



Maternal Mortality:

A Case Study in Washington, D.C.

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Key Points

Maternal deaths (*i.e.*, whenever a woman dies while pregnant or within 42 days of being pregnant from non-accidental causes related to being pregnant) are on the rise in the United States.

When mothers lack access to services such as pharmacies, grocery stores, and hospitals with maternity wards, they are at a much greater risk of developing health complications that lead to higher maternal death rates.

Washington, D.C.'s maternal mortality rate is among the highest in the country. It also has very few laws protecting life in the womb. This suggests that pro-abortion laws do not reduce the maternal mortality rate.

During pregnancy, death is the last thing mothers want to have on their minds. However, the rising rate of maternal deaths in the United States means that the issue cannot be ignored. Although there is no uniform solution to ending maternal mortality, there are opportunities to lower the tragic statistic.

Part of the problem rests in the wide discrepancy in how states collect data on maternal mortality and its causes. However, some of the key factors underlying the current maternal mortality crisis in the United States that have come to light are racial disparities and lack of access to resources necessary for human flourishing. Mothers who live in underserved areas typically suffer from an intersection of scarcity, as many areas

that can be deemed maternity care deserts are the same areas that lack access to pharmacies, grocery stores, and ease of transportation.

Residents of underserved areas disproportionately suffer from preventable health conditions such as obesity, diabetes, and high cholesterol—conditions largely associated with higher-risk pregnancies. There is also widespread agreement among medical professionals that most maternal deaths could be prevented but are not, largely due to a lack of proper medical care during different stages of pregnancy and postpartum.

This paper will explore the complexities preventing an understanding of and expedient solution to maternal mortality in the United States. Although maternal mortality rates vary by state and region, the nation's capital city, Washington, D.C., is an excellent case study. One thing implied by this case study is that lack of funding for or access to abortion does not significantly decrease maternal mortality. Although some causes of maternal mortality may yet be unknown, the best place to begin solving the problem is by preventing deaths when causes *are* known.

Background Information and Context

Definitions

To have a conversation about maternal mortality, one must begin by clarifying the definitions of relevant terms. When a pregnant woman or recently pregnant woman dies, the medical community has varying terms to categorize the death that depend upon whether (a) the pregnancy was in any way related to the cause of death and (b) when the death occurred in relation to the pregnancy.

A **pregnancy-associated death** is “[a] death during or within one year of pregnancy, regardless of the cause.”¹ This is the broadest categorization. Any woman who dies while pregnant or within one year of being pregnant falls into this category, regardless of the cause of death.

A **pregnancy-related death** is “[a] death during or within one year of pregnancy, from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy.”² Any woman who dies while pregnant or within one year of being pregnant and whose cause of death is at least distantly connected to her pregnancy falls into this narrower category.

A **maternal death** is “[t]he death of a woman while pregnant or within 42 days of termination of pregnancy, regardless of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental causes.”³ Any woman who dies while pregnant or within 42 days of being pregnant from non-accidental causes related to being pregnant falls into this narrowest category.

The **maternal mortality ratio** (or rate) is the number of maternal deaths per 100,000 live births.⁴

National Maternal Mortality

Despite priding itself on being a global leader, the United States has the sorry distinction of being one of only two nations to report a rising maternal mortality rate between 2000 and 2017 (the Dominican Republic was the other).⁵ In 2020, the United States had a national maternal mortality rate of 23.8 deaths per 100,000 live births;⁶ this number signifies a 3.7 leap from the 2019 maternal mortality rate of 20.1. In a study of 11 high-income nations, the United States had the highest maternal mortality rate by far in 2018, with the second-highest being France’s rate of 8.7.⁷

Lest one think that the United States has an accurate understanding of its maternal mortality crisis, it is important to remember that data collection and framing across the states is not always accurate. In Texas, for example, the 2012 maternal mortality rate was originally reported to be 147; a 2018 investigation discovered that the 2012 rate had actually only been 56.⁸ The unreliability of data reporting is a major contributor to America's difficulty grasping the full scope of its maternal mortality problem.

Maternity Care Deserts

One of maternal mortality's chief causes is a lack of access to the type of medical care that mothers and babies need throughout pregnancy. A region in which access to maternity health care services is severely limited or entirely absent is known as a maternity care desert.⁹ Even regions with hospitals can count as maternity care deserts if they do not have trained doctors, obstetricians/gynecologists, or certified nurse-midwives available to assist pregnant women.¹⁰

In one sense, the United States as a whole is a maternity care desert in comparison to other affluent, developed countries around the world. According to one study, "The U.S. and Canada have the lowest overall supply of midwives and ob-gyns — 12 and 15 providers per 1,000 live births, respectively. All other countries have a supply that is between two and six times greater."¹¹

About 35 percent of counties in the United States are categorized as maternity care deserts.¹² This means that 2.2 million American women of childbearing age live in counties with no hospital offering obstetric care and no birth center; an additional 4.8 million live in counties where maternity care is severely limited.¹³

Preventable Deaths

The medical community generally agrees that the majority of maternal deaths are preventable.¹⁴ Sixty-seven percent of pregnancy-related deaths occur during pregnancy, during delivery, or up to one week after delivery. The Centers for Disease Control and Prevention (CDC) estimates that 63.2 percent of all pregnancy-related deaths are preventable, meaning that about three in five pregnancy-related deaths could have been prevented with proper medical care at one or multiple stages of pregnancy.¹⁵

During pregnancy, the most common causes of maternal deaths are hemorrhaging and cardiovascular conditions. Within 42 days after delivery, infection becomes the most common cause of maternal death.¹⁶ The CDC estimates that 70 percent of maternal deaths from hemorrhaging and 68.2 percent from cardiovascular conditions are preventable.¹⁷

Racial Disproportionality

A discussion of maternal mortality in the United States would be incomplete without mentioning the enormous racial disparity in maternal deaths that has remained consistent for the past century. In 2020, black mothers were three to four times more at risk of maternal death than white mothers.¹⁸ In 2018, the mortality rate for black mothers was 37.1, compared to a rate of 14.7 for white mothers and 11.8 for Hispanic ones.¹⁹

In addition to the inequities in access to health care, black mothers tend to face a broader range of underlying medical conditions that can cause complications during pregnancy, such as preeclampsia, eclampsia, and embolism—conditions from which death is highly preventable so long as treatment is timed appropriately.²⁰

Abortion Industry Narrative

The abortion industry has capitalized on America’s shameful maternal mortality rate by promoting abortion as the solution. According to a late-term abortionist writing in *The New York Times*, “Pregnancy is a life-threatening condition. Women die from being pregnant. We have known that for thousands of years.”²¹ Texas state representative Donna Howard commented on her state’s new law protecting unborn life when a fetal heartbeat can be detected by saying, “we’re letting [mothers] die because you die at a higher rate due to pregnancy than you do due to abortion [...]”²² President Joe Biden’s recent \$1,408,536 grant to Planned Parenthood in Texas evinces the impact of such rhetoric claiming that abortion, rather than equitable health care access, saves lives.²³

Abortionist David Eisenberg, the former medical director of Planned Parenthood of the St. Louis Region and Southwest Missouri, said, “When you eliminate the ability for people who become pregnant to decide [...] it has a negative impact on the health of themselves, as well as their families and the communities they come from.”²⁴ When members of the abortion lobby detract from the maternal mortality issue to champion abortion, they steal resources from the actual problem at hand—lack of access to real health care and nutrition.

It is also important to consider that there is a severe lack of data on abortion complications, especially given the recent surge of dangerous chemical abortions due to the U.S. Food and Drug Administration (FDA) loosening its safety protections against the drug regimen.²⁵ Common medical complications from both chemical and surgical abortions include hemorrhaging and infection²⁶—two of the leading causes of death contributing to the maternal mortality rate. Until data representing the full impact of abortion on the maternal mortality crisis is accurately collected, it will be difficult to implement a comprehensive solution to maternal deaths across the states that considers all possible causes.

Maternal Mortality in Washington, D.C.

With the city's latest maternal mortality rate of 36.1, mothers in Washington, D.C., are almost twice as likely to die from pregnancy complications as mothers in the rest of the nation.²⁷ This statistic highlights the racial inequalities faced by mothers in the nation's capital. According to a Maternal Mortality Review Commission study, black mothers in D.C. accounted for about 90 percent²⁸ of all pregnancy-related deaths, despite African Americans only comprising 46 percent²⁹ of the city's population. The maternal mortality rate for black mothers in D.C. is 71, over 50 points higher than the national average, which is already higher than the rest of the developed world.³⁰

D.C. Abortion Laws and Funding

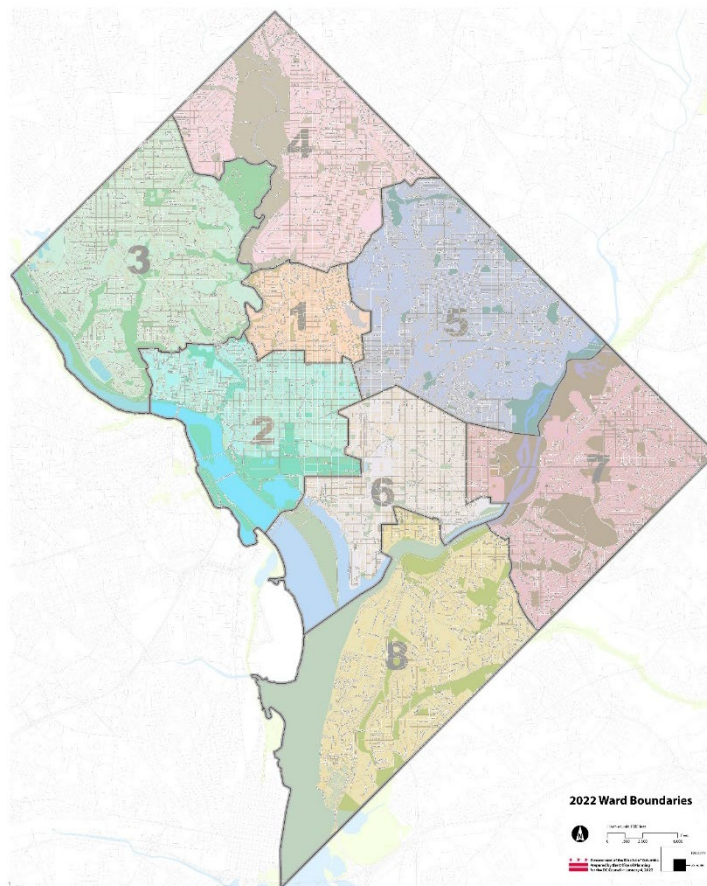
Washington, D.C.'s abortion laws are on par with the least protective abortion laws in the nation. Abortionists in D.C. can kill unborn children at any point throughout all nine months of pregnancy—and the abortionist does not have to be a doctor.

Not only are babies in D.C. unprotected throughout their entire gestation, but mothers are also subject to unprotective laws that allow abortions to occur outside of hospitals and with only one doctor present.³¹ Girls under the age of 18 do not need to inform their parents before undergoing abortions.³² Multiple abortion businesses within the District carry out abortions at any point during pregnancy.

Currently, the Hyde and Dornan Amendments prohibit D.C. from using federal and local tax dollars to pay for abortions. However, abortions in the city can be financed by the D.C. Abortion Fund, a private organization. Although the D.C. Abortion Fund's website admits, "for most of our clients, abortion is not the means that will eradicate poverty, homelessness, domestic violence, drug abuse, or other forms of oppression they face," it nevertheless pours money into preventing babies from being

born rather than providing their mothers with the financial assistance that families need to thrive.³³ The organization boasts, “To date, we have never turned away a single person who was eligible for DCAF funding.”

Map of the D.C. Wards (2022)³⁴



D.C. Ward System

Washington, D.C., is divided into eight wards, each roughly the same population size. By examining life in each of the different wards, trends of socioeconomic and racial segregation across the city become more readily apparent. The ward system is a helpful guide for understanding the limited resources available for the majority of the city’s black citizens and the dire health consequences for the black population.

Wards 7³⁵ and 8,³⁶ which lie predominantly east of the Anacostia River, have populations that are over 91 percent black. The median household income of black residents of these wards is below \$50,000,³⁷ while the median income of white residents living in the same wards is over \$100,000. The median household income of all D.C. residents is over \$102,000.³⁸ It is important to consider that the cost of living in D.C. is almost 55 points higher than the national average.³⁹

Maternity Care Deserts

The disparities in maternal care access and other factors necessary for human flourishing across the wards are striking. Ward 2, which is home to mostly high-income, white residents and has the lowest birth rate in the District at 6.2 births per 1,000 people, has 12 prenatal care facilities. Meanwhile, both Wards 7 and 8 each have only four facilities despite Ward 8 having the highest birth rate in the city⁴⁰ (18.5) and Ward 7 having the second-highest birth rate (16.2). Ward 4, which is also majority black, has the third-highest birth rate (16.1) and only two prenatal care facilities.⁴¹

There is currently no hospital or clinic in Wards 7 or 8 where mothers can give birth, meaning that mothers residing in these areas of the city must cross the Anacostia River to access a birthing hospital.⁴² The only hospital east of the Anacostia, which services Wards 7 and 8, is United Medical Center. This poorly rated hospital⁴³ shut down its maternity ward in 2017 due to malpractice⁴⁴ and is planning to cease operating entirely by 2023.⁴⁵ United Medical Center's unequipped emergency room is the only option for mothers in Wards 7 and 8 who cannot travel across the river to give birth. Even women who are able to travel to other parts of the city have been severely restricted since 2016, when Washington Hospital Center, "the highest-volume maternity care provider in D.C.," restricted the types of Medicaid that it accepts, thereby limiting its access for impoverished women.⁴⁶

The United Medical Center maternity care ward was one of two in the city that closed in 2017; Providence Hospital in Ward 5 also closed its obstetrics unit that year in a move that most deeply affected non-English speaking mothers and mothers on Medicaid.⁴⁷ Although a new hospital, St. Elizabeth's, is slated to open in Wards 7 and 8 in December 2024,⁴⁸ it will only have a level II neonatal care unit, meaning it will not be equipped to provide care for women in high-risk pregnancies such as those that are common to the underprivileged region.⁴⁹

Pharmaceutical and Food Deserts

Medical care is not the only area of support that mothers in underserved communities, such as Wards 7 and 8, are sorely lacking. Social determinants of health can include transportation, housing, education, and access to pharmacies and grocery stores.⁵⁰ The effects of these social determinants are clearly seen in the black population of D.C., whose life expectancies are 12 to 17 years lower than white residents. Black D.C. residents live with diabetes at nearly six times the rate of white residents and experience high blood pressure and cardiovascular issues at more than twice the rate.⁵¹ Each of these issues is correlated to a higher risk of maternal mortality.⁵²

Pharmacies are concentrated in the higher-income portions of the city, limiting opportunities for mothers in less privileged areas to purchase pregnancy supplies such as antibiotics needed to fight off infections, blood pressure cuffs to check for preeclampsia, and scales to check for healthy weight during pregnancy. Ward 2, for example, is serviced by 36 licensed pharmacies, while Ward 7 is only serviced by seven.⁵³

Food deserts that exist due to a lack of grocery store access are present in the same areas that can be categorized as maternity care deserts: Wards 5, 7, and 8. East of the Anacostia River, there are a total of only three grocery stores⁵⁴ that service upwards of 160,000 people living in Wards 7 and 8.⁵⁵

In contrast, the other six wards have a combined total of 71 groceries stores, an average of 11.8 per ward. Wards 5, 7, and 8 also rank considerably lower than others in terms of ease of transportation, making it even more difficult for families to access affordable and nutritious food—as well as medical care.⁵⁶

The health consequences of living in areas lacking these essential services are devastating, particularly for mothers. Residents of Wards 7 and 8 have significantly higher rates of diet-related diseases such as obesity, diabetes, high blood pressure, and high cholesterol. Given these factors, it is no wonder that Wards 7 and 8 have the lowest life expectancy in D.C.⁵⁷ These comorbidities are known to dramatically increase the risk of maternal mortality.⁵⁸

Conclusion

The maternal mortality rate is a devastating statistic that consistently and disproportionately represents the untimely deaths of black mothers. Washington, D.C., has a severe socioeconomic—and statistically racial—disparity in access to services necessary for human flourishing, such as pharmacies, grocery stores, and hospitals with maternity wards. When mothers lack these basic services, they are at a much greater risk of developing health complications that lead to higher maternal death rates.

It is unacceptable that organizations like the D.C. Abortion Fund are permitted to manipulate vulnerable and underprivileged mothers into believing that abortion is their best option rather than directing funding toward protecting the lives of mothers *and* babies. It is unacceptable that mothers living east of the Anacostia River in Wards 7 and 8 do not have access to a hospital with a birth ward. Abortion—which results in the death of their child—cannot be the only option for mothers waiting for an obstetrical unit to be built. Mothers should never be manipulated to believe that their own survival and the survival of their babies are mutually exclusive.

The United States cannot honestly claim to champion women’s rights while continuing to allow highly preventable maternal deaths to occur. Directing resources and energy into pressuring mothers to abort their children only detracts from solutions that prioritize the well-being of both mothers and babies. All available evidence points to equitable health care as a major solution to the issue of maternal mortality. The United States must strive to be a nation where all mothers, regardless of race, socioeconomic status, or place of residence, feel safe and confident when bringing a new life into the world.

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² Ibid.

³ Ibid.

⁴ Ibid.

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¹⁵ “Report from Nine Maternal Mortality Review Committees,” Building U.S. Capacity to Review and Prevent Maternal Deaths, 2018, accessed June 16, 2022, <https://www.cdcfoundation.org/sites/default/files/files/ReportfromNineMMRCs.pdf>.

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⁵⁴ “Still Minding the Grocery Gap in D.C.: 10th Anniversary Grocery Store Report,” D.C. Hunger Solutions, 2020, accessed June 16, 2022, <https://www.dchunger.org/wp-content/uploads/2021/01/StillMindingGroceryGap.pdf?bcs-agent-scanner=9eb05e84-55b1-504a-9461-31b4fee5b1a8>.

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⁵⁷ Ibid.

⁵⁸ “Report from Nine Maternal Mortality Review Committees,” Building U.S. Capacity to Review and Prevent Maternal Deaths, 2018, accessed June 16, 2022, <https://www.cdcfoundation.org/sites/default/files/files/ReportfromNineMMRCs.pdf>.