

Maternal Mortality in the USA

A Fact Sheet

- The World Health Organization reported in 2007 that 40 other countries have lower maternal death rates than the United States.
- The Centers for Disease Control (CDC) report that there has been no improvement in the maternal death rate in the United States since 1982.
- The CDC estimated in 1998 that the US maternal death rate is actually 1.3 to three times that reported in vital statistics records because of underreporting of such deaths. (1)
- The CDC reported in 1995 that the “magnitude of the pregnancy-related mortality problem is grossly understated.” (2)
- The rate of maternal death directly related to pregnancy or birth appears to be rising in the United States. In 1982, the rate was approximately 7.5 deaths per 100,000 live births. By 2004, that rate had risen to 13.1 deaths per 100,000 births. By 2005, the rate was 15.1 deaths.
- **The CDC estimates that more than half of the reported maternal deaths in the United States could have been prevented by early diagnosis and treatment. (1)**
- Autopsies should be performed on all women of childbearing age who die if there is to be complete ascertainment of maternal deaths.
- Numerous studies have found that in 25 to 40 percent of cases in which an autopsy is done, it reveals an undiagnosed cause of death.
- In the 1960s, autopsies were performed on almost half of deaths.
- The United States now does autopsies on fewer than 5 percent of hospital deaths.
- Reporting of maternal deaths in the United States is done via an honor system. There are no statutes providing for penalties for misreporting or failing to report maternal deaths.

- In the United States, the risk of maternal death among black women is about 4 times higher than among white women. *For 2005, the rate was 36.5 deaths per 100,000 live births.*
- Most countries with lower maternal death rates than the United States use a different definition of “maternal death”, which, unlike the United States’ definition, includes those deaths directly related to pregnancy or birth which take place during the period between six weeks postpartum and one year after the end of pregnancy.
- Complete and correct ascertainment of all maternal deaths is key to preventing maternal deaths.
- The Confidential Enquiry into Maternal Deaths in the United Kingdom (England, Scotland, Wales, Northern Ireland), which has functioned since 1952, is the system believed to have achieved the most complete ascertainment of maternal deaths while guaranteeing utmost confidentiality. See www.cemach.org.uk
- The maternal mortality rate for cesarean section is four times higher than for vaginal birth and is still twice as high when it is a routine repeat cesarean section without any emergency. (3,4)
- There is currently no federal legislation mandating maternal mortality review at a state level.
- Fewer than half of the states conduct state-wide maternal mortality review.
- Hospitals do not release reports of maternal deaths to the public; hospital employees are required to keep such information to themselves.
- The Healthy People 2010 Goal is no more than 3.3 maternal deaths per 100,000 births. This is a goal that other nations have achieved.

Notes

1. *Morbidity and Mortality Weekly Report*, September 4, 1998, Vol. 47, No. 34.
2. Atrash HK, Alexander S, Berg CJ. Maternal mortality in developed countries: Not just a concern of the past. *Obstet Gynecol* 1995;86:700-5.
3. Petitti D et al. In hospital maternal mortality in the United States. *Obstet Gynecol*, Vol 59, pp. 6-11, 1982.

4. Petitti D. Maternal mortality and morbidity in cesarean section. *Clin Obstet Gynecol*, Vol. 28, pp. 763-768, 1985.
5. The Confidential Enquiry into Maternal Deaths in the United Kingdom
www.cemach.org.uk

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