

Lawmakers are

Lawmakers are trying to determine why the District's maternal mortality rate is among the nation's highest

The Washington Post · 15 mar. 2018 · BY FENIT NIRAPPIL

looking for ways to reduce the District's high maternal mortality rate.



D.C. mothers are twice as likely to die because of pregnancy than the average American woman. The city's maternal mortality rate — among the nation's highest — has captured the attention of local leaders and those in Congress, who say avoidable deaths of mothers are unacceptable in the nation's capital.

Mayor Muriel E. Bowser (D) plans to sign legislation passed last week by the D.C. Council to form a commission to investigate deaths related to childbirth and recommend ways to address the root causes.

Meanwhile, the chairmen of congressional subcommittees overseeing Medicaid spending have asked the District's health department and its only public hospital to explain what they're doing to prevent these deaths.

About 41 women in the District die for every 100,000 live births, according to an analysis of 2010-2014 federal health data by United Health Foundation. That compares with about 20 deaths for every 100,000 births in the United States, which has the highest maternal mortality rate of any developed country.

"There's no question we are in a maternal health crisis," said D.C. Council member Charles Allen (D-Ward 6), who wrote the bill to create a maternal mortality review committee.

What is in question is what's driving maternal deaths.

Suspected factors include women entering pregnancy with a variety of other health problems, mothers starting prenatal care too late and even the stress of racism faced by black residents.

City health officials caution that the maternal mortality rate alone doesn't tell the full picture. Fewer than 10 women a year are dying, a relatively small number that makes it hard to spot patterns, they said.

"We know that a woman's health before pregnancy is critical for the health of moms and babies," Anjali Talwalkar, a senior deputy director in the city's health department, said in a

statement. "That's why we target the leading causes of poor birth outcomes in the District with programs that, for instance, help women stop smoking, control weight, treat diabetes and hypertension, etc."

Health advocates say maternal deaths, even if they are low in number, demand attention.

"It will always be urgent when we are at risk of losing moms," said Ruqiyah Abu-Anbar, an early childhood policy fellow at the research and advocacy group D.C. Action for Children. "Maternal mortality is a reflection of how we care for women."

The city's infant mortality rate is also troubling to policymakers. In Southeast D.C., babies die at more than twice the rate of the United States as a whole and nearly 10 times the rate of those in affluent Northwest Washington.

The scrutiny of the District's maternal mortality rate follows several troubling developments for expectant mothers.

Last year, District regulators shut down the maternity ward and nursery at the city-owned United Medical Center in Southeast after an investigation found repeated lapses in care for Somesha Ayobo, a pregnant woman who died shortly after she was admitted to the hospital.

Her death caught the attention of congressional lawmakers. Last Monday, they sent a letter asking the D.C. Department of Health about its efforts to monitor and address maternal and infant mortality, and a letter asking about United Medical Center's protocols for caring for women in high-risk pregnancies.

"While some progress in reducing infant mortality and improving health care outcomes for mothers and their infants has been made, there is a clear need to improve maternal and infant health in the District of Columbia," wrote U.S. Reps. Michael C. Burgess (R-Tex.) and Gregg Harper (R-Miss.) in both letters. "Mothers and their infants should never experience serious adverse or even fatal events due to avoidable failures from stakeholders that comprise the Medicaid safety net."

United Medical Center's board voted in December to close its obstetrics unit, weeks after Providence Hospital in Northeast also closed its maternity ward. That left many expectant mothers who live in poor communities east of the Anacostia River multiple bus rides away from the nearest hospital.

Moreover, the District ended MedStar's contract to manage care for Medicaid recipients last fall, forcing some women to seek new providers for prenatal care.

"It took this collection of independent events that happened consecutively for people to realize, oh, this is a problem," said Shana Bartley, acting executive director of D.C. Action for Children.

But to address the problem of maternal mortality, advocates say they need better data.

When newborn babies, children and people with development disabilities die in the District, teams of representatives from government agencies, health-care organizations and community groups examine the circumstances of the death and look for patterns.

The new Maternal Mortality Review Committee will do the same for mothers and produce an annual report with the chief medical examiner's office.

"It looks at every one of these deaths as unacceptable and asks how could we have avoided it, how could this have been prevented, and come up with the solutions to address the causes," said Allen.

Of particular interest is the disparity in these deaths. Infant mortality rates are much higher for black babies in poor neighborhoods of the District than in more affluent, white neighborhoods — and national data backs up similar racial disparities for maternal deaths.

"Hopefully, we are going to be looking at where the women are dying, where in the city they live, and one issue that comes up a lot is racial disparity, and that's really a nationwide problem," said Connie Bohon, a gynecologic oncologist who has worked on the issue with the American Board of Obstetrics and Gynecology.

The Community of Hope clinic in Northeast employs midwives who counsel expectant mothers throughout pregnancy, make home visits and deliver babies in low-risk pregnancies. Maternal mortality is often on the mind of staff, if not their patients.

"The one person who mentioned it was a woman here on a visa from Europe, here for a school thing. She read a whole bunch of reports on it and was pretty freaked out," said Ebony Marcelle, the organization's director of midwives. "But she's not a woman of color, and I said, 'Your odds are pretty good.' Patients here are just trying to survive."

One of those patients, Alicia Byrd, said she doesn't give too much thought to the city's maternal mortality rate, which she read about once. With her third child due on March 20, Byrd does worry about complications and delivering in an unfamiliar environment.

Paris Carter, a staffer at Community of Hope who oversees a support group of six women including Byrd, said she also felt leery about doctors when she had her baby.

"I felt as a Medicaid patient I was . . ."

"Brushed off?" Byrd interjected.

"Exactly," Carter responded. "'We'll give you the bare minimum; show up at the hospital and have your baby, and you'll be fine.' I don't think that's safe."

Community of Hope says making its predominantly black patients feel welcome is crucial to their safety, so women come for care regularly during pregnancy and problems that necessitate referrals to hospitals are spotted early. That includes having women of color on staff, offering gifts for the children and yoga classes for the mothers.

"If you go to places and feel like people are judging you and are not nice to you, you aren't going to go," said Marcelle. "There's a decent amount of women not getting treatment. Period."

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