Maternal Mortality among Non-Hispanic Black Women in NC

2018–2020

The North Carolina Maternal Mortality Review Committee (MMRC) was established by state law in 2015. The purpose of the MMRC is to review all maternal deaths of NC residents and develop actionable recommendations aimed at the prevention of future maternal deaths. This fact sheet highlights data for pregnancy-related deaths among NH Black women that occurred from 2018–2020 in North Carolina.

Pregnancy-Related Mortality Ratio (PRMR)

NH Black Women experience Pregnancy-Related Mortality Ratios

1.8x **higher than NH White Women**

Disparities in Pregnancy-related Mortality by Race/Ethnicity

57 **pregnancy-related deaths**

per 100,000 live births among NH Black Mothers

Source: NCDHHS | Division of Public Health | Women, Infant and Community Wellness Section I Maternal Health Branch | NC Maternal Mortality Review Committee

Pregnancy-related deaths per 100,000 live births by Race/Ethnicity, NC Residents 2018–2020

57	46	32	25
NH Black	**NH Other races***	**NH White**	**Hispanic**

NH=Non+Hispanic **The number of deaths for NH Asian/Pacific Islander, Multiracial & American Indian/Alaskan Native groups are too small to calculate reliable PRMRs*

Leading Cause(s) of Pregnancy-Related Deaths

Cardiovascular Conditions* were the Leading Cause of Pregnancy-Related Death among NH Black Women

12 Deaths from 2018–2020

**Including cardiomyopathy*

Other leading causes among NH Black Women:

- Homicide (7 deaths)
- Embolism (6 deaths)
- Infection (5 deaths)
- Hypertensive disorders of pregnancy (4 deaths)
- Cerebrovascular Accident (3 deaths)

Preventability

79% **of Pregnancy-related deaths among NH Black women were deemed preventable**

A death is **preventable** if there was at least some chance it could have been avoided with reasonable changes to patient, family, provider, facility, system, and/or community factors.

Timing of Pregnancy-Related Deaths: NH Black Women

21% **During pregnancy**

36% **1-42 days after end of pregnancy** (including day of delivery)

43% **43 days-1 year** after end of pregnancy

A Snapshot of Recommendations among NH Black Pregnancy-Related Deaths

- Health care teams should refer patients with newly diagnosed cardiac conditions to specialty care i.e. cardiology.
- Hospital systems, primary care and OBGYN offices should follow guidelines of management of hypertensive disorders of pregnancy and patients should be connected to primary care providers after delivery.
- Community groups and OB providers should educate pregnant and postpartum individuals and families about postpartum warning signs.
- Health care systems/hospitals should perform autopsy on unexpected deaths of pregnant patients or recently pregnant patients to determine cause of death with family consent.
- Health care systems should provide trainings on how to implement intimate partner violence screenings in the healthcare setting and enforceable protocols and resources. Screenings related to whether guns in the home are stored safely should be included.

**Note: Please see the full 2018-2020 MMRC report for additional recommendations*

Definition | Pregnancy-related death: A death while pregnant or within one year of the end 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. *(Q: "If she had not been pregnant, would she have died?")*

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Public Health

ERASE MM
Enhancing Reviews and Surveillance to Eliminate Maternal Mortality

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