if when how

Lawyering for Reproductive Justice

Maternal and Infant Health & Mortality

IF/WHEN/HOW ISSUE BRIEF

Contents

INTRODUCTION

If/When/How recognizes that most law school courses are not applying an intersectional, reproductive justice lens to complex issues. To address this gap, our issue briefs and primers are designed to illustrate how law and policies disparately impact individuals and communities. If/When/How is committed to transforming legal education by providing students, instructors, and practitioners with the tools and support they need to utilize an intersectional approach.

If/When/How, formerly Law Students for Reproductive Justice, trains, networks, and mobilizes law students and legal professionals to work within and beyond the legal system to champion reproductive justice. We work in partnership with local organizations and national movements to ensure all people have the ability to decide if, when, and how to create and sustain a family.

MATERNAL HEALTH AND MORTALITY

Maternal mortality is defined as the death of a woman during pregnancy, childbirth, or in the 42 days after delivery.[1] Over half of maternal deaths occur within 42 days of giving birth.[2]

- The United States, as reported in 2014, had the second-highest maternal mortality ratio among the 31 members of the Organization for Economic Cooperation and Development.[3]
- In 1987, the first year for which there is data, the maternal mortality rate for women in the U.S. was 7.2 deaths per 100,000 live births.[4] It has continued to rise each year.[5] Most recent data from the World Health Organization indicates the maternal mortality rate for American women was between 12-16 deaths per 100,000 live births.[6]
- As of 2016, approximately 830 women die from pregnancy- or childbirth-related complications around the world every day.[7] Maternal mortality is higher among women living in rural areas and poor communities. In the U.S., over 700 to 900 women die each year as a result of pregnancy or delivery complications.[8]
- The reduction of worldwide maternal mortality is part of the United Nations' Millennium Project.[9] Millennium Development Goal 5A was to reduce by 75%, between 1990 and 2015, the world's maternal mortality ratio.[10] During that time, the maternal mortality ratio fell by 45%, with 26 countries having less than a 25% reduction in the maternal mortality ratio.[11]
    - Nigeria and India accounted for approximately one-third of all maternal deaths worldwide in 2015, with approximately 58,000 and 45,000 maternal deaths, respectively.[12]
    - Nine countries that had maternal mortality ratios of >100 in 1990 are now categorized as having "achieved" Millennium Development Goal 5A, achieving a reduction of at least 75% between 1990 and 2015: Bhutan, Cambodia, Cabo Verde, the Islamic Republic of Iran, the Lao People's Democratic Republic, Maldives, Mongolia, Rwanda, and Timor-Leste.[13]

"NEAR MISSES"

Mortality rates do not tell the whole story. Each year, almost 34,000 women worldwide suffer a complication so severe – known as a "near miss," "severe maternal morbidity," or "severe obstetric morbidity"– that they *nearly* die during childbirth.[14]

- In the U.S., approximately 65,000 women nearly die from pregnancy or childbirth each year.[15]
- Additionally, more than one-third (1.7 million) of all women giving birth in the U.S. suffer pregnancy complications that have adverse health effects.[16]

MEDICAL INTERVENTIONS

Women in the U.S. are often subject to more medical intervention during labor and delivery than in other developed countries, resulting in an increase in cost and injury.[17] Unnecessary medical intervention during labor and delivery in the U.S. includes the rising rate of elective Cesarean sections (c-sections), which carry a greater risk of severe complication

and death than vaginal births. Risk of injury caused by such medical intervention includes risk of infection, hysterectomy, kidney failure, and life threatening blood clots.[18]

- C-sections also result in greater risks for future pregnancy, including increased risk of placenta previa.[19]
- The cesarean delivery rate increased from 26% to 36.5% between 2003 and 2009.[20]
- In 2015, the preliminary U.S. national cesarean rate was 32% of all births.[21] This is a slight drop from the national peak of 32.9% in 2009.[22] In contrast, the World Health Organization recommends c-sections only be used for 10-15% of births.[23]
- Most developed nations have a similar or slightly lower cesarean rate, and most countries in the world do not have a cesarean rate that falls within the WHO's target range.[24]

REPRODUCTIVE AND HUMAN RIGHTS AT RISK

According to Amnesty International, nearly half of all U.S. maternal deaths "could have been prevented if maternal health care were available, accessible, and of good quality for all women in the USA."[25] This includes prenatal, childbirth, and postpartum care.[26]

- Basic obstetric care "required to prevent most maternal deaths is not complicated" and "health centers in developing countries should be able to provide most of the [basic] services, and district hospitals should be providing [comprehensive] services."[27]
- In the 2006 *Listening to Mothers II* survey, U.S. mothers reported experiencing pressure from a health professional to have labor induction (11%), epidural analgesia (7%), and c-section (9%).[28] Most mothers felt that all (78-81% of those surveyed) or most (17-19% of those surveyed) complications for these interventions should be disclosed.[29] The survey found that whether mothers had the intervention or not, most had an incorrect understanding of the complications or were not sure about them.[30] Concerningly, the great majority (73%) of mothers who experienced episiotomy (an incision in the perineum) stated that they did not have a choice in this decision.[31]
- The U.S. has no nationally-implemented comprehensive guidelines and protocols for maternal health care and for preventing and managing obstetric emergencies.[32] This results in significant variation of care from hospital to hospital and state to state in obstetrics practice and use of procedures across the country.[33]
- At least 28 states currently have or are forming Maternal Mortality Review Committees.[34] However, 29 states and the District of Columbia lack a maternal mortality review committee.[35] Maternal mortality review committees work to identify patterns and trends in maternal deaths, make recommendations to improve maternal health, and improve coordination with federal government agencies to prioritize maternal health.[36] The CDC, the Association of Maternal and Child Health Programs, and the CDC Foundation are currently collaborating to enhance maternal mortality review and create linkage between Review Committees across jurisdictional lines.[37]
- In 2014 and 2017, federal lawmakers attempted to pass the Maternal Health Accountability Act.[38] Most recently, the act was introduced in the Senate, read twice, and was later referred to the Committee on Health, Education, Labor, and Pensions.[39] Since that time, neither chamber voted on the bill. The Maternal Health Accountability Act was introduced to help establish a mortality review board in every state, fight disparities with new research and pilot programs, and develop definitions of severe maternal morbidity (complications) to improve data collection and maternal health research.[40]
- The Health Equity and Accountability Act of 2016, H.R. 5475, was introduced to Congress in June 2016 but was never enacted.[41] It sought to improve access by removing barriers to healthcare for minorities including the establishment of state maternal mortality review committees. The committees would have developed a confidential process for reporting maternal death, identifying maternal mortality trends and factors, and investigating individual maternal deaths.

DISPARITIES IN MATERNAL HEALTH

Experts have pointed to racial and economic disparities in healthcare as a leading cause of maternal mortality in the U.S.[42] For example:

- Three to four times as many Black women die from pregnancy than white women.[43] In New York City alone in 2008, one Black woman died about every 1,200 live births.[44] The Center for Research and Policy in the Public Interest conducted a study that found that "black women face a maternal mortality rate of 79 deaths per 100,000 live births, compared to 10 per 100,000 live births for white women."[45]

- Non-Hispanic Black, American Indian/ Alaskan Native, and Hawaiian/other Pacific Islander women have the lowest rates of receiving early prenatal care (63.6%, 59.4%, and 54.7% respectively), while non-Hispanic white and non-Hispanic Asian women have the highest rates of prenatal care (79.0% and 78.0% respectively).[46]
- People with high-risk pregnancies are 5.3 times more likely to die if they do not receive prenatal care.[47]
- Although women of color make up only 36.3% of women in the U.S., they account for 53.2% of uninsured women.[48]
- Black women residing in southern states are particularly at risk of maternal mortality.[49] In addition, high rates of maternal mortality among southern Black women persist regardless of class or education status.
  - In 2014, Black women in Georgia faced a maternal mortality ratio of 90.3 pregnancy-related deaths per 100,000 live births. In 2012,[50] Black women made up 68% of pregnancy-related deaths in Georgia.
  - Although Black women only make up 11% of Texas' population, they accounted for 29% of the state's maternal deaths between 2011 and 2012.[51] When discharged from a pregnancy-related hospital stay, Black women in Texas are at twice the risk of dying than women of other races or ethnicities.
  - In 2012, a study found that Black women in Louisiana faced a maternal mortality ratio of 119.1 pregnancy-related deaths per 100,000 live births.[52] In addition, Black women in Louisiana are more likely to suffer non-fatal maternal complications at 1.1 to 1.2 times the rate as White women.
- Obstacles preventing marginalized people from accessing healthcare include institutionalized racism, discrimination (including on the basis of national origin), lack of information, logistics (child care, transportation), financial and language barriers, the bureaucracy involved in Medicaid coverage (lack of prenatal care reimbursement and doctors refusing to treat low-income women), and lack of ability to adequately participate in reproductive health decisions.[53]

INFANT HEALTH AND MORTALITY

Infant mortality is one of the most important indicators of the health of a nation, as it is associated with a variety of factors such as maternal health, quality and access to medical care, socioeconomic conditions, and public health practices.[54]

- The infant mortality rate is the rate at which babies less than one year of age die.[55]
- Although most newborns grow and thrive, six out of every 100,000 babies in the U.S. die within their first year after birth.[56]

Among the 39 "advanced economy" nations, as classified by the International Monetary Fund (IMF),[57] the U.S. ranks third highest for 2015 infant mortality rate.[58]

CAUSES OF INFANT MORTALITY

High rates of premature birth are the main reason the U.S. has higher infant mortality compared to many other developed countries.[59]

- After decades of increases, the rate of premature birth has now been on a steady decline for the last several years to a current rate of 9.6% of U.S. births.[60] Despite this progress, 380,000 premature babies are born each year.[61] Worldwide, 15 million babies are born prematurely.[62]
- Low birth weight is a leading cause of infant mortality in the U.S., and infants with low birth weight are at increased risk of immediate life-threatening health problems as well as long-term complications and developmental delays.[63]
- An increase in c-sections and labor-inducing drugs to deliver babies before they are full term may contribute to premature newborns.[64]
- Sudden Infant Death Syndrome (SIDS), the unexpected death of an infant less than one year of age that cannot be explained, is the leading cause of infant death,[65] despite significant declines in SIDS rates since 1990.[66] Infant mortality rates for SIDS, congenital malformations, and unintentional injuries have been substantially higher for non-Hispanic Black than for non-Hispanic white women.[67]

DISPARITIES IN INFANT HEALTH

Infant mortality rates differ largely by race and ethnicity. Non-Hispanic Black, American Indian and Alaskan Native, and Puerto Rican women have the highest infant mortality rates.[68] Infant mortality rates are lowest for Asian and Pacific Islander, Central and South American, and Cuban American women.[69]

- Black infants have 2.2 times the infant mortality rate as non-Hispanic whites.[70] Black infants are 3.5 times as likely to die due to complications related to low birth weight, as compared to non-Hispanic White infants.[71]
- The rate of preterm birth among Black women (13%) was about 50% higher than the rate of preterm birth among white women (9%).[72]
- Black infants had just under two times the SIDS mortality rate as non-Hispanic Whites in 2013.[73]
- The percentage of mothers who received late (after first trimester) or no entry into prenatal care is 25.8% for non-Hispanic Black mothers compared with 12% of non-Hispanic White mothers.[74]
- Racial discrimination plays a dominant role in infant mortality.[75]
  - More segregated cities have greater Black to White infant mortality disparities. In addition, women whose babies are born drastically underweight are more likely to report experiences of discrimination.[76]
  - Constant sources of stress throughout a person's lifetime, such as racial discrimination, raise cortisol levels and trigger inflammatory responses.[77] These factors result in premature labor and the restriction of blood flow to the placenta, which stunts infant growth. The effects of discrimination influence a pregnant person's allostatic load – the cumulative wear and tear on the body's systems.[78] According to an article in the American Journal of Public Health, "these effects may be felt particularly by Black women because of [gender and racial discrimination]."
  - Some examples of discrimination that influence allostatic load include disparities in the criminal justice system, education, and predatory lending as well as personal experiences such as the unequal treatment of Black patients in doctors' offices as compared to white patients.[79]

RELATED ISSUES

YOUNG PARENTS

Worldwide, about sixteen million girls aged 15 to 19 and some one million girls under 15 give birth every year—most in low- and middle-income countries.[80] There has been a marked, although uneven, decrease in the birth rates among adolescent girls since 1990, but some 11% of all births worldwide are still to girls aged 15 to 19 years old. [81] In 2015, a total of 229,715 babies were born to women aged 15-19 years, equaling a birth rate of 22.3 per 1,000 women in this age group. This is an 8% drop from the birth rate among teens in 2014. However, the U.S. teen pregnancy rate is much higher than in other western, industrialized nations. In addition, racial/ethnic and geographic disparities in teen birth rates persist. [82]

- Teenage mothers are less likely to receive adequate prenatal care than older mothers, which may result in major pregnancy-related complications.[83] Mothers who do not receive prenatal care are three times as likely to give birth to a low-weight baby, meaning infant mortality is five times more likely to occur.[84]
- Key risk factors that increase the likelihood of teen pregnancy are living in poverty, limited maternal educational achievement, having a mother who gave birth before the age of 20, being from a single-parent home, living in a home with frequent family conflict, early sexual activity, early use of alcohol and drugs, and low self-esteem. [85]
- Rather than being linked solely to the age of the mother, most health risks for young mothers and their children stem from social, economic, and cultural exclusion.[86] Stigma associated with teen motherhood can also impact health and social disparities and impede effective clinical care.[87] According to the National Latina Institute for Reproductive Health, "the current discourse surrounding young motherhood is both stigmatizing and insensitive, and presents young motherhood as a problem in itself as opposed to the real problems that often surround it, such as poverty and lack of access to timely and high quality health care services and education opportunities."[88]

PREGNANCY AND VIOLENCE

- Women with unintended pregnancies are four times more likely to experience violence from their intimate partner than women with wanted pregnancies.[89]

- Pregnant and recently pregnant women are more likely to be homicide victims than to die of any other cause; however, exact numbers are impossible to determine since neither the definition of maternal death or the ratio used to determine maternal mortality includes death due to domestic violence.[90]
- The risk of unintended pregnancy increases significantly if a woman has been the victim of domestic abuse.[91] Today, high rates of domestic violence and disproportionately high rates of maternal mortality are recognized as critical issues in global health.[92]
- A study conducted by the University of Michigan has associated the abuse of pregnant women with emotional and behavioral trauma symptoms in children in their first year of life.[93]

PREGNANCY AND POVERTY

- Welfare family caps, sometimes called "maximum family grant" rules, prevent women on welfare from receiving additional money if they have more children. As of 2016, 17 states have some version of a family cap in place.[94]
- The following common misconceptions drive support for family caps: 1) women on welfare are motivated to have children for financial gain; 2) women on welfare have more children than parents in the general population; and 3) caps will somehow cause welfare recipients to have fewer children.[95]
- Researchers and organizations have studied the effects of welfare family caps, and found that they do not lower the number of children born to welfare recipients, but have increased the poverty rate of families already on welfare.[96]
- Children raised in poverty are more likely to engage in criminal activity and are at substantially higher risk for developmental challenges and poor health, which continues into adulthood.[97]
- Advocates are working to repeal harmful family cap policies, and several states are beginning to or have repealed their cap rules in response.[98]

PROMISING POLICIES

GLOBAL ATTENTION

- The U.S. failed to meet its 2010 goals calling for a 50% reduction in maternal mortality and actually worsened its maternal mortality rates by the 2010 Healthy People initiative.[99] The U.S. revised its goals for 2020 and is aiming for a 10% reduction in infant mortality and a 10% reduction in maternal mortality.[100] Another primary goal is to ensure 77% of women have access to "early and adequate" prenatal care.[101]

HEALTHCARE REFORM

The Affordable Care Act (ACA), which was signed into law in March 2010 by President Obama, seeks to increase access and affordability of health care insurance and coverage for uninsured pregnant women.[102]

- The ACA provides protection for childbearing women and newborns with the inclusion of maternal and newborn care in a defined package of "essential health benefits." The ACA would also improve access to preventive services, including comprehensive counseling and support and access to supplies for breastfeeding and nursing women, folic acid supplements for women who may become pregnant, and screening for gestational diabetes.[103]
- Beginning in 2014 "essential" services must be covered in policies available through insurance exchanges.[104] Furthermore, the ACA assigns a phased-in elimination of "pre-existing condition" clauses which exclude persons from coverage and treatment.[105] This is particularly important for pregnant women seeking insurance and for women with health issues that might cause an increased risk of maternal mortality because some insurance companies consider pregnancy and/or prior c-section births a pre-existing condition.[106]For example, untreated diabetes is linked to an increased risk of miscarriage and developing preeclampsia.[107]

- The Health Insurance Portability and Accountability Act of 1996 prevents insurers from applying pre-existing condition clauses to pregnancy, but the Act does not apply to individual insurance plans, only group employer plans.[108]
- A Republican majority is currently working to "repeal and replace" the Affordable Care Act. Repeal and replace efforts have taken many iterations.[109] However, each proposal would increase the number of uninsured by more than 20 million people in 10 years. In addition, each of the six versions of the bill would make deep cuts to Medicaid.[110]

NEW PROGRAMS FOR FAMILIES

The ACA also created two new programs for child bearing families, the Maternal, Infant and Early Childhood Home Visiting Program and the Pregnancy Assistance Fund.[111]

- **Maternal, Infant and Early Childhood Home Visiting Program:** Awards grants for services in at-risk communities, with a focus on strengthening families and community resources and improving maternal and newborn health, child health, and school readiness.[112] According to the Health Resources & Services Administration, all 50 states, the District of Columbia and six jurisdictions, have received grants for evidence-based home visiting programs.[113]
- **Pregnancy Assistance Fund:** Provides grants to states and tribes to help support pregnant and parenting teens and women who are enrolled in higher education programs with child care, housing, baby supplies and food, and other support and protective services.[114] The act also provides grants to organizations to provide personal responsibility education to young people to reduce pregnancy and sexually transmitted infection rates by delaying sexual activity and increasing contraceptive use when sexually active.[115] Since 2010, 27 states and 4 tribal entities developed and implemented programs through the Pregnancy Assistance Fund. Most recently, fifteen states and one tribal entity were funded in July 2017.[116]
- **Community Health Centers:** The ACA provides $11 billion for Community Health Centers, an important health care access point for undocumented immigrants and uninsured people.[117] In 2015, the Department of Health and Human Services announced it would receive $101 million in ACA funding for 164 new health center sites.[118] To date, the ACA has supported renovation and construction projects on hundreds of health centers, and has created more than 550 new health centers across the country.[119] These health centers will provide and ensure primary health care to underserved communities. They are critical in helping people sign up for health insurance through the Marketplace and have helped more than 9 million individuals become insured since 2009.[120]

THE ROLE OF MIDWIVES

In the U.S. in 1989, the first year for which data is available, 3% of births were attended by a midwife instead of an obstetrician.[121] In 2013, the most recent year for which data is available, the number was close to 9%.[122]

- Planned homebirths attended by a midwife are associated with fewer maternal interventions than planned hospital birth, but are also associated with more than a twofold increased risk of perinatal death and a threefold increased risk of neonatal seizures or serious neurologic dysfunction.[123]
- Midwives often offer life-saving postpartum care that traditional hospitals do not, including home visits the first ten days after birth.[124] Women cared for by certified nurse-midwives (CNMs) are less likely to experience a cesarean delivery or episiotomy.[125]
- Midwife led births held a c-section rate well below the national average, at 9.3%.[126] Women who gave birth with a midwife were also more likely to breast feed, with a national average of 85.3% of women breastfeeding within the first 48 hours of life.[127]
- Compared with women who planned a hospital birth, benefits of a planned home birth include lower rates of maternal morbidity, such as postpartum hemorrhage, and perineal lacerations.[128] Women who have a planned home birth have high rates of satisfaction related to home being a more comfortable environment and feeling more control of the experience.[129]

- Certified nurse-midwives (CNMs) tend to serve not only childbearing women, but women in all stages of life.[130] A survey from Massachusetts shows that a substantial number of CNMs care for young women (under 20 years of age), recent immigrants, and women whose first language is not English.[131] A significant amount of CNMs noted that a significant proportion of their reimbursement comes through government-assisted health care.[132]
- In New York State the Midwifery Modernization Act passed in 2010.[133] New York's maternal mortality ratio is higher than the national average and both rural and urban areas face shortages of health care providers, including obstetric providers.[134] New legislation, New York's Midwifery Modernization Act, will improve access to quality maternal care, particularly for women in medically underserved areas by allowing licensed midwives to practice to the full extent of their training.[135]
- Despite reduced rates of complication compared to births attended by physicians, midwives face many barriers to practicing.[136] In many states, midwives must enter collaborative prescribing agreements with physicians in order to have access to prescriptions for their patients,[137] despite examining, ordering and interpreting tests, and diagnosing and treating patients independently.[138]
- Under the ACA, however, birth centers and midwife care have been added as mandatory Medicaid services, and many hope for the expansion of midwife services in the near future.[139]

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