Maternal Health

DEFINITION

Maternal health includes adequacy of prenatal care, health before pregnancy begins, mental and physical health in the perinatal period, and maternal morbidity and mortality. Data are reported by place of mother's residence, not place of infant's birth.

SIGNIFICANCE

Maternal health before pregnancy (preconception), during pregnancy, and after birth (postpartum) impacts health outcomes for mothers and children.[1] Currently, there is a maternal health crisis nationally and in Rhode Island. Beyond that, there are persistent racial and ethnic disparities that disproportionately impact health outcomes for Black, Indigenous, and Women of Color.[2] Social determinants of health, including economic and food security, safety, and social supports impact pregnancy and postpartum health, as well as infant health.[3]

Early, adequate, and appropriate prenatal care is an important way to identify and treat health problems as well as influence behaviors that can affect the health and well-being of infants and mothers. Women receiving late or no prenatal care are at increased risk of poor birth outcomes, such as having babies who are low birthweight or who die within the first year of life.[4,5]

Effective prenatal care screens for and intervenes with a range of maternal needs including nutrition, social support, mental health, smoking cessation, substance use, domestic violence, and unmet needs for food and shelter. A prenatal visit to a pediatrician is the first step in establishing an infant's medical home and can provide valuable links to other services.[6,7]

Early prenatal care is especially important for women who face multiple risks for poor birth outcomes, as is ensuring access to health care services before pregnancy. Effective monitoring and treatment of chronic disease, providing health education, and ensuring access to culturally and linguistically competent health care can improve maternal and infant outcomes.[5,8]

Perinatal mood and anxiety disorders are the most common complication of pregnancy and the first year postpartum. If these issues are not addressed, they can result in poor outcomes including preterm birth, trouble bonding with infants, and breastfeeding challenges. Meeting maternal mental and behavioral health needs improves outcomes for babies.[9]

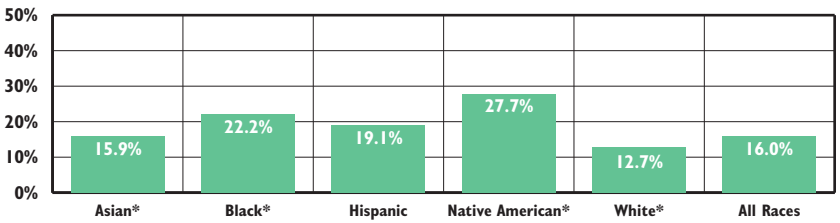
Food and economic security in pregnancy are vital for maternal health. Women living in poverty are at higher risk for poor pregnancy outcomes, and pregnancy exacerbates income disparities that have far-reaching consequences for children and families.[10,11]

Prenatal Care Access & Benefits

◆ **Barriers to appropriate prenatal care include not knowing one is pregnant, not being able to get an appointment or start care when desired, lack of transportation or child care, inability to get time off work, and lack of insurance or money to pay for desired care.[12] Rhode Island women with delayed prenatal care are more likely to report their pregnancy was unintended than women who initiated care in the first trimester. Access to contraception, preventative health care services, and the overall health and economic well-being of individuals impact pregnancy intention.[13,14]**

◆ **Access to primary care for women of reproductive age is a vital component of successful pregnancy care. Well-visits are an important opportunity to discuss preconception health for those who intend to become pregnant, offering an opportunity to discuss management of chronic health conditions or past health history that may have an impact on pregnancy health, birth outcomes, and postpartum health, such as management of hypertension before pregnancy to reduce the risk of preeclampsia.[15,16]**

Women With Delayed or No Prenatal Care by Race/Ethnicity, Rhode Island, 2020-2024



Source: Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2020-2024. * Race categories are non-Hispanic.

◆ **In Rhode Island between 2020 and 2024, 16.0% of women who gave birth did not begin care until the second or third trimester, if at all. Between 2020 and 2024 in Rhode Island, Native American (27.7%), Black (22.2%), Hispanic (19.1%), and Asian women (15.9%) were more likely to receive delayed prenatal care than white women (12.7%).[17]**

Insurance Coverage Improves Access to Prenatal Care

◆ In the U.S. and Rhode Island, women with private insurance have the highest rates of timely prenatal care. Health care before pregnancy is important for maintaining women's reproductive health and ensuring that they can access the reproductive health services they need.[16,17]

◆ Between 2020 and 2024, women with health coverage through Rite Care (Rhode Island's Medicaid managed care program) were much less likely (21.2%) to receive delayed/no prenatal care than women who were uninsured (41.6%). Women with private insurance coverage were the least likely to receive delayed/no prenatal care (11.9%).[17]

Social Factors Impacting Maternal Health

◆ In Rhode Island in 2023, nearly one in five women (19.7%) reported food or housing insecurity in the 12 months before birth.[18] Malnutrition during pregnancy can lead to later health problems in children, including obesity, diabetes, and heart disease.[19] Housing instability and homelessness during pregnancy are associated with higher rates of preterm birth, low birth weight infants, neonatal intensive care unit (NICU) admission, and delivery complications.[17]

◆ Of Rhode Island women who worked during their pregnancy in 2023, over two thirds (67.6%) felt they were able to take too little time off.[18] Rhode Island recently increased the number of weeks available through the state's paid family leave program to eight weeks beginning in January 2026 and increased the wage replacement rate. However, it still lags behind other states that provide paid family leave.[11,20–23]

◆ Between 2020 and 2024 in Rhode Island, women who did not graduate from high school were more likely to receive delayed prenatal care than women with more than a high school education (27.9% compared to 12.9%). Adolescent and teen mothers were more likely to receive delayed prenatal care than older mothers in Rhode Island. About one in five (20.1%) pregnant women in the five core cities received delayed prenatal care compared to 13.3% in the remainder of the state.[17]

Maternal Mental Health

◆ Perinatal mood and anxiety disorders (including anxiety and depression that occurs during pregnancy or in the first year after birth) are one of the most common complications of pregnancy.[24] Approximately one in six Rhode Island women report experiencing depression during pregnancy.[9]

◆ Untreated mental health disorders during pregnancy and after having a baby can lead to negative outcomes such as preterm birth, trouble bonding with infants, and difficulty breastfeeding.[9]

◆ In addition to the impacts on individual families, untreated perinatal mood and anxiety disorders are estimated to cost Rhode Island $9.7 million annually.[9]

◆ Identification and treatment is crucial in managing mental health during pregnancy and postpartum. Rhode Island's MomsPRN (psychiatry resource network) program is a statewide teleconsultation program that supports health care professionals in identifying and managing the mental health and substance use needs of pregnant and postpartum patients. In 2025, RI MomsPRN helped 358 perinatal patients. Of these patients, 56.1% had public insurance, 43.2% had commercial insurance, and <1% had no insurance.[25]

RI MomsPRN Perinatal Patients Served by Race in Rhode Island, 2025

American Indian or Alaska Native	3.0%
Asian	1.3%
Black or African American	16.4%
Native Hawaiian or Other Pacific Islander	2.7%
Multiracial/ Other Race	16.5%
White	60.1%

Source: Rhode Island Department of Health. (2026).

Maternal Health

Substance Use During Pregnancy and at Birth

◆ Nearly one in four Rhode Island women report substance use, including alcohol, tobacco, e-cigarettes, cannabis, opioids, or other drugs, immediately before, during, or after their pregnancy.[24]

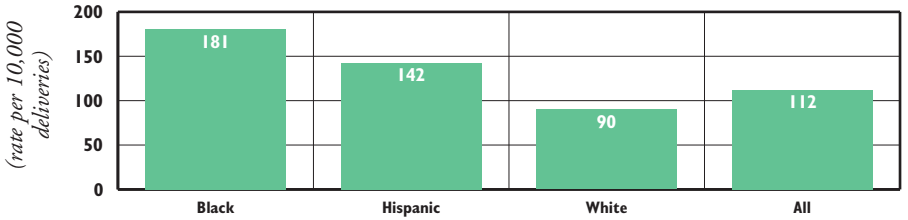
◆ Consistent with national laws, Rhode Island has a Plan of Safe Care process that supports infants born affected by substance exposure, withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder, and their families. Substances can include illicit drugs, cannabis, opioids and opioid agonists, including methadone or buprenorphine, or misused prescription medications. This Plan of Safe Care, known in Rhode Island as Circle of Care Plan, aims to ensure that infants and caregivers affected by prenatal substance exposure have access to the supports and services they need and want after they are discharged from the hospital, including services like Family Home Visiting, Early Intervention, and recovery and treatment supports for caregivers.[26] In Rhode Island between 2020-2024, 693 Circle of Care Plans were developed for substance exposed newborns and their caregivers.[24,26–29]

◆ Neonatal abstinence syndrome (NAS) refers to a withdrawal syndrome that can occur in newborns exposed to certain substances, including opioids. Neonatal opioid withdrawal syndrome (NOWS) more specifically refers to the withdrawal symptoms related to opioid exposure. Not all substance exposed newborns are diagnosed with NAS or NOWS.[31–33]

◆ In Rhode Island in 2024, the NAS rate of 42 per 10,000 newborn hospitalizations represents a decrease from 2023 when the rate was 52 per 10,000 newborn hospitalizations.[30]

◆ NAS rates will not decrease until Opioid Use Disorder (OUD) rates decrease in the general population. Adequate treatment options and services for those struggling with OUD are needed before and during pregnancy, at birth, and throughout parenting for the whole family.[34] There is a need for universal protocols when working with parents, children, and families impacted by substance use and a critical need to address discriminatory attitudes and beliefs about maternal substance use and substance exposed children.[34,35]

Severe Maternal Morbidity Rate per 10,000 deliveries by Race/Ethnicity, Rhode Island, 2021-2024*



Source: Rhode Island Department of Health, Center for Data and Analysis, 2021-2024 *The definition of severe maternal morbidity has been updated and data in the 2026 Factbook cannot be compared to previous years.

◆ Nationally, Black women are almost three times more likely than white women to die of pregnancy-related complications. Racial disparities in maternal mortality span all levels of education, age, income, and insurance status.[36,37]

◆ Across the United States, homicide is one of the leading causes of pregnancy-associated death.[38] Forty percent of pregnancy-associated homicides are related to intimate partner violence. In Rhode Island, about three quarters of women who had a well visit in the 12 months before pregnancy reported that their provider talked to them about intimate partner violence.[18,39]

◆ Pervasive racial bias and unequal treatment of Black women in the health care system often result in inadequate treatment for pain.[14,40] This, coupled with stress from racism and racial discrimination, contribute to the unacceptable health outcomes among Black women and their infants.[37]

◆ In Rhode Island, maternal mortality numbers are too small to report. To better measure maternal health during pregnancy and after childbirth, Rhode Island reports the prevalence of severe maternal morbidity. Severe maternal morbidity is defined as unintended outcomes of labor and delivery that result in significant consequences to a woman's health.[14]

◆ In 2024, the Rhode Island severe maternal morbidity rate was 119 per 10,000 delivery hospitalizations. Black women (181 per 10,000) and Hispanic women (142 per 10,000) had higher rates of maternal morbidity than white women (90 per 10,000) between 2021 and 2024.[17]

Table 16.

Maternal Health, Rhode Island

CITY/TOWN	2020-2024 WOMEN WITH DELAYED PRENATAL CARE # BIRTHS	# WITH DELAYED CARE	% WITH DELAYED CARE	2021-2024 SEVERE MATERNAL MORBIDITY RATE # DELIVERIES	SEVERE MATERNAL MORBIDITY	SEVERE MATERNAL MORBIDITY RATE PER 10,000 DELIVERY HOSPITALIZATIONS
Barrington	564	87	15.4	436	<5	*
Bristol	682	94	13.8	476	5	*
Burrillville	659	87	13.2	435	<5	*
Central Falls	1,441	339	23.5	1,151	24	208.5^
Charlestown	259	24	9.3	203	<5	*
Coventry	1,444	154	10.7	1,132	10	*
Cranston	3,847	585	15.2	3,151	39	123.8
Cumberland	1,682	218	13.0	1,134	14	123.5^
East Greenwich	679	73	10.8	521	<5	*
East Providence	2,199	298	13.6	1,686	16	94.9^
Exeter	219	23	10.5	156	<5	*
Foster	225	25	11.1	165	0	0.0
Glocester	310	44	14.2	248	<5	*
Hopkinton	304	27	8.9	226	<5	*
Jamestown	137	9	*	97	0	0.0
Johnston	1,381	214	15.5	1,067	8	*
Lincoln	928	132	14.2	695	8	*
Little Compton	78	14	17.9^	34	0	0.0
Middletown	701	84	12.0	520	5	*
Narragansett	271	31	11.4	212	<5	*
New Shoreham	38	5	*	26	0	0.0
Newport	982	172	17.5	744	5	*
North Kingstown	1,067	116	10.9	861	7	*
North Providence	1,566	267	17.0	1,294	18	139.1^
North Smithfield	465	75	16.1	324	<5	*
Pawtucket	4,111	818	19.9	3,116	39	125.2
Portsmouth	625	73	11.7	461	<5	*
Providence	11,091	2,312	20.8	8,600	119	138.4
Richmond	356	31	8.7	224	<5	*
Scituate	450	60	13.3	369	7	*
Smithfield	701	97	13.8	521	<5	*
South Kingstown	819	84	10.3	689	6	*
Tiverton	569	75	13.2	281	<5	*
Warren	427	65	15.2	303	<5	*
Warwick	3,407	440	12.9	2,698	18	66.7^
West Greenwich	239	35	14.6	206	<5	*
West Warwick	1,391	182	13.1	1,136	13	114.4^
Westerly	820	85	10.4	561	<5	*
Woonsocket	2,472	405	16.4	1,841	23	124.9^
Five Core Cities	*20,097*	*4,046*	*20.1*	*15,452*	*210*	*135.9*
Remainder of State	*29,509*	*3,913*	*13.3*	*22,548*	*206*	*91.4*
Rhode Island	*49,606*	*7,962*	*16.0*	*41,513*	*466*	*112.3*

Source of Data for Table/Methodology

Rhode Island Department of Health, Center for Health Data and Analysis, Maternal and Child Health Database, 2020-2024.

The denominator for Delayed Prenatal Care is the total number of live births to Rhode Island residents from 2020-2024 and is reported from birth records of live births for which there is known prenatal care information. The denominator for Severe Maternal Morbidity is the total number of delivery hospitalizations in Rhode Island from 2021-2024 and is reported from delivery records. Not every inpatient delivery results in a newborn outcome or a live birth. The denominators for Delayed Prenatal Care and Severe Maternal Morbidity are not comparable because they are reported from different data sources with different time frames and populations of interest. The method of calculating Severe Maternal Morbidity changed, and data in the 2026 Factbook cannot be compared to previous Factbooks.

*The data are statistically unreliable, and rates are not reported and should not be calculated.

^The data are statistically unstable, and rates or percentages should be interpreted with caution.

Five core cities are Central Falls, Newport, Pawtucket, Providence, and Woonsocket.

Due to birth certificate changes that began in 2015, comparisons with previous years should be made with caution. Delayed prenatal care is now a calculated variable that is based on the number of visits over 90 days (3 months). "No prenatal care" is not broken out.

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