ARKANSAS ADVOCATES FOR CHILDREN & FAMILIES

ARKANSAS'S MATERNAL HEALTH CRISIS:

WOMEN ACROSS THE STATE SHARE THEIR EXPERIENCES AND VIEWS

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About Arkansas Advocates for Children and Families

Arkansas Advocates for Children and Families is a statewide, nonprofit child advocacy organization established in 1977. Our mission is to ensure that all children and their families have the resources and opportunities to lead healthy and productive lives and to realize their full potential. For more information, visit aradvocates.org

Background

Arkansas has one of the highest maternal mortality rates in the country. In our state, the overall pregnancy-associated mortality rate (all deaths during pregnancy and within the first year postpartum) from 2018 to 2021 was 97.6 deaths per 100,000 live births.[1] And according to the Arkansas Maternal Mortality Review Committee, 95% of maternal deaths from 2018-2021 were preventable.[2] This data has led to conversations in communities around Arkansas and at the state Capitol about what can be done to improve maternal health outcomes. However, during many of the conversations hosted thus far, an important voice has often been left out of the room — women who are pregnant or have recently given birth. To elevate the voices of these women into important policy conversations, Arkansas Advocates for Children and Families hosted four focus groups around the state, two with Black women in the Delta, one with women enrolled in a residential substance-use disorder treatment facility (Specialized Women's Services Program), and a final focus group with Marshallese women in Northwest Arkansas.

The focus groups were hosted in November and December 2024 and were organized with the assistance of our local partners. Focus groups ranged from about eight to 12 participants. Discussions in the Delta were hosted in Phillips County and Chicot County. These counties were selected because of low access to maternal health care in the counties. The median number of minutes to travel to delivery facilities from Phillips County is 51 minutes and 45 minutes for Chicot County.[3] Chicot County is considered by the March of Dimes to be a maternity care desert, defined as an area "without access to birthing facilities or maternity care providers."[4] The same March of Dimes report also found that both counties have high chronic health burdens (percentage of women who had one or more chronic health conditions) and preterm births.[5] And both counties' populations are majority Black.[6]

Black and Marshallese women in Arkansas have a pregnancy mortality rate significantly higher than that of non-Hispanic White women and higher than the state average. As previously noted, the overall pregnancy-associated mortality rate (all deaths during pregnancy and within the first year postpartum) from 2018 to 2021 in Arkansas was 97.6 deaths per 100,000 live births. The rate for non-Hispanic White women was 79 deaths per 100,000. By contrast, the rate for Black women was 146 deaths per 100,000 and was 198.3 per 100,000 for Asian/Pacific Islander women.[7]

Black women also experience a higher rate of morbidity (illnesses and complications) per birth than women of other races at 22.2 per 1,000 births as compared to 21.6 with women whose race was identified as "Other," 18.1 for Asian/Pacific Islander women, 12.5 for non-Hispanic White women, 9.6 for Hispanic women, and 6.8 for American Indian/Alaskan Native women.[8] And data show that a significant percentage of Marshallese/Asian Pacific Islander women receive inadequate prenatal care.[9]

Another important issue impacting the health of pregnant Marshallese Arkansans is that, due to a decades-old federal law, Marshallese Arkansans did not qualify for Medicaid until 2021, after a new law passed in the United States Congress.[10] The lack of access to Medicaid caused many Marshallese Arkansans to go uninsured until recently, likely impacting their health outcomes. To determine how the state might address these stark disparities, it was important to us to ensure our focus groups highlighted their voices.

We also talked with women with substance use disorders enrolled in a Specialized Women's Services treatment program. In a report from the Arkansas Maternal Mortality Review Committee released in 2023, the Committee cited substance use as a major cause of pregnancy-associated deaths,[11] making it a critical issue to address to improve maternal health outcomes.

Introduction

Though each person's experiences were distinctive, during our conversations with pregnant women and women who have recently given birth, some common themes emerged. Women appreciated when their medical team were good communicators and listeners, but there were some serious consequences for their health and well-being when communication was poor. They struggled with traveling long distances to appointments. Medicaid proved critical in allowing the women to get medical care, but it was sometimes cut off too quickly, and women were left uninsured postpartum. And many women were not aware of what postpartum depression is, and wished they had more access to education and care. Women with substance use disorders often felt judged by their medical team and were hesitant to seek care. Below you will read more of those common themes, but also, vitally, the stories and experiences of the women themselves and how the current state of maternal health in Arkansas has impacted them.

Focus Group Findings

Medicaid

Pregnancy Medicaid

In 2023, 41% of births in Arkansas were paid for by Medicaid.[12] In one focus group, women who were enrolled in Full Pregnant Women Medicaid expressed their appreciation for the benefits they received. A participant said, "I didn't have to pay for anything whenever I got pregnant. Department of Human Services made sure that I had insurance, made sure that I didn't have to worry about any of that at all. And so, my dental care, my OB, all of that was paid for."

Difficulties with Medicaid

Women who were already enrolled in Full Pregnant Women Medicaid encouraged others to enroll as well and said the process for approval was fast. One participant suggested there should be a policy that people should automatically be enrolled in Full Pregnancy Medicaid.

Women in the focus groups also noted several challenges with their Medicaid coverage.

1. Maintaining Medicaid insurance coverage

There are multiple Medicaid coverage options including Full Pregnant Women Medicaid, which all pregnant women who qualify for Medicaid and are citizens are automatically enrolled in when the Department of Human Services is alerted that a woman is pregnant. In Arkansas, that coverage ends 60 days after giving birth, at which point women are supposed to be moved into other coverage options. But our focus group participants reported that is not always the case. Multiple women reported not being moved to another form of health insurance when their Full Pregnant Women Medicaid insurance ended, leaving them uninsured in their postpartum months. Shanta said:

> *I was going to say the cutting off part. They just do it way too fast. Then you have to go through a lot of ups and downs just to get it on. Then when your stuff is messed up, they won't see you because you don't have it. So, something could be going on, and I can't see or tell the doctors about it because something is wrong with my insurance. That's the messed up part about that.*

While some women told us they received a letter in the mail saying their Full Pregnant Women Medicaid insurance coverage would end, others said they did not receive a letter. And one person reported that it was a struggle to get their Medicaid coverage back after her Full Pregnant Women Medicaid ended.

2. Translated materials

Marshallese women in the focus group noted poorly translated materials being sent by the Department of Human Services. For instance, during the unwinding of the public health emergency, the Department sent incorrectly translated letters to Marshallese Medicaid recipients, stating that their coverage had been cancelled because they were lying about their eligibility, rather than stating they had not submitted necessary documents.

3. Billing

The Marshallese women in the focus group also mentioned issues around billing. Specifically, though epidurals for giving birth are covered under Medicaid, they were still charged by their hospital for them.

Dental coverage

Women in the Specialized Women Services Program focus group talked about the importance of Medicaid dental coverage. In 2021, only 41.3% of pregnant Arkansans had a dental cleaning.[13] While not all types of Medicaid health insurance include dental benefits, women on Full Pregnant Women Medicaid receive the full range of benefits, including dental coverage.[14]

Education on benefits

In two of the four focus groups, participants wished that they could have received more information about what was covered under their Medicaid insurance in an understandable way, without jargon.

Quality of care

Communication from medical staff

At all four locations, the women in our focus groups reported appreciating the feeling of being heard and cared for by their doctors, nurses, and other medical staff. Tat talked about a doctor in Northeast Arkansas: “He sits there, and he talks to you; he will understand where you’re coming from, and I love the nurses he has.” In serious medical situations, such as preeclampsia and a baby’s heart rate dropping, the women especially appreciated clear communication about what was happening and was going to happen.

But not all focus group participants felt like their medical team were good communicators. Shanta said, “Down here [the Delta] they just want to get you in and out.” Jalyen reported that after telling her doctor she did not want an epidural, she was pressured into getting one. She said it was not properly administered, and she still felt pain. She also said she was not able to build a relationship with her doctor because her doctors were frequently changing. Another woman said that she had preeclampsia, but her doctor never told her. She did not find out until she started vomiting blood and went to the emergency room.

Treatment of pregnant women with substance use disorder

Many of the women with substance use disorders talked about their concerns around judgement and poor treatment by medical staff. Taylor shared:

> *Whenever I gave birth to my son, I totally expected judgement having drugs in my system, my son having drugs in his system, totally expected it. But they could have done better at trying to hide that and just do what they were there for. And that's to be a doctor and to help with my health, my son's health, you know? But I was having messed up comments, looks. Like the lady that was delivering my baby for the most part until the doctor came in, she was so nice the whole delivery. And whenever I went to speak to her after [the delivery], she made it a point not to look in my direction. I got some really terrible treatment.*

Katie said if medical staff were less judgmental, more people would feel comfortable going to the doctor when they are in active addiction. Jennie reported that she was afraid to go to the doctor because she was pregnant and using. But not everyone had a negative experience.

Cassidy said that she had a good experience at the University of Arkansas for Medical Sciences. They were nonjudgemental and gave her options of what to do when she was pregnant and after birth. But she said that it was important that she was honest with them about her substance use history to get the care that she needed. Disclosing substance use was a topic of debate among focus group participants. Some said people feared repercussions if they told their doctor that they had a substance use disorder. One person suggested that drug testing be required to make sure people who were afraid to disclose their substance use to their doctor could still get resources. But several focus group participants said that if drug testing were required, many pregnant people with a substance use disorder would not seek medical treatment at all during their pregnancy.

Serious medical issues

Multiple women in the focus groups reported experiencing serious medical issues while they were pregnant and giving birth. In one focus group several women received emergency c-sections, and they questioned if a regional doctor was only performing c-sections for the money. A report by the Arkansas Center for Health Improvement found

that the c-section rate for women living in Chicot County was 42.8% and 38.1% for women living in Phillips County. The national average is 33.5%.[15]

One woman in the Specialized Women Services Program focus group said she relapsed during pregnancy and had to go to a residential treatment facility. She was concerned that her behavioral health doctor and OBGYN provided conflicting information on the safety of the medicine she received during her relapse. Her OBGYN told her that her mental health care medicine would damage her fetus. Another participant said she had a lump in her breast that turned out to be a clogged milk duct. She said medical staff ignored her concerns, and she ended up requiring major surgery.

Women in three of the four focus groups also reported having preeclampsia, with mixed experiences on the care they received. As mentioned above, one woman went to the emergency room. Another said she gave birth early because of her preeclampsia and appreciated the care and support she received from medical staff. A third woman said she had preeclampsia during all three of her pregnancies. Because of that, she wanted to receive a tubal ligation, but the doctor questioned her decision.

Doulas

Doulas provide a range of services for pregnant and postpartum women, including emotional support, advocating with hospital staff, breastfeeding support, and creating a birthing plan.[16] When asked about what services would be helpful during or after pregnancy, LaShay immediately answered, “Doulas! I wanted a doula. There are no doulas here anymore. I felt like having access would help and advocate for us and my health — to me that would help.” Several other women in the group agreed. And participants of a separate focus group felt that doulas would be helpful once they learned about the services they provide. A recent study by the University of Arkansas for Medical Sciences found that, as of November 2024, there were fewer than 50 trained doulas in Arkansas.[17] And Arkansas Medicaid does not currently cover doula services.[18]

Specialized Women’s Services

Women who participated in the focus group at the Specialized Women’s Services residential treatment facility were grateful for the program. Solange said, “Thank God for Specialized Women’s Services!” Specialized Women Services programs are guided by the Department of Human Services and are for parenting mothers. The residential drug and

alcohol treatment programs allow women to bring up to two of their children to live with them. The program also provides parenting classes, childcare, and more.[19] Women in the focus group were appreciative of the services that the program provides like childcare, cooking classes, and budgeting classes. But a couple of the women in the group were concerned about the funding for Specialized Women's Services, saying it requires a lot of funding, and they felt people should be advocating for the program.

Access to care

The lack of OBGYNs in certain areas of the state and the corresponding travel distance to receive medical care was a major concern in three of the four focus groups. According to the March of Dimes, 45.3% of Arkansas counties are maternity care deserts.[20] In the Delta, several women reported traveling to Mississippi for prenatal care and to give birth. Kaee told us, "We need some more medical labor doctors. Helena only has one and Forrest City only has one." One woman recounted giving birth in an ambulance on the way to the hospital, and another said she was sent to Memphis during a medical emergency when she was pregnant. Shanta told us that while she was in labor, her husband was speeding in the car to get to the hospital in time. The police pulled them over, and after an explanation, the police escorted them to the hospital. When talking about access to care in the Delta, V said, "It is horrible to be pregnant here."

Travel to appointments was time consuming, burdensome, and costly for many of the women in the Delta focus groups, as well as the focus group of women in the Specialized Women Services Program. People reported having to travel for up to two hours for regular prenatal check-ups. And once at appointments, it could take several hours to complete their appointment. Kaee said, "My appointment was at 3[:00 p.m.], and I didn't leave till 6[:00 p.m.]" Several people said they were charged significant amounts of money by friends and family to drive them to appointments. When discussing transportation provided by Medicaid, there was a mix of opinions; including that the transportation went to too few towns, had too many stops, was helpful, and should be promoted more because they had not heard of it before.

Postpartum depression

In 2021, 19.7% of women in Arkansas who recently gave birth reported having frequent depressive symptoms[21] compared to 12.7% nationally.[22] Several focus group participants shared their experiences with postpartum depression. In the focus group of women in the Specialized Women Services Program, Katie said on reflection she thinks she had postpartum depression, but at the time she did not know what it was and was focused on physical health concerns. Solange told us she had bad postpartum depression but had not tried to access mental health services. Marshallese Arkansans told us that it is culturally taboo to talk about postpartum depression. And in folklore women can become a "monster" after birth and have "a spirit take a hold of them." The stories were likely referencing postpartum depression.

Few focus group participants talked about being provided with or seeking out support postpartum. In fact, more reported that they had not sought or received help. But V said, "The doctors reach out to you. In Monticello, they call every week and ask you if you are ok. They reach out to help." Two new Arkansas laws passed in 2023 require that women be offered postpartum depression screenings within the first six weeks of giving birth[23] and that Medicaid reimburse for depression screenings.[24]

There were still several suggestions for postpartum mental health care. Shanta said that there should be more information and empathy provided during check-ins. "A lot of people don't know what it is after they have a baby to go through the postpartum [depression] and go through it alone." People suggested that women should be able to receive mental health classes, not only postpartum, but throughout pregnancy, as well. Tat said:

> *I feel like once we have the baby it should be like someone like a social worker or something where we can sit down and talk to about how we feel after having the baby. Because you know when you're pregnant they say you're being emotional and your mind is everywhere. I feel like during and after the pregnancy we should have someone to talk to about how we really feel.*

In the focus group of Marshallese Arkansans, one person said that there should be increased discussion and education about postpartum depression within the community and that, currently, most moms who have postpartum depression will not address it.

Additional resources

During the focus groups, participants talked about a wide range of services and supports that would be helpful during pregnancy and after giving birth.

Food security

Marshallese women reported issues with accessing and maintaining benefits through the Supplemental Nutritional Assistance Program (SNAP), particularly around proving their income and payments received through Cash App. One person said that there should be Pregnancy SNAP benefits — like there is a special Medicaid program for pregnant women — that would help cover the cost of food for the household of the pregnant person and during their maternity leave.

Child welfare services

Multiple women in the Specialized Women's Services Program talked about their children being removed from their custody by the Department of Human Services after giving birth. Most of them said they were never told that their children could be taken away if they, the child, or the umbilical cord tested positive for illegal substances. They told us that it was a traumatic experience, and the reunification process was difficult. The women said they think that people should be alerted to the possibility of their child being removed from their custody and should receive information about how the reunification process works.

The legal definition of child neglect in Arkansas includes the presence of an illegal substance in the child's or mother's system at the time of birth.[25] Certain health care providers are required to report positive results, frequently referred to as Garrett's Law reports, to the Child Abuse Hotline.[26] From July 2023-June 2024 the state received 1,360 Garrett's Law reports. The state substantiated 86% of the reports.[27] And in 10% of those substantiated reports, the child was removed from the parent's custody.[28]

Other supports and services

Focus group participants suggested several other supports and services that would be helpful, as well including lactation support; parenting classes; support groups with other pregnant women and women who just gave birth; increased community support, instead of ostracization, for pregnant teens; and more home visiting programs.

Conclusion

In 2024, the Arkansas Strategic Committee for Maternal Health, organized by the state government, hosted a series of working groups in which Arkansas Advocates participated. The Committee made recommendations on how to move forward on improving maternal health in Arkansas.[29] Some of the recommendations from the women in the focus groups overlap with the report, such as expanding access to substance use treatment, reducing transportation barriers, and adopting policies to increase the number of OBGYNs in the state.[30]

But from our focus groups, we found that women who are pregnant or who have recently given birth need additional supports, as well. For instance, they discussed wanting improved postpartum care including eliminating gaps in Medicaid coverage and creating an education campaign for Marshallese Arkansans on postpartum depression. Another important thing to the women was the need to be respected, heard, and have clear communication with medical staff at a time when they are vulnerable and sometimes afraid.

One clear takeaway for Arkansas Advocates is that a concerted effort needs to be made by decision makers to include pregnant women and those who have recently given birth in conversations about improving maternal health care in the state. Otherwise, some of the biggest issues impacting women's outcomes may continue to go unnoticed and unaddressed.

Acknowledgments

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Note: Participants who agreed to be quoted chose to use either their first name only or a pseudonym to protect their identity.

Endnotes

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