Framing with Data on Pregnancy-Related Mortality & Morbidity

When framed effectively, a compelling statistic can help people better understand the causes of pregnancy-related complications and death. But too often, public health communicators use data in ways that fall flat or send messages we don't intend.

Here are a few framing guidelines to keep in mind when you are sharing numbers about maternal mortality and morbidity.

Framing Guideline 1: Order matters.

Many of us were trained to start a paper or presentation with background data. There are good reasons to rethink this habit. Order matters: what comes first has a strong priming effect, influencing how people interpret what follows. If we start out with a lot of data without cues for how to interpret it, we leave room for people to *mis*interpret it. If we highlight a disparity among groups without explaining its cause, people often fall back on stereotypes or misconceptions to explain it for themselves.

The framing fix: First, state a clear message, then bring in data to back it up.

One way to do this is to express an aspirational goal or value that you'd like people to have in mind when they hear your data. Another way is to help people understand how things should work—and what's not working—before presenting any data. For instance, when talking about a health disparity, be sure to explain "how it happens" before talking about "who it happens to more often." Explain the foundations of community health (safe housing, quality education, nutritious food, etc.) as *universal* needs before showing that, for some communities, those needs are not being met.

Pro tip: If you can't highlight a heading or sentence that states what you want people to take away from a statistic, keep working.

Leading with data	Leading with values
In 2019, 700 women died in the United States from pregnancy-related complications, and the numbers appear to be rising. More than 80% of pregnancy-related deaths are preventable.	To ensure that everyone has a full and fair chance for health and wellbeing, we can take steps that could prevent more than 80% of pregnancy-related deaths.

Framing Guideline 2: Less is more.

If we stack up statistics to emphasize the severity of a problem, we're more likely to spark *overwhelm* than action. When we *reduce* the quantity of numbers we share, we *increase* people's ability to think them through. We also give ourselves room to offer some context and help people understand what it all means.

The framing fix: Treat your data like a curator treats art.

Be selective. Don't communicate with data just because you have it. Only include a number if it's the best support for a larger point. Spend time and effort on presenting it elegantly. Can you rewrite a graph's title so it tells the audience how to interpret the trend? Can you arrange the data to clarify the story it tells?

Framed with data, data, data	Reframed with numbers nested in narrative
Access to care and continuity of care are associated with maternal health outcomes. Maternal morbidity is three to four times more likely among women who do not receive prenatal care, compared to women who do receive prenatal care. Health insurance enrollment is a prerequisite for access to quality health care before, during, and after pregnancy. Racial and ethnic disparities in health care coverage exist. White women are more likely to have continuous insurance from preconception to postpartum than other racial and ethnic groups. For example, in 2020, 75% of white non-Hispanic women had continuous insurance, compared to 55% of Black non-Hispanic women, 50% of American Indian/Alaska Native women, and 21% of Hispanic Spanish-speaking women.	Consistent and continuous access to health care is essential before, during, and after pregnancy. About half of pregnancy-related deaths happen six weeks to a year after delivery. Yet women in the US can't count on continuous health care coverage during the postpartum period. In states that have not accepted the federal funding that allows Medicaid to cover more low-income people, 6 out of 10 pregnant participants lose their coverage during the year after delivery. Coverage gaps are even more likely among groups that experience higher rates of maternal mortality—Black, American Indian/Alaska Native, and Hispanic communities. Expanding Medicaid eligibility and offering coverage for 12 months postpartum are steps states can take to reducing racial and ethnic disparities in maternal health.

Framing Guideline 3: Highlight structures, not struggles.

Numbers can carry authority, so it's important to use them to convey the ideas that are essential to a public health analysis and mindset. When we only share data on negative health behaviors or health burdens, we reinforce the myth that poor outcomes stem from poor personal choices and miss opportunities to direct attention upstream.

The framing fix: Share data points that help people see the need to fix systems, not people.

Lean toward (and seek out) data that illustrate upstream causes, and limit numbers on downstream consequences. For example, illustrate disparities in health care access rather than disparities in health problems. Present information about policies that limit health care access, quality, and continuity rather than zooming in on the behavior of patients or providers. When we show that a problem lies in a policy or system that humans designed, we imply that they can be redesigned to work better.

Framed with downstream behaviors	Reframed with upstream influences
Many women and people of color—particularly Black women—report mistreatment in health care settings during pregnancy and childbirth. Women report having their pain ignored, requests for help denied, or being made to accept unwanted treatment. Twenty percent of those surveyed reported experiences of mistreatment during maternity care. Thirty percent of Black, 29% of Hispanic, and 27% of multiracial women reported mistreatment.	In the US, 1 in 5 women report being mistreated during maternity care, with reported rates even higher among women of color. Because effective models to monitor and reduce mistreatment and bias exist, federal agencies and networks of hospitals in 49 states are working together on improving treatment and training. But right now, only 28 states receive federal funding for this vital work.

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