WAL Writing Contest 1st Place Article

Maternal Mortality and Domestic Violence: The Intersectionality of Pregnancy and Violence[1]

By: Khyra Kolidakis

I. What is the challenge? How are women harmed?

The maternal mortality rate shocked researchers when it doubled between 2010 and 2012[2]. The researchers found that 148 women died in 2012 as a result of pregnancy.[3] Black women in Texas are dying with frightening frequency after childbirth — at a rate of nearly three times higher than that of white women.[4] No one has figured out why. According to the Texas Tribune three major state and federal agencies, working with several non-profit organizations in Texas, came together in 2013 to provide statistics and solutions for this problem; however, the issue remains at the top of the health disparities list today.

Although the Department of State Health Services' website shows that Texas' maternal mortality rate was 35.2 per 100,000 births between 2012 and 2015 using CDC data, agency officials now say that the number of mothers who died during that period is actually more than 30 percent lower — 24.3 deaths per 100,000 births — as a result of a new methodology the state recently began using to calculate deaths. While state officials say the new, lower mortality rate is more accurate, they stopped short of calling it the official maternal mortality rate because the new methodology is still being "refined".[5] While the new numbers may be giving state officials a reason to celebrate, it would appear that there is a much different narrative being pushed on the ground. The Texas Tribune has told harrowing tales of mothers enduring medical nightmares: They bled out, had strokes and heart attacks, and lost babies during delivery.

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[1] Khyra Kolidakis Term Paper for Domestic Violence. Fall 2019. Contributions made by Professor Janet Heppard and Professor Diane McManus.

[2] *See* https://www.washingtonpost.com/news/morning-mix/wp/2018/04/11/texas-maternal-mortality-rate-was-unbelievably-high-now-we-know-why/

[3] *See id.*

[4] *See* https://www.washingtonpost.com/national/health-science/dying-after-childbirth-women-in-texas-are-at-high-risk-especially-if-theyre-black/2017/07/21/0a835f0a-6b00-11e7-b9e2-2056e768a7e5_story.html

[5] https://apps.texastribune.org/dangerous-deliveries/

Dozens of experts and advocates say maternal deaths are a symptom of a bigger problem. According to the Texas Women's Healthcare Coalition, 1.3 million women who need routine checkups and birth control cannot afford it and cannot access it, according to the Texas Women's Health Coalition. Too many Texas women — particularly low-income women — do not have access to health insurance, birth control, mental health care, substance abuse treatment and other services that could help them become healthier before and after pregnancy.

In October of 2018, a legislative task force released a report showing that the Texas women most at risk of dying after giving birth include black women over 40, unmarried women, women who use Medicaid, women who have little or no insurance and women who give birth through cesarean delivery.[6] These same women are also more likely to enter pregnancy with health problems like obesity, diabetes, high blood pressure and smoking habits.[7]

Women make up half the workforce, and, according to census figures, a slight majority of the U.S. population; so, their suffering and undiagnosed health problems create costs and burdens that ultimately hurt our economy and slow our businesses. For example, growing obesity in Texas women and increased cases of hypertension and other ailments while pregnant make low-income women a health risk unlike any seen in recent years[8]. Faced with alarming public health statistics that drew national attention, Texas lawmakers created a Task Force on Maternal Mortality and Morbidity in 2013 to study the problem and make recommendations to curb the state's rising rate.

The Texas Tribune's investigation found that lawmakers have squandered opportunities to help more women access services that could save their lives. Hundreds of thousands of low-income women who, under federal law, would be eligible for publicly funded health insurance do not qualify for coverage in Texas because state leaders rejected a Medicaid coverage expansion offered under the Affordable Care Act.[9] According to Jamila Taylor, an advocate at the Center for American Progress, state legislators' decision in 2011 to change how Texas offers women's health services has left thousands of women without "crucial" health care before, during and after pregnancy.[10] That included a $73.6

[6] *See id.*

[7] *See id.*

[8] *See* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2621047/

[9] *See* https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/

[10] https://www.americanprogress.org/issues/women/reports/2019/05/02/469186/eliminating-racial-disparities-maternal-

million cut to Family Planning Services which led to roughly 100,000 fewer people being served in 2012.[11] That same year, Republican state leaders moved to exclude Planned Parenthood funding even though its participating clinics were not performing the Texan-scorned abortions.[12] It is worth noting that Planned Parenthood has been the top healthcare provider for low-income women, and that the healthcare being mentioned includes more than abortions.

In the place of defunded Planned Parenthood clinics that offered real women's health services (like pap smears and birth control), unfamiliar clinics have sprung up with solo practitioners offering behavioral health services; a.k.a. pills. For women to receive care if they are uninsured, they have to attend a location for mental health, a separate location for birth control and gynecology services, another location for general primary care; and they have to pay a hefty cost at each different location. If a woman is not married and without a college education, above the age of 26, or without a stable home, living in Texas it is likely that she cannot afford healthcare. So, when we ask the question "why are low-income women dying from childbirth?"; we should be aware that the climate these women are forced to live in has been created by the Texas legislature.

II. What is the relevant law(s)?

According to the National Institutes of Health, intimate partner violence (IPV), or domestic violence, affects as many as 300,000 pregnant women every year in the U.S. from every age group, religion, ethnicity, socioeconomic level and educational background."[13]" IPV increases behavioral risk factors in pregnant women, such as smoking, drug or alcohol abuse, possibly because these are coping mechanisms for survivors."[14] "Intimate partner violence during pregnancy has been found to be associated with fatal and non-fatal adverse health outcomes for the pregnant woman and her baby due to the direct trauma of abuse to a pregnant woman's body, as well as the physiological effects of stress from current or past abuse on fetal growth and development."[15] "Physical, sexual and psychological intimate partner violence during pregnancy [is] associated with higher levels of depression, anxiety, and stress, as well as suicide attempts,

infant-mortality/

[11] *See* https://apps.texastribune.org/dangerous-deliveries/

[12] *See id.*

[13] https://www.domesticshelters.org/articles/statistics/when-pregnancy-triggers-violence

[14] *Id.*

[15] https://apps.who.int/iris/bitstream/handle/10665/70764/WHO_RHR_11.35_eng.pdf?sequence=1

lack of attachment to the child and lower rates of breastfeeding."[16] "Possible explanations are that women smoke, drink or take drugs for self-medication to cope with the stress, shame, and suffering caused by the abuse."[17]

The Task Force was a result of the legislative charge to curb maternal mortality and severe morbidity through recommendations. Because accurate and actionable data is integral for the success of efforts to curb maternal deaths, the Department of State Health Services worked to complement the Task Force and legislative efforts through continued analysis of available maternal mortality data. This has included, but is not limited to, an analysis that breaks down causes of maternal death along a pregnancy and postpartum timeline. The timeline analysis has also been used to support the work of the Department of State Health Services and other agencies to identify opportunities within the few existing programs to prevent maternal deaths and severe morbidity outcomes.

The work of the Task Force (the only known legal action in Texas addressing the maternal mortality issue so far) can best be understood by their final report issued in December of 2017 and a table that was published in this report. To distinguish those maternal deaths directly related to pregnancy from those not directly related, the Department of State Health Services examined the timing and cause of all 382 confirmed maternal deaths that took place between 2012 and 2015. The Task Force noted that analysis of more comprehensive data was necessary to offer a full and complete report, but the only existing comprehensive data for the state of Texas is as follows:

[16] *Id.*
[17] *Id.*

Table 1: Confirmed Maternal Deaths by Timing and Cause of Death

Texas, Over a Four-Year Period, 2012-2015[18]

Cause of Death	While Pregnant	0-7 Days Post-partum	8-42 Days Post-partum	43-60 Days Post-partum	61+ Days Post-partum	Total
Amniotic Embolism	1	9	0	0	0	10
Cardiac Event	2	12	9	5	27	55
Cerebrovascular Event	0	8	9	1	9	27
Drug Overdose	0	3	7	5	49	64
Hemorrhage	3	12	2	0	3	20
Homicide	2	1	5	2	32	42
Hypertension/Eclampsia	0	7	4	0	7	18
Infection/Sepsis	1	3	14	3	11	32
Pulmonary Embolism	2	3	4	2	2	13
Substance Use Sequelae (e.g., liver cirrhosis)	0	0	2	0	3	5
Suicide	0	1	2	2	28	33
Other	5	5	6	3	44	63
Total	16	64	64	23	215	382

Homicide was found to be the second-leading cause of injury-related death for pregnant women, after car accidents, in a study by the National Institute of Health.[19] "The NCADV found that between 1990 and 2004, 1,300 pregnant women in the U.S. were murdered, with 56 percent being shot to death (the rest were stabbed or strangled)."[20] "More than two-thirds were killed during their first trimester."[21] "In other words, partners who batter pregnant women are often particularly more dangerous and more likely to kill their partners."[22]

While this data may seem comprehensive, the Task Force overlooks several contributing factors to the rising maternal mortality rate that especially effect low-income mothers. When neighborhoods work well, they are a place where individuals derive many social benefits. However, when neighborhoods are characterized by residential segregation, often linked to ethnic/racial minority population concentrations, then women living in those neighborhoods have higher rates of morbidity and mortality.

[18] https://dshs.texas.gov/mch/pdf/Dec2017-Investigating-Maternal-Mortality-Brief-FINAL.pdf
[19] *See* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1449204/

[20] https://www.domesticshelters.org/articles/statistics/when-pregnancy-triggers-violence

[21] *Id.*
[22] *Id.*

Residential segregation that creates concentrated neighborhoods where residents are predominantly poor, racial/ethnic minority, or of immigrant status are social spaces with concentrated social problems. This increases the chances that residents, whatever their individual backgrounds, will experience greater exposure to stressful environments while also having fewer resources with which to cope with these exposures. "Even though Hispanic and [B]lack women have similar rates of chronic health issues like obesity, diabetes and heart disease, [T]ask [F]orce members and researchers say they can't explain why Hispanic mothers are more likely to survive pregnancy complications."[23] Perhaps this discrepancy has to do with the cultural support systems inherent in Hispanic families, as opposed to Black women who are often stereotyped and expected to be single mothers.

Quality maternal mortality data is sorely lacking. The U.S. government hasn't published an official nationwide rate since 2007. Researchers, including Texas' maternal mortality Task Force members, primarily rely upon the National Vital Statistics System, which compiles data from each state based on death certificates completed by doctors and coroners. This data is deeply flawed and inconsistent because there simply aren't enough resources to analyze the data that exist. In addition, the data is easily manipulated to reflect the desires of a state with vested political interest.

III. How should the challenge be addressed?

There are a diverse number of disciplines involved in pregnancy-related violence research including such fields as sociology, psychology, criminal justice, nursing, education, and public health, to name a few. "[I]t is relatively uncommon for researchers in these fields to work together to develop a multidisciplinary research project. Such collaboration could prove to be extremely beneficial in increasing the range of knowledge on the subject of pregnancy-related violence and ultimately working toward its reduction."[24] Although the Department of State Health Services, Maternal Mortality Task Force, and the Health and Human Services Commission is still working together to interpret legislation from the 85th Texas legislature, the solutions proposed so far have been immensely inadequate.

Research indicates that there have been several answers proposed to solve to this looming problem including: maternal safety bundles, bills in the legislature to extend behavioral health services for women a year after delivery or in the treatment of opioid use, and several proposed forums to strategize on more solutions that can span throughout

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[23] https://apps.texastribune.org/dangerous-deliveries/

[24] Jasinski, J., "Pregnancy and Domestic Violence: A Review of the Literature," TRAUMA, VIOLENCE, & ABUSE, Vol. 5, No. 1, at 58 (Jan. 2004) (hereinafter, "Jasinski").

Texas. The answer will not be simple and easy, nor will it narrow the numbers of women being addressed (as the current strategy seems to do). Clinical prevention methods will be needed at different points in time, in multiple locations, both within and outside of the hospital setting.

According to the American College of Obstetricians and Gynecologists, a maternal safety bundle is guidance and literature that is issued by several organizations in a collaborative fashion to various hospitals.[25] The guidance represents best practices for maternity care and includes "action plans" (or suggestions) on systems to be implemented by hospital staff to address several complications that could lead to maternal death during pregnancy or the postpartum period including hemorrhaging, severe hypertension, deep vein thrombosis, low-risk C-sections, and peripartum/postpartum racial disparities. It is worth noting that these safety bundles are touted most often by the state as the best solution; however, there isn't a single website that explains what these bundles will do in terms that are reasonable for a consumer (a.k.a. the mother, the patient). Maternal safety bundles sound great for those that have insurance or can afford to pay hospital costs out of pocket. For those without insurance, maternal safety bundles -in terms of a solution- mean nothing.

Expanding behavioral health services for women one year after delivery is certainly a start; however, this sort of allocation of services that should be considered mandatory is not nearly enough. The risk of moderate to severe violence appears to be greatest in the postpartum period. "Women may need protection from violence and intimidation by their partners and it is important that there are provisions to accommodate this need."[26] According to the Texas Department of Human Health Services, 33 mothers were lost from 2012 to 2015 as a result of suicide. How many of those deaths could have been prevented with the proper support systems already in place? There are children who will never see their mothers simply because the state government didn't care enough to provide access. And, what about the 64 mothers in Texas that died from drug overdose in 2012 to 2015 after a 61-day period? The data from the National Vital Statistics System does not begin to estimate how much of those drug-related deaths were from opioid use; but at least the Texas legislature will begin to cover prevention and treatment for those women-after their baby is born.

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[25] *See* https://www.acog.org/news/news-releases/2018/08/aim-program-awarded-millions-to-expand-efforts-to-reduce-maternal-mortality-and-morbidity

[26] Mezey, G. and Bewley, S., "Domestic Violence and Pregnancy: Risk is Greatest After Delivery," BMJ VOLUME 314 at 1295 (May 3, 1997).

2 million women are physically assaulted annually and more than 50 million are assaulted in their lifetime. Consequences of pregnancy-related violence include later entry into prenatal care, low birth weight babies, premature labor, fetal trauma, unhealthy maternal behaviors, and health issues for the mother.[27] "There's a racial divide in postpartum care in Texas, too. Hispanic women in Texas skip postpartum visits at a rate of 18.9 percent; 10.1 percent of black mothers don't get postpartum checkups, nor do 9.6 percent of white women, according to the 2015 Pregnancy Risk Assessment Monitoring System."[28] "The issue of research sample . . . remains an important factor to consider when interpreting prevalence estimates."[29] "Notably, analysis of population-based data from the Centers for Disease Control and Prevention's (1999) Pregnancy Risk Assessment Monitoring System (PRAMS) 1996 Surveillance Report found reported rates of pregnancy-linked abuse to be much lower than studies using hospital-based samples, ranging from 2.9% to 5.7% among several thousand women across 11 states participating in PRAMS . . ."[30]

When women lack access to livable wages, flexible scheduling, and paid family leave, it can have a harmful impact on both their physical and mental health, leading to negative impacts on the population as a whole. "PRAMS 1996 Surveillance Report asks only a few limited questions on abuse and questions are not behaviorally specific."[31] Women were asked whether they were "physically abused by a husband or partner during the 12 months preceding their most recent pregnancy."[32] "Both the limited number of items and the use of the term "abuse" . . . may lead to underestimates of assaults preceding or coinciding with pregnancy."[33] A lack of insurance makes it harder for women to manage long-term health issues — and for women of child-bearing age to get the prenatal care that can help prevent maternal deaths. "Kami Geoffray, CEO of the Women's Health and Family Planning Association of Texas, an organization that works to increase access to family planning programs, said lawmakers haven't gotten serious about addressing shortcomings in the state's health care programs for women,"[34] and I would agree.

"Although studies using probability samples seem to agree that pregnancy does not increase the risk for violent victimization, they were not designed to specifically look at this issue and therefore have not included the necessary

[27] *See* Jasinski at 55.
[28] https://apps.texastribune.org/dangerous-deliveries/
[29] Jasinski at 48.
[30] *Id.*
[31] *Id.* at 49.
[32] *Id.*
[33] *Id.*
[34] https://apps.texastribune.org/dangerous-deliveries/

questions to create a complete picture of the violence-pregnancy relationship."[35] Studies have consistently reported no difference in risk due to pregnancy. "However, persistent violence was more likely to occur among couples in which the male partner perceived that the pregnancy of his female partner occurred sooner than intended."[36] "Regardless of the exact dynamics of pregnancy-related violence, most of the research finds that women who were abused while they were pregnant had a history of victimization. . . . This would suggest that women who have a history of victimization should be identified as an at-risk group, with specific intervention efforts targeted to them."[37] "One factor that has emerged as a consistent risk factor for violence is low socio-economic status (measured with educational levels, income, and/or employment) . . ."[38] "[W]omen who are abused do not have the same levels of social support as do women who are not abused."[39] "[A] pregnancy not planned by the male partner might represent something that he could not control and therefore increases risk for violence."[40] "Violence tends to be higher when certain conditions are present, such as a high level of conflict and stress in the family, and intervening variables such as belief in the legitimacy of violence to deal with family members who do wrong."[41]

IV. Conclusion

Pregnant women who are screened for previous violence in their relationship should be provided with information about available services if they should need them either during or after the child is born. "Health care providers should also provide follow-up services to women postpartum in order to prevent any reoccurrence of violent behavior."[42] Medical documentation can be used to substantiate assertions of abuse, to obtain protective relief in the form of a restraining order, and/or to be eligible for certain exemptions or statuses related to housing, insurance, and financial assistance. "Isaac and Enos suggested that health care providers can be of most assistance legally by improving their record keeping."[43]

In short, the expansion of treatment and healthcare for women is necessary, now. Lawmakers must come

[35] Jasinski at 52.
[36] *Id.*
[37] *Id.* at 54.
[38] *Id.*
[39] *Id.*
[40] *Id.* at 55.
[41] *Id.*
[42] *Id.* at 59.
[43] *Id.* at 60.

together with legal providers on the ground to provide mandatory healthcare for those who need it. It is no longer an answer to cut off healthcare for those who can't afford it because eventually the truth will present itself. The added burden of gender discrimination and lack of structural supports in the workplace are also critically important when examining what will help women experience better maternal health outcomes. The continuing legacy of poor health in women of color despite the overall improved conditions of their lives is one compelling reason to take a closer look at the role that discrimination may play in healthcare. No collaborative committee or expensive institutional report is required to see that without the expansion of proper healthcare for women there is a generation of children in Texas who will go without their mothers, and the fault (or cost) will rest with the state.

"At the federal level, the idea of extending postpartum Medicaid is getting more attention."[44] At a September House hearing, representatives from the American Medical Association, the Icahn School of Medicine and the Kaiser Family Foundation called for expanding postpartum Medicaid as a possible solution to the maternal mortality crisis.[45] "The American College of Obstetricians and Gynecologists has also recommended it. (Kaiser Health News is an editorially independent program of the foundation)."[46] "Beyond protecting women during the medically vulnerable time after they deliver, experts think increasing Medicaid could go a long way toward addressing the racial disparities that exist in maternal mortality rates."[47]

[44] https://khn.org/news/medicaid-tweak-might-offer-means-to-improve-u-s-maternal-health/

[45] *See id.*
[46] *Id.*
[47] *Id.*