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Intrapartum Care Experiences Associated With Postpartum Visit Attendance

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ABSTRACT

Introduction: The postpartum visit is an important opportunity to prevent pregnancy-related morbidity and mortality; however, about 1 in 10 birthing people do not attend this visit. Intrapartum care experiences are an understudied factor that may contribute to postpartum healthcare engagement.

Materials and Methods: We analyze data from a novel survey supplement on intrapartum care experiences administered to a probability-based population sample of people who have recently given birth through the Wisconsin Pregnancy Risk Assessment Monitoring System.

Results: In regression models adjusting for a robust set of individual characteristics and birth hospital clustering, we find that lower provider responsiveness during intrapartum care is associated with increased odds of forgoing the postpartum visit (aOR 1.4, 95% CI 1.0–2.0).

Discussion: The quality of care received during the birth hospitalization may shape how birthing people feel about health care providers and their willingness to attend future visits. Experiences of care during the intrapartum period may contribute to future health care utilization. Improving these experiences is an opportunity to promote long-term health.

1 | Introduction

Attendance at a postpartum visit is a critical factor in understanding the persistent and increasing maternal mortality ratio in the United States, which is higher than that in other wealthy nations and has been increasing in recent years [1]. More than half of pregnancy-associated deaths in the U.S. occur after the day of birth, with cardiovascular conditions and mental health-related conditions being the primary contributors to postpartum mortality that occurs between 43 days and 1 year postpartum [2]. High-quality postpartum care, including a comprehensive physical, mental, and social well-being assessment no later than 12 weeks postpartum [3], is a critical access point for identifying possible risk factors and connecting birthing people to appropriate care and resources, including family planning services, mental health and substance use treatment services, chronic disease management, and social supports like the Supplemental Nutrition Program for Women, Infants, and Children (WIC). The postpartum visit is therefore an important opportunity for improving health trajectories and decreasing the burden of maternal morbidity and mortality.

One important but understudied factor that could influence postpartum visit attendance is the intrapartum healthcare experience, that is, the care received during labor and delivery. There is growing evidence of negative experiences of intrapartum care in the United States. For example, in one cross-sectional study of postpartum people, one in six respondents reported experiencing at least one instance of mistreatment, including verbal or physical abuse, loss of autonomy, or neglect [4], and another study documented evidence of providers initiating procedures without providing an opportunity for informed consent or against the wishes of the birthing person [5]. Negative experiences that do not rise to the level of mistreatment have also been widely documented, including poor communication and perceived discrimination [6], with intrapartum care providers influencing how birthing people feel about healthcare providers and how willing they are to seek healthcare services in the future. There is also evidence that mistreatment during labor and delivery and poor provider communication are more commonly experienced by Black and Indigenous birthing people [4, 6]; therefore, an association between these experiences and postpartum visit attendance could partially explain racial inequities in postpartum visit utilization and maternal health outcomes.

In the United States, approximately one in ten birthing people in the United States does not receive this important preventive visit, and there are significant racial inequities in postpartum visit receipt [7, 8]. Lower socioeconomic status, urban residence, having more children, younger age, lack of medical complications, and lower previous health care use are also associated with a lower likelihood of receiving a postpartum visit [9]. The barriers to healthcare access resulting from structural racism may therefore compound the other health risks created by structural inequality, contributing to preventable morbidities and premature death.

Few studies have explicitly linked negative intrapartum experiences with postpartum visit attendance. There has been a concerted effort among health care practitioners and advocates to improve the quality of intrapartum care over the last decades, with a focus on standardizing processes [10] and implementing evidence-based care bundles to prevent extreme outcomes like postpartum hemorrhage [11]. Less attention, however, has been paid to the emotional safety of birthing people and the emotional harm sometimes created by health systems [12–14]. Specific to childbirth, research has shown that the physiological response to experiences of fear or anxiety can affect the duration of labor [15], which can then increase exposure to additional medical interventions. Receiving more intrapartum medical interventions [16, 17], having a lack of involvement in care decisions [17], and maternal Black race [16] (as a proxy for racial discrimination) have been associated with lower satisfaction with labor and delivery care. Some negative intrapartum care experiences, such as subjective distress and being pressured to accept labor induction or epidural analgesia, have been linked to birth-related Post-Traumatic Stress Disorder [18, 19].

Prior research finds that dissatisfaction with health care providers [20] and experiences of discrimination during delivery [21, 22] are associated with a lower likelihood of attending a postpartum visit, suggesting the importance of each healthcare interaction in shaping future healthcare use. The potential effect on health care utilization may be especially relevant for people who hold marginalized identities, as historical abuses have already contributed to low levels of trust in health care [23]. However, the way in which intrapartum care experiences have been operationalized in prior research does not clearly point to the specific experiences during labor and delivery that contribute to non-attendance at the postpartum visit, making it difficult to design quality improvement efforts.

In sum, intrapartum care experiences represent an understudied and modifiable factor that could be targeted for quality improvement efforts aimed at decreasing maternal morbidity and mortality. The current study seeks to elucidate the relationship between intrapartum care experiences and postpartum visit utilization, using data on self-reported intrapartum care experiences from a racially diverse, probability-based population sample of birthing people, including some of the first population data for Indigenous birthing people. Our novel measures of specific experiences with intrapartum care providers contribute to creating informed policy and program interventions.

2 | Materials and Methods

2.1 | Data

Our data come from the 2020 Wisconsin Pregnancy Risk Assessment Monitoring System (PRAMS), a survey of people who recently gave birth. The sample is generated using a race-stratified random sampling of birth records. The survey was conducted following the standard procedures for PRAMS [24], which include sequential multi-mode data collection (first a mail self-administered questionnaire, followed by phone interviews). The 2020 Wisconsin PRAMS had four sampling strata: Native American/Alaska Native (hereafter called "Indigenous"), regardless of ethnicity; non-Hispanic (NH) Black; non-Hispanic white; and other races/ethnicities (including Hispanic and Asian).

2.2 | Measures

2.2.1 | Independent Variables

The 2020 Wisconsin PRAMS survey also included a survey supplement of 9 items asking about intrapartum care experiences. Four binary measures asked respondents whether, during their labor and delivery, they: ever felt unsafe, were disrespected by their care providers, felt that their care providers withheld information from them, and were able to have a companion of choice with them. Five questions with 5-item rating scales asked to what extent: healthcare providers were responsive to their needs, healthcare providers worked together with them to make care decisions, and healthcare providers pressured them to have an induction, epidural, or cesarean delivery. Questions were developed based on patient- and person-centered care frameworks [25–27] and a literature review of existing scales of intrapartum care experiences [28, 29]. These items were also tested using cognitive interviews to identify comprehension, retrieval, and question-answering difficulties

[30, 31]; survey questions were adjusted based on interview findings and finalized after two rounds of cognitive interviews with members of each racial stratum of birthing people (Black $n=6$, white $n=6$, Indigenous $n=3$, other race (including Hispanic) $n=6$).

2.2.2 | Dependent Variables

Postpartum visit attendance was measured by self-response on the survey to the question: *Since your new baby was born, have you had a postpartum checkup for yourself?(Yes/No).* Studies have found that self-reported attendance at the postpartum visit is higher than that from administrative records [8], suggesting that some of the people who reported attending a visit may have seen a provider for something other than a comprehensive postpartum visit. Therefore, our measure of postpartum visit non-attendance is a conservative estimate.

2.3 | Analysis

Data are weighted using the sample weights provided by the Centers for Disease Control and Prevention. These weights account for the complex sampling scheme, survey non-coverage, and survey non-response, and are based on more than 20 birthing person characteristics from the birth record [24]. The study sample includes all respondents to the 2020 Wisconsin PRAMS survey who delivered at a birth hospital and responded to at least one of the intrapartum experience questions ($n=1619$). We exclude 44 respondents who did not respond to any birth care experience questions and 29 respondents who gave birth in settings other than birth hospitals (e.g., emergency departments, free-standing birth centers, at home, etc.) We exclude people who gave birth outside of hospital settings, as the dynamic between providers and birthing persons is very different and cannot be easily compared. We use chained regression and predictive mean matching to multiply impute missing birthing person race and covariates used in our regressions (with 5 repetitions). We compare the results from the imputed data with those for complete case analysis and find no substantive differences (Results not presented, but available on request).

For our analysis, we were interested in the possible association of each intrapartum care experience measured with postpartum visit attendance. Therefore, we first estimate minimally adjusted survey-weighted regression models for each individual intrapartum care experience. For those experiences that were significantly associated with each outcome at the $p=0.05$ level, we retain them for the final model, which also includes additional covariates associated with the outcomes.

The minimally adjusted models adjust for age, race, pre-pregnancy health care utilization, birth payer, and birth mode (vaginal, vaginal instrumental, cesarean). The final model for postpartum visit attendance also adjusts for characteristics that prior research has shown to be related to postpartum visit attendance. These include pre-pregnancy anxiety and depression [32] (both self-reported), parity [33], plurality [34], prenatal care adequacy [35], marital status [36], maternal education [34], and racial discrimination in the 12 months prior to delivery [22].

3 | Results

The study sample included all respondents to the 2020 Wisconsin PRAMS survey, which had an overall response rate of 50.6% and a stratum-weighted response rate of 64.1%, which exceeded the 50% CDC threshold for inclusion in the national PRAMS data set. By design, the sample was similarly distributed among the racial/ethnic groups of Non-Hispanic (NH) Indigenous ($n=437$), NH Black ($n=338$), NH white ($n=369$), and Hispanic ($n=315$) birthing people, with an additional 157 individuals with other racial identities, mostly of Asian descent. The majority of the sample was between 25 and 35 years at the time of birth (60.4%), delivered vaginally (67.7%), had completed high school or some college (61.2%), was not married (53.4%), and had Medicaid coverage for their birth (54.4%). (See Table 1 for full sample characteristics).

Having providers who were "a little" or "not at all" responsive was the least common negative intrapartum care experience (3.9% of the sample reported this), while not having a support person present was the most common (14.9%).

3.1 | Postpartum Visit Attendance

Two hundred fifty-six, or 15.5% of the study sample, reported that they did not have a postpartum care visit. In two-way tables between each intrapartum care experience and postpartum visit attendance, all experiences except for experiencing provider pressure to accept medical interventions (induction, epidural, and cesarean) were significantly associated with a lower probability of postpartum visit non-attendance (see Table 2).

In minimally adjusted regression models of each intrapartum care experience adjusted for age, race, pre-pregnancy health care utilization, birth payer, and birth mode, provider disrespect was associated with more than two times the odds of visit non-attendance (aOR 2.2, 95% CI 1.1–4.6), and feeling unsafe was associated with 2.8 times the odds of non-attendance (95% CI 0.8–9.3). In addition, lower levels of provider responsiveness to the needs of the birthing person were also associated with higher odds of non-attendance at the postpartum visit, where a one-category change in the level of provider responsiveness (e.g., a little responsive, compared with somewhat responsive) was associated with 1.5 times the odds of postpartum visit non-attendance (95% CI 1.1–2.1).

In the fully adjusted model, provider disrespect was still associated with 1.6 times the odds of postpartum visit non-attendance, although the relationship became marginally significant ($p=0.08$). However, lower levels of provider responsiveness were still significantly associated with postpartum visit non-attendance (aOR 1.4, 95% CI 1.1–2.0; $p=0.02$). (See Table 3).

4 | Discussion

This is one of the first studies to examine the relationship between intrapartum care experiences and later health and

TABLE 1 | Sample characteristics, 2020 Wisconsin Pregnancy Risk Assessment Monitoring System.

Sample characteristic	*N* (Total = 1619)	%
Postpartum visit non-attendance (missing = 43)	256	15.5%
Race/ethnicity (missing = 3)		
Non-Hispanic Indigenous	437	27.0%
Non-Hispanic Black	338	20.9%
Hispanic	315	19.5%
White	369	22.8%
Other (Asian, multi-race)	157	9.7%
Maternal age		
< 25 years	370	22.9%
25–35 years	978	60.4%
> 35 years	271	16.7%
Birth mode		
Cesarean	469	29.0%
Instrumental vaginal	54	3.3%
Non-instrumental vaginal	1096	67.7%
Maternal education (missing = 15)		
Less than high school	199	12.3%
High school diploma or GED	495	30.6%
Some college	496	30.6%
College or graduate degree	429	26.5%
Marital status		
Married	754	46.6%
Other	865	53.4%
Birth payer (missing = 8)		
Medicaid	880	54.4%
Private insurance	695	42.9%
Other (Tri-Care, Indian Health Service, Self-pay)	36	2.2%

healthcare outcomes, and the first to include a robust sample of Indigenous birthing people, who are disproportionately affected by negative perinatal and infant health outcomes [37, 38]. We find that how people report being treated by their intrapartum care providers is significantly associated with attendance at the postpartum, after adjusting for other individual factors including past healthcare utilization.

Our study provides some of the first evidence for the U.S. context that the interpersonal aspects of intrapartum care may shape later health trajectories and healthcare utilization. Our findings are consistent with previous research that showed that experiences of discrimination during intrapartum care are associated with later healthcare use [21, 22]. However, our results suggest that negative experiences of healthcare providers during labor and delivery may also shape engagement with healthcare, regardless of whether the treatment was due to perceived discrimination. This association with the utilization of postpartum care could have important impacts on health outcomes, including early detection and treatment of life-threatening postpartum complications, both physical and mental, as well as management of pregnancy-associated morbidities and chronic conditions.

Previous research on determinants of attendance at the postpartum visit suggests that many factors shape utilization. While many postpartum people view the postpartum visit as a resource for support and contraceptive access, the timing does not always fit their needs [39]. Medicaid-insured birthing people who lose coverage after the postpartum period have a lower likelihood of attendance at this visit [34, 40], despite the fact that it may be even more critical for them since they may lose access to preventive healthcare. Some research has found that people with non-birth-related pre-existing medical conditions may be more likely to attend a postpartum visit [41], which may suggest that previous experiences with health care providers or comfort interacting with health systems may be positively associated with attendance, which would be consistent with our findings. The current recommendations of the American College of Obstetricians and Gynecologists to treat postpartum care as a process rather than a single visit [42], may lead to improvements in postpartum contact between birthing people and health systems. However, the current research points to the birth hospitalization as an important piece of the ongoing process of care, which really constitutes the first postpartum care received.

We use a robust and racially diverse population-based sample of birthing people. Moreover, due to the linkage between the PRAMS survey and the birth certificate, we are able to adjust for a robust set of covariates in our models. While all survey research is potentially subject to bias due to non-response, it is only one source of total survey error, and sample representativeness is likely a better indicator of data quality than response rate [43]. Due to the stratified sample strategy used in Wisconsin PRAMS and the complex survey weighting using over 20 characteristics from the birth certificate, the data in our study closely approximate the study population.

Given the racial inequities in intrapartum care, postpartum care, and perinatal outcomes, it is possible that the relationship among these phenomena varies across racial groups. Variations in provider type, health system, and region may also be important for these associations. Unfortunately, we were not able to explore possible differences due to the sample size, but these are areas for future investigation.

All people who utilize healthcare services, including birthing people, are entitled to respectful care, but this study underscores the potential sequelae of its absence beyond the birth hospitalization itself. For individuals with barriers to healthcare access, perinatal and intrapartum care may represent some of the few interactions they have with healthcare systems, making these interactions especially significant for how these people view healthcare systems and providers and their likelihood to access healthcare services in the future. For this

TABLE 2 | Percent of sample reporting negative intrapartum care experiences, by postpartum depressive symptoms and attendance at postpartum visits.

	Overall	Did not attend PPV	Attended PPV	*p*
Felt unsafe	5.5%	9.1%	4.9%	<0.0001
Did not have support person	14.9%	19.6%	14.0%	<0.0001
Felt disrespected	9.93%	16.8%	8.6%	<0.0001
Providers withheld information	7.6%	9.5%	7.2%	0.0069
Providers "a little" or "not at all" responsive	3.9%	10.0%	2.7%	<0.0001
Participated in decisions about care "a little" or "not at all"	7.0%	14.6%	5.6%	<0.0001
Felt "extremely" or "very" pressured to induce	13.0%	14.5%	12.7%	0.077
Felt "extremely" or "very" pressured to use epidural	6.2%	7.2%	6.1%	0.131
Felt "extremely" or "very" pressured to cesarean	10.5%	9.5%	10.7%	0.2336

TABLE 3 | Associations between intrapartum care experiences and postpartum visit attendance, Survey-weighted logistic regression of 2020 Wisconsin Pregnancy Risk Assessment Monitoring System.

	Minimally adjusted individual regressions[a]			Final model[b]		
	Estimate	Lower CL	Upper CL	Estimate	Lower CL	Upper CL
Disrespect	2.25	1.095	4.609	1.624	0.938	2.814
Unsafe	2.79	0.842	9.263	—	—	—
Withheld Information	1.84	0.527	6.438	—	—	—
Support Companion	0.89	0.450	1.771	—	—	—
Less responsive providers[c]	1.53	1.123	2.097	1.467	1.051	2.046
Less participation in decision-making[d]	1.35	0.979	1.869	—	—	—
Greater provider pressure to induce labor[e]	1.01	0.844	1.202	—	—	—
Greater provider pressure to use epidural[e]	0.97	0.78	1.23	—	—	—
Greater provider pressure to deliver by cesarean[e]	0.948	0.718	1.250	—	—	—

[a]Adjusted for age, race, pre-pregnancy anxiety and depression, and pre-pregnancy self-rated health.
[b]Adjusted for age, race, pre-pregnancy anxiety and depression, and pre-pregnancy self-rated health, parity, plurality, prenatal care adequacy, marital status, maternal education, birth payer, racial discrimination.
[c]1 = Extremely responsive... 5 = Not at all.
[d]1 = A great deal... 5 = Not at all.
[e]1 = Not at all... 5 = A great deal.

reason, perinatal healthcare providers have an additional responsibility to ensure that their patients have positive experiences, characterized by respect for patient autonomy and dignity.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section.