The 2021 Report Card highlights the latest key indicators to describe and improve maternal and infant health in the U.S. It features grades for preterm birth and measures on infant mortality in addition to social drivers of health, low-risk Cesarean birth rates and inadequate access to prenatal care. Our Supplemental Report Card highlights the stark disparities across race/ethnicity within these factors.

With the onset of the COVID-19 pandemic, pre-existing health disparities have been magnified. Comprehensive data collection and analysis of these measures, and the resulting disparities, inform the development of policies and programs that move us closer to health equity. The Report Card looks at policies like Medicaid expansion and programs like Maternal Mortality Review Committees, that can help improve equitable maternal and infant health for families across the country.

Puerto Rico is not included in the United States total.

Preterm is less than 37 completed weeks of gestation, based on obstetric estimate of gestational age.

Source: National Center for Health Statistics, 2020 final natality data.

Grades assigned by March of Dimes Perinatal Data Center.

 Puerto Rico is not included in the United States total.

Preterm is less than 37 completed weeks of gestation, based on obstetric estimate of gestational age.

Source: National Center for Health Statistics, 2020 final natality data.

Grades assigned by March of Dimes Perinatal Data Center.

**A TIME FOR PARTNERSHIP AND ACTION:**

EXAMINING THE U.S. MATERNAL AND INFANT HEALTH CRISIS AND POLICIES NEEDED FOR CHANGE

March of Dimes recommends state policy actions that are rooted in addressing disparities in maternal and infant health outcomes, see [www.marchofdimes.org/reportcard](http://www.marchofdimes.org/reportcard)

For details on data sources and calculations, see Technical Notes. Scan the QR code to the right to access the full U.S. Report Card.

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Aggregate 2017-2019 preterm birth rates are shown for each of the five bridged racial and ethnic groups. The racial/ethnic group with the highest rate is compared to the combined rate for all other racial/ethnic groups.

In the United States, the preterm birth rate among Black women is 51% higher than the rate among all other women.

The March of Dimes disparity ratio measures and tracks progress towards the elimination of racial/ethnic disparities in preterm birth. It’s based on Healthy People 2020 methodology and compares the group with the lowest preterm birth rate to the average for all other groups. Progress is evaluated by comparing the current disparity ratio to a baseline disparity ratio. A lower disparity ratio is better, with a disparity ratio of 1 indicating no disparity.

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INFANT MORTALITY

Infant mortality rates are an indication of overall health. Leading causes of infant death include birth defects, prematurity, low birth weight, maternal complications and sudden infant death syndrome.

INFANT MORTALITY RATE

5.6

RATE BY RACE AND ETHNICITY

2018 infant mortality rates per 1,000 live births are shown for each of the bridged racial and ethnic groups. The highest rate of infant mortality are seen for non-Hispanic Black women.

INFANT MORTALITY BY STATE

Infant mortality rate per 1,000 live births

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UNITED STATES
MATERNAL HEALTH

There is a critical connection between infant health, maternal health and the health of a family. All are dependent on their lived social context, the quality and accessibility of healthcare and the policies within a state. Each factor can provide insight into how a state serves its population.

SOCIAL VULNERABILITY INDEX
Where you live matters.

March of Dimes is offering the opportunity to examine social determinants of health at the county level using the Social Vulnerability Index (SVI). Socially vulnerable populations are at greater risk of experiencing poor health outcomes during a public health emergency. The same factors used in the index also contribute to poor maternal and infant health outcomes, including poor access to maternity care. The differences in counties are measured using 15 social factors, grouped into four areas including: socioeconomic status; household composition and disability; minority status and language; housing type and transportation. Each aspect of the index uses physical or social factors that help to estimate where poor health outcomes may be more prevalent.

The overall SVI for each county represents the amount of vulnerability relative to other counties in the state. The SVI measure is always a number between 0 and 1. A lower SVI indicates lesser vulnerability and a higher SVI indicates greater vulnerability.

CLINICAL MEASURES
Your healthcare matters.

Access to and quality of healthcare before, during and after pregnancy can affect health outcomes in the future. An unnecessary Cesarean birth can lead to medical complications and inadequate prenatal care can miss important milestones in pregnancy.

25.6 PERCENT
LOW-RISK CESAREAN BIRTH
This rate shows Cesarean births for first-time moms, carrying a single baby, positioned head first and at least 37 weeks pregnant.

14.9 PERCENT
INADEQUATE PRENATAL CARE
Percent of women who received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant’s gestational age.

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UNITED STATES

MATERNAL HEALTH

ADOPTED in 39 STATES (INCLUDING D.C.)

MEDICAID EXPANSION
Medicaid expansion to cover individuals up to 138% of the federal poverty level can play an essential role in improving maternal and infant health. Medicaid expansion has reduced the rates of uninsured women of childbearing age. Increased access and utilization of health care are significantly associated with Medicaid expansion.7

RECENT ACTION on MEDICAID EXPANSION
The adoption of this policy allows women to qualify for pregnancy-related Medicaid coverage for more than the standard 60 days after pregnancy for up to one year.8 Extending this coverage typically requires both state legislation and an appropriation in addition to a Section 1115 waiver in order to receive federal match.9 Three states have extended the full benefits of Medicaid extension at this time.

LEGISLATION IN 30 STATES

MIDWIFERY POLICY
Midwives are health care professionals that may be part of the birth care team or stand alone in providing prenatal, delivery and postpartum care. States that have policies to allow direct entry midwives and certified nurse midwives to practice may increase access to care, especially in under-resourced areas. Midwifery care can further reduce medical interventions that contribute to the risk of maternal mortality and morbidity in initial and subsequent pregnancies, lower costs, and potentially improve the health of mothers and babies.

13 STATES REIMBURSE DOULA CARE

DOULA LEGISLATION
Doulas are non-clinical professionals that emotionally and physically support women during the perinatal period, including birth and postpartum.14 Increased access to doula care can help improve birth outcomes and reduce the higher rates of maternal morbidity and mortality among women of color in the United States. Doula support is not routinely covered by health insurance. Insurance coverage for doula support through Medicaid, the Children’s Health Insurance Program, private insurance, and other programs may be a way to improve birth outcomes.

38 STATES (INCLUDING D.C.) REVIEW MATERNAL DEATHS UP TO ONE YEAR AFTER BIRTH

MATERNAL MORTALITY REVIEW COMMITTEE
These committees investigate deaths related to pregnancy to determine underlying causes of death and respond to improve conditions and practices. The committees can be made up of representatives from public health, nursing, maternal-fetal medicine, obstetrics and gynecology, midwifery, patient advocacy groups and community-based organizations.10 States that have an MMRC are better equipped to prevent pregnancy-related deaths. States who review pregnancy-related deaths up to one year after pregnancy will best help us understand all the causes of pregnancy-related mortality.

45 STATES (INCLUDING D.C.) HAVE A PQC TO IMPROVE QUALITY OF CARE

PERINATAL QUALITY COLLABORATIVE
The PQC involves partnerships with families, key state agencies and organizations in order to identify and initiate programs or procedures that increase the quality of care in clinical settings. The work done by PQC’s across the nation focus on a collaborative learning method between healthcare providers and the members of the PQC.12

*To access the full citation list, see our Technical Notes document here.

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The 2021 U.S. March of Dimes Report Card assigns grades to the 100 cities with the greatest number of live births in 2019. Report Card grades are assigned by comparing the 2019 preterm birth rate in a city to the March of Dimes goal of 8.1 percent by 2020.

**GRADE AND RANGE**

<table>
<thead>
<tr>
<th>Grade</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Less than or equal to 7.7%</td>
</tr>
<tr>
<td>A-</td>
<td>7.8%-8.1%</td>
</tr>
<tr>
<td>B+</td>
<td>8.2%-8.5%</td>
</tr>
<tr>
<td>B</td>
<td>8.6%-8.9%</td>
</tr>
<tr>
<td>B-</td>
<td>9.0%-9.2%</td>
</tr>
<tr>
<td>C+</td>
<td>9.3%-9.6%</td>
</tr>
<tr>
<td>C</td>
<td>9.7%-10.0%</td>
</tr>
<tr>
<td>C-</td>
<td>10.1%-10.3%</td>
</tr>
<tr>
<td>D+</td>
<td>10.4%-10.7%</td>
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<tr>
<td>D</td>
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<td>11.2%-11.4%</td>
</tr>
<tr>
<td>F</td>
<td>11.5% or greater</td>
</tr>
</tbody>
</table>

**Notes:**
- Preterm is less than 37 weeks gestation based on obstetric estimate of gestational age.
- Cities represent those with the greatest number of live births out of all cities with a population of >100,000, as defined by the National Center for Health Statistics.
- *Data for Honolulu represent the combined city and county of Honolulu.
- See the U.S. 2021 March of Dimes Report Card for more information.

**Source:** National Center for Health Statistics, 2019 final natality data. **Prepared by:** March of Dimes Perinatal Data Center, 2021.