Despite advances in medicine, rates of adverse maternal outcomes, such as severe maternal morbidity and maternal mortality, are increasing in high-income countries. Of particular concern is the observation that such increases include widening disparities among underserved and minoritized populations. Elsewhere in JAMA Network Open, Gleason et al add to the literature on maternal health disparities by using data from the Consortium on Safe Labor to examine the risks of obstetric interventions and adverse maternal outcomes, including severe maternal morbidity and maternal mortality, among 2142 women with a physical, sensory, or intellectual disability compared with 221,252 women without disabilities. They found women with disabilities were at elevated risk of a range of obstetric interventions, including cesarean delivery (adjusted relative risk [aRR], 1.33; 95% CI, 1.25-1.42), and adverse maternal outcomes, including individual markers of severe maternal morbidity, such as cardiovascular events (aRR, 4.02; 95% CI, 2.87-5.63), infection (aRR, 2.69; 95% CI, 1.97-3.67), and venous thromboembolism (aRR, 6.08; 95% CI, 4.03-9.16) as well as maternal mortality (aRR, 11.19; 95% CI, 2.40-52.19), after adjustment for covariates. Findings were largely consistent by disability type, although some analyses were limited by small sample sizes.

This study makes an important contribution to the literature. Women with disabilities have long been ignored in obstetric research and clinical practice. Their invisibility in this area stems from a history of eugenic practices, including institutionalization and sterilization, imposed on people with disabilities throughout the 20th century, and lingering negative societal assumptions about and attitudes toward disability, sexuality, pregnancy, and parenting that persist today—despite the United Nations Convention on the Rights of Persons with Disabilities protecting the reproductive rights of people with disabilities. More than 12% of reproductive-aged women have a physical, sensory, or intellectual disability, and US Medical Expenditure Panel Survey data show that women with disabilities report similar past-year pregnancy rates as those without disabilities. These data demonstrate a need for information on maternal outcomes among women with disabilities to inform clinical practice, particularly given that women with disabilities experience significant preconception social, health, and health care disparities, such as elevated rates of poverty, chronic illness, depression and anxiety, and barriers accessing health care—all known risk factors for adverse maternal outcomes. Indeed, growing evidence shows elevated rates of common complications of pregnancy, such as gestational diabetes, gestational hypertension, and cesarean delivery, among women with disabilities. Few studies, however, have been able to examine rare but serious outcomes, such as severe maternal morbidity and maternal mortality. Gleason et al make a notable contribution by showing that women with disabilities had elevated risk of maternal mortality as well as all of the top severe maternal morbidity indicators associated with mortality, including cardiovascular events, infection, preeclampsia/eclampsia, obstetrical hemorrhage, and venous thromboembolism. Even when these complications do not result in death, they have significant implications for families, including separation of mothers and newborns at a time that is critical for bonding and breastfeeding, as well as potential long-term negative impacts on women’s well-being. The data presented by Gleason et al reflect the urgency of the need for further consideration of disability in obstetric research and clinical practice.

To facilitate further research on maternal disability and obstetric outcomes, there is a need for routine inclusion of disability indicators in health administrative data. One of the limitations of the
analysis by Gleason et al\textsuperscript{2} was that their definition of disability was based on a medical model of
disability, using diagnostic codes to identify disability in health administrative data\textsuperscript{2} rather than using
self-reported activity limitations or participation restrictions. This is also a limitation of other similar
studies on this topic\textsuperscript{6} and reflects a lack of data on constructs related to health equity and the social
determinants of health in medical records and other sources of health administrative data. There are
some recent initiatives that address this data gap. For example, the National Institutes of Health and
the US Centers for Disease Control and Prevention are expanding questions related to disability in the
Pregnancy Risk Assessment Monitoring System survey.\textsuperscript{7} These data will enhance understanding of
the obstetric outcomes of women with disabilities. The research by Gleason et al,\textsuperscript{2} along with the
growing body of evidence on disparities in maternal outcomes experienced by women with
disabilities,\textsuperscript{6} shows that inclusion of disability indicators needs to be the norm—not the exception—in
health administrative data so that these disparities can be regularly tracked and addressed.

There is also a need for further research examining factors that are associated with risks of
severe maternal morbidity and maternal mortality among women with disabilities. It is well-
established that women with disabilities experience preconception social, health, and health care
disparities, such as poverty, chronic illness, and barriers to health care, that are known risk factors for
adverse maternal outcomes.\textsuperscript{4} Disability is also overrepresented in other underserved groups such as
racialized populations, who also experience disparities in severe maternal morbidity and maternal
mortality.\textsuperscript{1} However, few studies have specifically investigated the ways in which these other factors
intersect with disability and experiences of ableism to exacerbate, or explain, risks of adverse
maternal outcomes. This is an important oversight given that such data could offer clues about
so-called high-risk groups that may be multiply marginalized and could be targeted by tailored
interventions to meet their specific needs, as well as potential modifiable risk factors that could be
addressed in interventions to improve maternal outcomes.

As research continues to move forward, there is a parallel need for health care professional
education about the needs of pregnant women with disabilities. One of the most frequent concerns
raised by women with disabilities is a lack of health care professional knowledge and awareness
about how their disability could affect their pregnancy and how pregnancy might affect disability-
related symptoms, progression, and other concerns.\textsuperscript{3} Likewise, health care professionals report a
lack of training and insufficient resources related to disability.\textsuperscript{3} Given that 12% of reproductive-aged
women have a disability,\textsuperscript{4} that pregnancy rates are similar among women with and without
disabilities,\textsuperscript{6} and that women with disabilities are at elevated risk of a range of adverse maternal
outcomes,\textsuperscript{2,6} including severe maternal morbidity and maternal mortality,\textsuperscript{2} disability modules should
be a mandatory component of education for obstetricians and midwives as well as other obstetrical
health care professionals. Along with information on medical outcomes of pregnancy, such education
should prioritize training on the accommodation-related needs of women with disabilities (eg,
accessibility of spaces for those with physical disabilities, communication needs of those with
sensory disabilities, and learning needs of those with intellectual disabilities), along with how
disability intersects with other social determinants of health, including poverty and experiences of
racism. Such education should also extend to preconception care practitioners to promote a life
course perspective on maternal health among women with disabilities so that risks and concerns are
addressed before pregnancy.

The data reported by Gleason et al\textsuperscript{2} contribute to the growing body of evidence supporting the
need for better obstetrical care for women with disabilities. Routine inclusion of disability in health
administrative data, examination of intersections between disability and other factors influencing
maternal outcomes, and health care professional education are important next steps in addressing
the maternal disparities identified by this and other studies.
REFERENCES


