, giving them the opportunity to choose when they would like to become a parent. Moreover, without insurance coverage, many pregnant women go without prenatal care which increases rates of maternal and infant mortality (8).

The following table looks at the prevalence of early prenatal care across racial and ethnic groups to understand any trends and disparities that continue to exist across these groups and how they have changed over time. This data was collected across different sources which used different methods of collecting data such as conducting surveys or viewing birth record data. The data is represented for the following racial and ethnic groups: White, Black, American Indian/ Alaska Native, Asian/ Pacific Islander, and Hispanic mothers. Some sources did not represent all five groups that were studied in this project. Instead, the data from these studies were then grouped across multiple groups to be used in this project. Another discrepancy in the data of the table is discussed in the footnotes of the table.

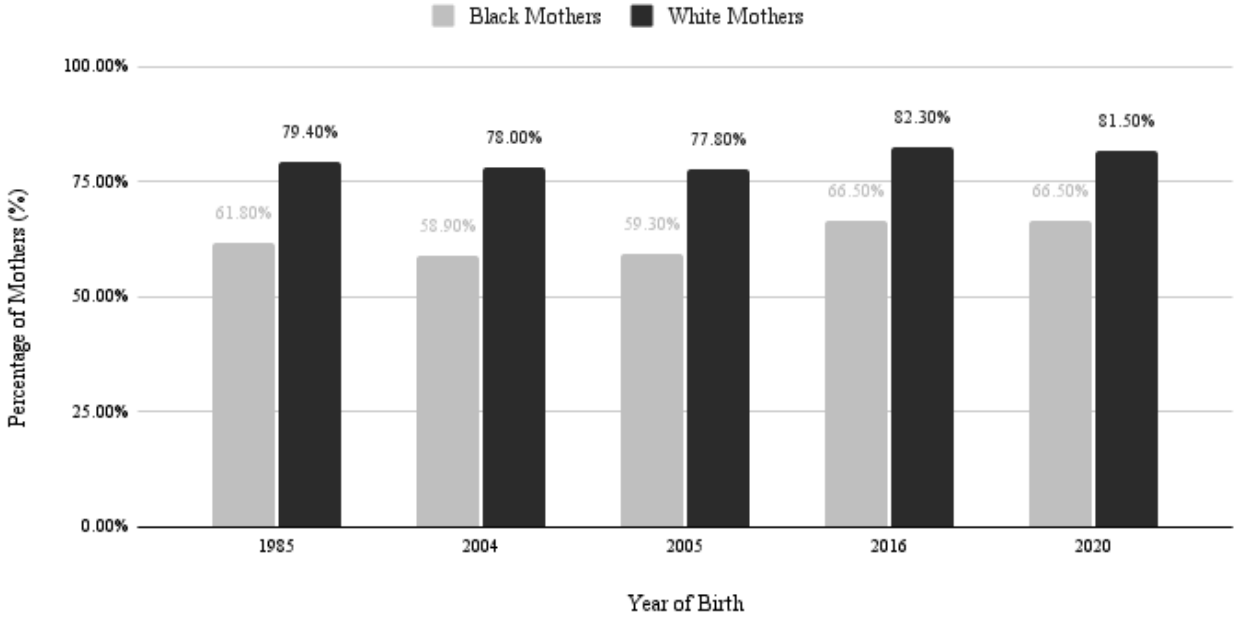
TABLE 1

Variable:	**% of Mothers Recieving Early Prenatal Care by Race**						
STUDY	**YEAR**	**REGION**	**WHITE**	**BLACK**	**AMERICAN INDIAN/ ALASKA NATIVE**	**ASIAN/ PACIFIC ISLANDER**	**HISPANIC**
[1]*	2018-2020	West Coast	81.92%	71.39%	63.71%	76.37%	74.77%
[1]*	2018-2020	Midwest	83.88%	66.13%	62.13%	74.63%	69.10%
[1]*	2018-2020	Northeast	85.95%	71.21%	75.71%	83.47%	74.48%
[1]*	2018-2020	South	80.08%	67.95%	71.78%	73.78%	64.31%
[1]*	2018-2020	National	82.84%	69.09%	68.04%	76.81%	70.51%
[5]**	2020	National	81.50%	66.50%	62.30%	80.80%	70.60%
[2]**	2016	National	82.30%	66.50%	63.00%	80.60%	72.00%
[4]**	2005	National	77.80%	59.30%	72.80%		57.00%
[4]**	2004	National	78.00%	58.90%	72.90%		56.50%
[3]**	1985	National	79.40%	61.80%	76.20%		

* - This study presents the percent of live births to mothers recieving early prenatal care.

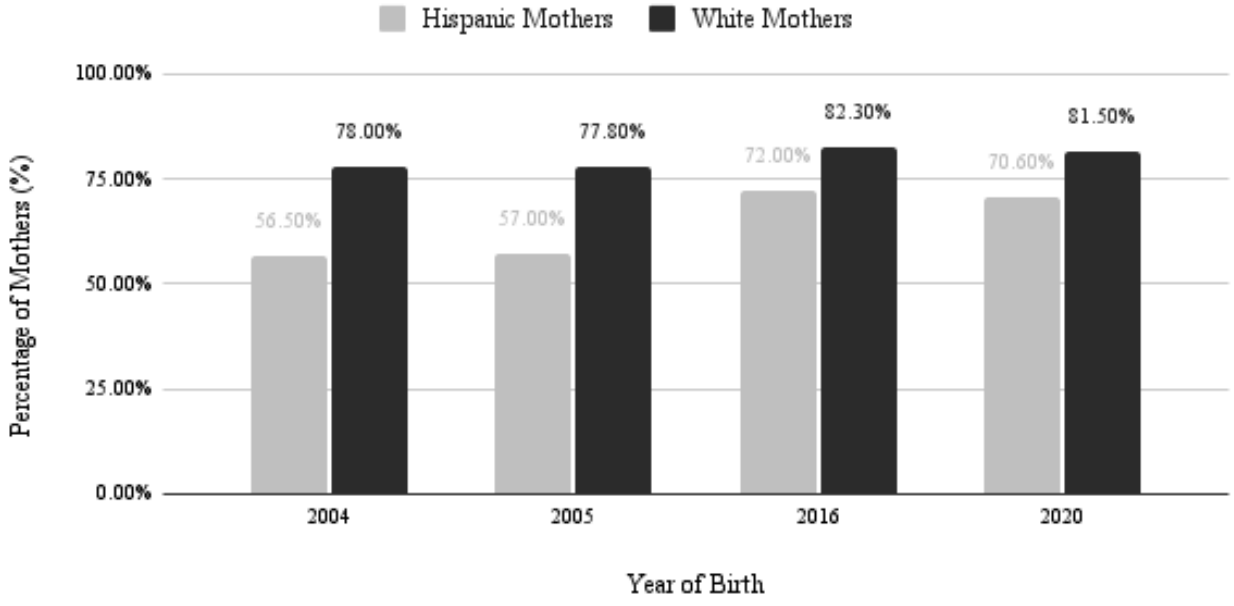
** - These studies present the percentage of all mothers receiving early prenatal care regardless of live birth status.

Figure 1: Comparison of Black and White Mothers Receiving Early Prenatal Care from 1985 to 2020



*The data from source 1 is not represented in this graph since it represented a range of years

Figure 2: Comparison of Hispanic and White Mothers Receiving Early Prenatal Care from 1985 to 2020



*The data from source 1 is not represented in this graph since it represented a range of years

**The data from source 3 is not represented because the source did not separate Hispanic mothers from American Indian/ Alaska Native mothers or Asian/ Pacific Islander mothers.

The following table looks at the effect of race and ethnicity on the insurance status of women, especially as it affects mothers during pregnancy or women of reproductive age. The data was collected from a variety of sources which collected data using different methods such as studying population surveys or other databases. The data is represented for the following racial and ethnic groups: White, Black, American Indian/ Alaska Native, Asian/ Pacific Islander, and Hispanic mothers. In some cases, data was not available for specific races and ethnicities and was labeled with NA. In other cases, data was grouped together because race and ethnicity were grouped differently across different sources. Other data discrepancies are discussed in the footnotes of the table.

TABLE 2								
Topic:	**Insurance Status of Women**							
STUDY	**YEAR**	**REGION**	**VARIABLE**	**WHITE**	**BLACK**	**AMERICAN INDIAN/ ALASKA NATIVE**	**ASIAN/ PACIFIC ISLANDER**	**HISPANIC**
[6]*	2017	National	% of women uninsured before pregnancy	8.59%	11.83%	NA		32.32%
[7]	2019	South	% of women of reproductive age (19-49) with incomes below the poverty line without insurance	35.00%	29.00%	1.00%	1.00%	35.00%
[8]**	2013	National	% of women without health care (ages 18-64)	12.80%	19.30%	26.60%	16.50%*	30.40%
[8]**	2016	National	% of women without health care (ages 18-64)	7.90%	12.20%	18.60%	8.12%*	19.50%
[8]**	2017	National	% of women without health care (ages 18-64)	8.00%	13.90%	21.10%	9.00%*	19.90%
[9]	2019	National	% of women without health care (ages 18-44)	12.00%	13.30%	24.00%	7.70%	24.30%
[10]	2019	National	% of women without health care (ages 15-44)	38.00%	14.00%	1.00%	4.00%	40.00%
[11]	2015	National	% of women without health care (ages 15-44)	8.60%	14.10%	10.50%		24.70%

*This data only includes 41 of the 50 states averaged together

*The data for Asian/ pacific islander mothers only represents asian mothers and does not include pacific islanders

Discuss

In TABLE 1, we see a general increase in the percentage of mothers receiving early prenatal care over the years. Hispanic mothers received the lowest percentage of prenatal care across the time period in which the data was collected at 56.50% in 2004. Moreover, Hispanic mothers also displayed the largest increase in care receivable with an increase to 70.51% in the 2018-2020 year range. This is an overall increase of ~14.01% in 16 years. However, this is still ~12.33% below the number of white mothers receiving early prenatal care in the 2018-2020 range. For black mothers, this percentage

difference is even more at ~13.75%. This shows that while there has been an increase in more representative healthcare over the last few years, there are still massive disparities in healthcare access for mothers in the United States across racial and ethnic groups. These discrepancies are visually seen in Figure 1 where early prenatal care receivable for black and white mothers are compared over the years. Black mothers consistently displayed and continue to display lower rates of early prenatal care receivable which desperately need to be addressed to better our healthcare system.

In TABLE 2, we see that the of women of reproductive age without insurance is generally higher for women of color compared to their white counterparts. Hispanic women show the highest percentages of uninsured women at ~40% in 2019. In this same year, ~38% of white women and ~14% of black women of reproductive age were uninsured (10). This data set was particularly interesting because it displayed that black women of reproductive age were more likely to be insured than white women. A similar discrepancy is visible in source 7. However, from the general discussions present in the sources from which the data was collected, it can be inferred that women of color of reproductive age still experience higher percentages of uninsurance. This discrepancy may be pointed to one key difference among the data in TABLE 2: the reproductive age gap. As the sources from which data was gathered were changed, the age gap which was considered to be the reproductive age of a woman also changed. There seems to be no universal rule defining the reproductive age of a woman. As a result, it means that making accurate comparisons across sources from TABLE 2 will most likely not prove to be accurate. There is no visible trend in the data.

Comparing TABLE 1 and TABLE 2, we can conclude that there is, in fact, a correlation between the percentage of women who are uninsured and those who receive early prenatal care, by race and ethnicity. Hispanic mothers were ~12.33% below the percentage of white mothers receiving early prenatal care from 2018-2020. In looking at Hispanic women at reproductive age and their insurance status, they are ~10-15% more likely to be uninsured than their white counterparts. The same can be said about black mothers who are ~5-7% more likely to be uninsured than their white counterparts. Given these trends, there likely exists a barrier to care for uninsured women of reproductive age such that when women of color are uninsured, they are less likely to pursue early prenatal care because they do not have the facilities to do so.

This project also aimed to look at the educational attainment of mothers at the time of birth and compare it across races. Educational attainment is important in understanding prenatal care disparities because it is usually known that more educated mothers are more likely to receive prenatal care. However, it is also known that educational attainment varies greatly among racial and ethnic groups, which may have an impact on care disparities. Unfortunately, no data was found that compared the educational attainment of mothers by race in this small-scale meta-analysis. This variable was therefore omitted from the study of this topic. A future study aims to investigate educational attainment data by the race of mothers to provide an interesting perspective on a bigger issue of racism within the education system.

Conclusion

As we have progressed into the 21st century, medical racism within the healthcare system has seen improvements but still continues to exist. The United States has one of these most advanced medical systems but the rates at which maternal and fetal mortality still exist are higher than in any other country. This is in part due to the barriers women, especially marginalized women, experience in accessing healthcare. These barriers need to be addressed by policymakers to ensure that women are able to receive the healthcare they need to prosper and for the next generation to be healthy.

This project only concerned two variables affecting medical racism as it pertained to prenatal care. However, future plans for this project include opportunities to study educational attainment across races, transportation barriers, myths about prenatal care across races, a comparison of prenatal care across countries, and many other variables to understand other ways in which medical racism continues to present itself. Medical racism is not, however, limited to prenatal care only. Within maternal and fetal healthcare, medical racism continues to present itself within postnatal and perinatal care. It continues to exist in the barriers that prevent women, regardless of pregnancy status, from receiving general healthcare. Moreover, it is present in every realm of healthcare from geriatrics to pediatrics, etc.

Acknowledgments

This project has benefitted greatly from the support and advice of professor Naima Shifa, and the DePauw Honor Scholar Program for their support of the class.

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