TESTIMONY OF STACEY D. STEWART
PRESIDENT AND CEO, MARCH OF DIMES

BEFORE A HEARING OF
THE HOUSE COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEE ON
LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES

"ADDRESSING THE MATERNAL HEALTH CRISIS."

U.S. HOUSE OF REPRESENTATIVES
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MARCH OF DIMES

Good morning, Chair DeLauro, Ranking Member Cole, and members of the Subcommittee. Thank you for the opportunity to testify at today's hearing to shine a light on key programs that improve both maternal and infant health. I am Stacey Stewart, President and CEO of March of Dimes. We lead the fight for the health of all moms and babies. We began that fight more than 80 years ago as an organization dedicated to eradicating polio in the U.S., a goal that we achieved. We continue that fight today as we work to address some of the biggest threats to moms and babies, such as premature birth and maternal mortality, through research, education, programs and advocacy.

March of Dimes' ongoing work to improve maternal and infant health is more important than ever as our nation is in the midst of a dire maternal and infant health crisis. Rates of preterm birth are increasing, the U.S. is one of the most dangerous places to give birth in the developed world, and there are unacceptable disparities in birth outcomes between women and infants of color and their White peers.

We know the pandemic has only worsened this crisis. According to CDC data, expectant mothers with the virus had a 50 percent higher chance of being admitted to intensive care and a 70 percent higher chance of being intubated than non-pregnant women in their childbearing years.[i] The data also shows pregnant Latina and Black women were infected at higher rates than White women. As we know, COVID-19 strikes the respiratory and cardiovascular systems, which are the two systems already strained during pregnancy.

Pregnancy affects every system in a woman's body and the immune system changes so that it can protect not only the mother, but the baby. This can make pregnant women more

susceptible to certain infections as different parts of the immune system are enhanced while others are suppressed. Therefore, it is crucial that pregnant and lactating women have access to COVID-19 vaccines. They must be included in vaccine trials so that there is data to allow them to make informed decisions with their medical providers about getting the vaccine and to ensure that the vaccine is safe and effective for them.

We also know, the health and well-being of mothers and infants are inextricably linked. By improving the health of women before, during and between pregnancies, we can improve outcomes for both them and their infants. But we have many challenges before us.

OUR NATION IS IN THE MIDST OF A MATERNAL AND INFANT HEALTH CRISIS

Nearly every measure of the health of pregnant women, new mothers, and infants living in the U.S. is going in the wrong direction. In many communities, infant mortality rates exceed those in developing nations.[ii] Approximately every 12 hours, a woman dies due to pregnancy-related complications.[iii]

Preterm Birth

Each year, March of Dimes releases its annual Report Card grading the U.S., each of the states, DC, and Puerto Rico, on their progress toward improving maternal and infant health.[iv] Our most recent 2020 report found the nation's preterm birth rate rose for the fifth year in a row in 2019 to 10.2 percent. This startling increase comes after nearly a decade of decline. As you might expect, the worsening national picture does not signal good news in individual states. Between 2018 and 2019, preterm birth rates worsened in 38 states. While we have four states, New Hampshire, Oregon, Vermont, and Washington, earning a B+, we have eight states and one

territory earning a F. What do these statistics mean for the nation's families? They mean 1 in every 10 babies are born preterm, which can lead to life-long health problems and, in the most tragic cases, a baby's death.

These topline numbers tell only part of the story. Diving deeper into the data highlights an even starker reality for certain communities. With preterm birth rates as high as 14.6 percent (Mississippi), 13.1 percent (Louisiana), and 12.5 percent (Alabama), infants born in the southeastern U.S. are much more likely to be born early than in other parts of the country. Racial disparities exist across the U.S., Hispanic, American Indian/Alaska Native, and Black babies are born premature at a rate surpassing their White peers. In fact, the preterm birth rate among Black women is 50 percent higher than the rate among all other women-combined.

Maternal Health

The state of maternal health mirrors that of infants born too soon. Outcomes are getting worse and those worsening outcomes are driven by disparities. Each year, about 700 women die from complications related to pregnancy.[v] For every maternal death, another 70 women suffer life-threating health challenges. That's over 50,000 women each year.[vi] While other countries have reduced their maternal mortality rates since the 1990s, the U.S. maternal mortality rate continues to rise.[vii]

The threat of maternal mortality and morbidity is especially acute for women of color. Black mothers of all ages are three times more likely to die from pregnancy-related complications than their White peers.[viii] The rates of pregnancy-related death for Black and American Indian/Alaska Native women over the age of thirty are 4 to 5 times higher than their White

peers.[ix] Black women are 27 percent more likely to experience severe pregnancy complications than White women.[x] These disparities cannot be explained by differences in age or education. According to the latest CDC data, maternal mortality rates among Black women with a completed college education or higher was 1.6 times that of White women with less than a high school diploma.[xi]

Maternal mortality is also significantly higher in rural areas, where obstetric providers may not be available[xii] and delivery in rural hospitals is associated with higher rates of postpartum hemorrhage.[xiii] In September 2020, March of Dimes released an updated report showing that 2.2 million women of childbearing age live in "maternity care deserts," which are counties without a hospital, birth center or providers offering obstetric services.[xiv] An additional 4.8 million women of childbearing age live in counties with limited access to maternity care. Each year, 150,000 babies are born to mothers living in these maternity care deserts.[xv]

But it is not just access to quality prenatal care that makes the difference. Improving the health of a mom before she becomes pregnant and in the postpartum period are essential to maternal and infant health. Chronic conditions begin long before a woman becomes pregnant, such as high blood pressure, diabetes, heart disease and obesity, putting women at higher risk of pregnancy complications and must be appropriately managed. We know that more than one-third of pregnancy-related deaths from 2011 to 2016 were associated with cardiovascular conditions.[xvi]

We also know the "4th trimester," the 12-week period immediately after birth, is a vulnerable time for moms, babies and families and so it is imperative to ensure mothers are receiving

adequate care during this postpartum period. About 1 in 8 women experience symptoms of postpartum depression.[xvii] These conditions are the most common complication of pregnancy and childbirth, impacting an estimated 800,000 women in the U.S. each year.[xviii]

Sadly, maternal mental health conditions often go undiagnosed and untreated, increasing the risk of multigenerational long-term negative impact on the mother's and child's physical, emotional, and developmental health, and the risk of poor health outcomes. Furthermore, women of color and women who live in poverty are disproportionately impacted by both the pandemic and maternal mental health conditions, experiencing both at rates 2-3 times higher than White women.[xix] [xx]

A MULTIFACETED RESPONSE IS NECESSARY

This has led to an urgent crisis that demands a comprehensive response by policymakers. The causes of our nation's maternal and infant health crisis are complex, and there is still much we do not know. That is why March of Dimes was pleased Congress passed the *Preventing Maternal Deaths Act* (P.L. 115-344) and the *PREEMIE Reauthorization Act* (P.L. 115-328) in late 2018. Both bills enable the continuation of vital programs to collect enhanced data on the causes of maternal mortality and premature birth, respectively, and translate that data into meaningful action to prevent future deaths.

We are hopeful new efforts will spur further action. March of Dimes is thrilled to see that the Biden-Harris Administration is fully committed to ensuring maternal and infant health disparities are eliminated. March of Dimes has engaged with HHS in a public-private partnership to specifically address advancing equity in maternal health through hospital-based

quality improvement activities. This project is just getting off the ground and we are working closely to ensure the partnership and the resulting actions that will be implemented, are not only centered-around the voices of Black women, but are also led and informed by Black maternal health experts.

UnitedHealthcare Community & State has made the first significant investment of $2.85 million in the HHS-March of Dimes public-private partnership to fund a quality improvement pilot program aimed at improving maternal health outcomes for Black women in the South. March of Dimes and HHS plan to scale this program to 100 hospitals over the next five years. We are excited about this new initiative and look forward to sharing more on its progress in the future.

March of Dimes offers the following recommendations for FY22 funding priorities:

National Institutes of Health (NIH)

Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD)

March of Dimes requests the Subcommittee provide at least $1.7 billion for NICHD's groundbreaking biomedical research activities. Increased funding will allow NICHD to sustain vital research on preterm birth, maternal mortality, maternal substance use, and prenatal substance exposure and its long-term impacts through extramural grants, the Maternal-Fetal Medicine Units Network, and the Neonatal Research Network and intramural research program. It will also ensure NICHD can continue research on the impact of COVID-19 on pregnant women, new mothers, and infants by expanding research to identify safe and effective therapies.

Additionally, now that the Task Force on Research Specific to Pregnant and Lactating Women (PRGLAC) has made its recommendations, as mandated by Congress in the *21st Century Cures Act* (P.L. 114-255), to promote the inclusion of pregnant and lactating people in clinical trials, and has further detailed them in an implementation report to the HHS Secretary released in August 2020. We recommend an HHS advisory committee be established to ensure that the steps recommended by PRGLAC are implemented and progress is monitored going forward.

Centers for Disease Control and Prevention (CDC)

Surveillance for Emerging Threats to Mothers and Babies Network

March of Dimes recommends funding for CDC's Surveillance for Emerging Threats to Mothers and Babies Network (SET-NET) within the National Center for Birth Defects and Developmental Disabilities (NCBDDD) at $100 million. SET-NET was created during the Zika outbreak, which allowed CDC to create, a unique nationwide mother-baby linked surveillance network to monitor the virus' impact in real-time to inform clinical guidance, educate health care providers and the community, and connect families to care. Unfortunately, states were unable to sustain systems due to the program being chronically underfunded, and we were left without a national system to mobilize when the coronavirus struck.

Now as the pandemic continues, we have an incomplete picture on how to best care for mothers and babies with confirmed or suspected virus infection as the CDC currently only supports 29 state, local, and territorial health departments. The increased funding will allow for CDC to address these knowledge gaps and expand the initiative to provide real-time clinical and survey data from all 50 states, territories and jurisdictions on the impact of COVID-19.

Safe Motherhood and Infant Health

Maternal Mortality Review Committees (MMRCs)

Under the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) Program, CDC provides funding, technical assistance, and guidance to state maternal mortality review committees. These multidisciplinary committees identify, review and characterize maternal deaths and prevention opportunities. Currently, CDC has made 24 awards and supports 25 state agencies and organizations that coordinate and manage MMRCs. However, more standardized data collection is needed to help examine all the factors contributing to severe maternal mortality, preventable deaths, and poor birth outcomes.[xxi] To this end, we request $30 million, an increase of $15 million from FY21, to reach all 50 states, DC and Puerto Rico with enhanced technical assistance and work with tribes to maximize MMRCs.

Perinatal Quality Collaborative (PQCs)

PQCs are state or multistate networks working to improve the quality of obstetric care and improve outcomes. Currently, CDC funds 13 state-based PQCs that are implementing recommendations across health facility networks.[xxii] For example, Illinois' PQC has improved timely treatment for women with severe high blood pressure. The Northern New England PQC has improved care for women with opioid use disorder and California's PQC has reduced serious pregnancy complications among women with severe bleeding during pregnancy or delivery.[xxiii] However, many PQCs lack adequate resources to meet demands and reach their maximum potential. We request $30 million to fully scale these programs in all states, an increase of $26.5 million from FY21.

Pregnancy Risk Assessment Monitoring System (PRAMS)

This survey system collects state-specific, population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy. PRAMS surveillance currently covers about 83 percent of all U.S. births[xxiv] and is the only surveillance system that provides data about pregnancy behaviors and the first months after birth.[xxv] We request funding of $2 million, as authorized, to help identify groups of women and infants at high risks for health problems, monitor changes in health status, and measure progress in improving health outcomes.

Newborn Screening

Newborn screening is one of our nation's most successful public health programs. Each year, 98 percent of the approximately 4 million infants born in the U.S. is screened for certain genetic, metabolic, hormonal and/or functional conditions.[xxvi] If left untreated, these conditions can cause disability, developmental delay, serious illness, and even death. The early detection afforded by newborn screening ensures that infants who test positive for a screened condition receive prompt treatment, saving or improving the lives of more than 13,000 infants each year.[xxvii]

Both the Newborn Screening Quality Assurance Program (NSQAP) at CDC and the Heritable Disorders program at Health Resources and Services Administration (HRSA) have significantly improved the quality of newborn screening programs. NSQAP is the only federal agency that works hand-in-hand with state laboratories by performing quality testing for more than 500 laboratories to ensure the accuracy of newborn screening tests in the U.S. and around the world.[xxviii] The Heritable Disorders program provides assistance to states to improve and expand

their newborn screening programs and promote parent and provider education. It also supports the Advisory Committee on Heritable Disorders in Newborns and Children (ACHDNC), which provides recommendations to the HHS Secretary for conditions on the Recommended Uniform Screening Panel (RUSP). In order to sustain, improve, and enhance these programs, we urge $28 million for NSQAP and $28.883 million for the Heritable Disorders program.

HRSA Maternal and Child Health Bureau (MCHB)

Screening and Treatment for Maternal Depression and Related Behavior Disorders Program

This program provides state grants to address maternal depression helping new mothers and their babies achieve the best start possible.[xxix] At the current funding level, only seven states have received grants, after 30 states applied, to create programs to address maternal depression, through real-time psychiatric consultation, care coordination, and training for front-line providers to better screen, assess, refer and treat pregnant and postpartum women for depression and other behavioral health conditions. We urge $10 million to add five states and provide technical assistance to non-grantees, a $5 million increase over FY21.

Maternal Mental Health Hotline

We thank the Subcommittee for funding $3 million in FY21 to the maternal mental health hotline. New funding will allow qualified counselors to staff a hotline 24 hours a day and conduct outreach efforts on maternal mental health issues. COVID-19 has exacerbated maternal mental health conditions at 3-4 times the rate prior to the pandemic and leaving these conditions untreated can have a long-term effects.[xxx] We urge the Subcommittee to

provide $5 million to allow for the hotline to provide text messaging services, culturally-appropriate support, and continue public awareness efforts.

CONCLUSION

March of Dimes thanks the Subcommittee for focusing attention on the nation's urgent maternal and infant health crisis. As we continue to work on advancing new policies like the Black Maternal Health Momnibus Act, our nation must invest in the programs already in our toolbox to fight this crisis. With your help, we can make strides to prevent preterm birth, end preventable maternal deaths, and address the maternal mental health issues that impact mothers, infants and families. March of Dimes stands ready to work with you to achieve that change. I look forward to your questions.

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