Comparative Effectiveness Review Disposition of Comments Report

Title: *Social and Structural Determinants of Maternal Morbidity and Mortality: An Evidence Map*

Draft report available for public comment from November 26, 2022, to December 4, 2022.

Citation: Slaughter-Acey J, Behrens K, Claussen AM, Usset T, Neerland C, Bilal-Roby S, Bashir H, Westby A, Wagner B, Dixon M, Xiao M, Butler M. Social and Structural Determinants of Maternal Morbidity and Mortality: An Evidence Map. Comparative Effectiveness Review No. 264. (Prepared by the Minnesota Evidence-based Practice Center under Contract No. 75Q80120D00008.) AHRQ Publication No. 23(24)-EHC014. Rockville, MD: Agency for Healthcare Research and Quality; December 2023.
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Comments to Draft Report

The Effective Health Care (EHC) Program encourages the public to participate in the development of its research projects. Each draft report is posted to the EHC Program website or AHRQ website for public comment for a 3- to 4-week period. Comments can be submitted via the website, mail, or email. At the conclusion of the public comment period, authors use the commentators' comments to revise the draft report.

Comments on draft reports and the authors' responses to the comments are posted for public viewing on the website approximately 3 months after the final report is published. Comments are not edited for spelling, grammar, or other content errors. Each comment is listed with the name and affiliation of the commentator if this information is provided. Commentators are not required to provide their names or affiliations in order to submit suggestions or comments.

This document includes the responses by the authors of the report to comments that were submitted for this draft report. The responses to comments in this disposition report are those of the authors, who are responsible for its contents, and do not necessarily represent the views of the Agency for Healthcare Research and Quality.

Summary of Public Comments and Author Response

This research review underwent peer review before the draft report was posted for public comment on the EHC website. Responses to peer review comments are summarized here.

- We revised the report title to be more informative of the report purpose. This was requested by both peer reviewers and the EPC Associate Editor (AE).
- Several peer reviewers found the term "social-structural determinants of health" confusing because it is not a commonly used term. We clarified that we intend the phrase to indicate that the report includes the full spectrum of social and structural determinants of health but also to highlight the importance of the structural aspects, and we added the adapted Williams framework in furthering this intention.
- While not a theme, the peer reviewer that best represented the population of interest and community voice requested we include the positions of the authors so readers may understand what personal biases or intellectual conflicts of interest the authors may bring to the project. We added the Author Statement at the end of the Methods section to honor this request.
- The importance and role of data in risk factor research was raised primarily by one peer reviewer, but echoes were present from others as well. We added a table to Chapter 3 that summarized reported study data sources. and we revised the Future Research section to further refine the future research considerations. We also included other minor additions to the Future Research section to incorporate other helpful suggestions from peer reviewers to clarify or add details for nuance.
- The overall response for the alluvial graphs was positive. Based on some suggestions, we made further refinements to the Notes provided with the alluvial graphs to help readers interpret the graphs.
- Several peer reviewers noted the care given to the intent to use inclusive language in the reports. We made several other word edits suggested by peer reviewers to refine the effort to balance inclusion for multiple perspectives and accuracy of reported studies.

Public Panel Comments and Author Response

Reviewer	Section	Comment	Response
Public Commenter #1 Kathleen Simpson, MCN (American Journal of Maternal/Child Nursing)	Evidence Summary	Please update the maternal mortality data based on the US GAO report here and throughout the document: United States Government Accountability Office. (2022 October 19). Maternal health outcomes worsened and disparities persisted during the pandemic (Report to Congressional Addressees). https://www.gao.gov/products/gao-23-105871	Thank you for the suggestion. We have added the citation regarding the disparities worsening during the pandemic to the Introduction section.
Public Commenter #3 David Gregory, Carilion Clinic	Evidence Summary	The content is similar to other focuses in this work. The information will likely help hospitals with anticipated needs for reducing mortality in manners related with their care, training and referrals	Thank you for the comment.
Public Commenter #7 Healthy Nourishments, LLC	Evidence Summary	These inequities will continue and will worsen until USA quits pushing women, in general, to the back of the bus and, in particular, pushing women of colour off the bus, by the refusal of adequate supports such as guaranteed and effective health care, national paid leave and equitable breastfeeding support. Our abilities as women to Bear, Birth and Breastfeed become vicious disabilities due to the lack of support from our country and health care system. Not only will maternal/infant morbidity and mortality continue to soar, but infertility and birth strikes will radically decrease our birth rates if women do not receive the righteous support they need and deserve.	Thank you for the comment.
Public Commenter #8 Katy Kozhimannil, University of Minnesota	Evidence Summary	The following sentence appears on page ES-1: “Nationally, if rural Indigenous birthing women experienced severe maternal morbidity and mortality at the same rate as urban white women, they would see a 9 percent reduction in cases.” My research is cited with this statement, but the sentence is not accurate as written. Either “9% should be changed to “49%,” or the words “Indigenous” and “white” should be omitted, and the citation should be changed to the following: Kozhimannil KB, Interrante JD, Henning-Smith C, Admon LK. Rural-Urban Differences In Severe Maternal Morbidity And Mortality In The US, 2007-15. Health Aff (Millwood). 2019;38(12):2077-2085. doi:10.1377/hlthaff.2019.00805	Thank you for noting the typo. We have corrected the statistic to read as “49 percent” in the Evidence Summary Main Points. The statistic was reported correctly in the Results section of the Evidence Summary and later in the Results section of the full report.

Reviewer	Section	Comment	Response
Public Commenter #12 Marsha Walker, National Lactation Consultant Alliance	Evidence Summary	Studies accessed did not appear to consider the lactation status of the reported populations. Such an omission could have altered the results, implications, and conclusions of the review.	Thank you for the comment. The populations of interest were people during pregnancy and people at the time just prior to, during, and immediately after delivery. These periods would have included people in the first stage of lactogenesis by default. No identified studies noted lactation status as a variable of interest. Studies may have noted breastfeeding behavior as maternal/infant outcome, but breastfeeding is not an outcome directly related to, or measuring, maternal health or poor maternal outcomes, and thus was not an outcome of interest.
Public Commenter #13 American Psychological Association	Evidence Summary	Minor editorial note: In some instances, the following sentence lists the statistics as 9% and in others it states 49%. o Nationally, if rural Indigenous birthing women experienced severe maternal morbidity and mortality at the same rate as urban white women, they would see a 9 percent reduction in cases.	Thank you for noting the typo. We have corrected the statistic to read as "49 percent" in the Evidence Summary Main Points. The statistic was reported correctly in the Results section of the Evidence Summary and later in the Results section of the full report.

Reviewer	Section	Comment	Response
Public Commenter #15 Amy Fox	Evidence Summary	Final bullet in Main Points section of Executive Summary is not worded correctly. It would be better to state the rate of maternal morbidity and mortality for urban white women and the rate for rural Indigenous women clearly. There are references to the postpartum period and how it is defined differently by different studies, but how that is defined in the paper is not clear.	Thank you for noting the typo. We have corrected the statistic to read as "49 percent" in the Evidence Summary Main Points. The statistic was reported correctly in the Results section of the Evidence Summary and later in the Results section of the full report.
Public Commenter #10 Anonymous	Introduction	The Background section is very heavy on jargon and is hard to understand. There is not enough focus on discrimination on the basis of sex and there is considerable muddling of evidence-based facts and theoretical frameworks, as shown in this quoted (and non-cited) section: "The overuse of social group categories as proxies for experience obscures the unique concerns and priorities of vulnerable or underserved pregnant and birthing people. This practice also stands in the way of addressing the root causes that are central to creating unique and/or marginalizing experiences of motherhood associated with race, gender, class, disability, and maternal morbidity and mortality inequities." The Introduction would be stronger with greater editing and focus on citations.	Thank you for the suggestion. The draft report has undergone several revisions based on internal and peer review, with the intention to write to a relatively broad audience yet retain a certain level of academic presentation.
Public Commenter #11 Tammy Hall	Introduction	The introduction hit right on the main points . Maternal health, structural is important to everyone's well being. It's a wonderful thing that you're researching, studies.	Thank you for the comment.
Public Commenter #12 Marsha Walker, National Lactation Consultant Alliance	Introduction	Under the Terminology section, outcomes that use the term "mother" should be reported as such.	Thank you for the suggestion. We have added the term "mother" along with "women."

Reviewer	Section	Comment	Response
Public Commenter #15 Amy Fox	Introduction	There is no mention of studies that discussed the impact of care by certified nurse-midwives on the overall maternal mortality rate. They are only briefly mentioned in the last paragraph on page 1. Also, centering programs in which a cohort of expectant patients meet regularly as a group to do their appointments with a midwife and a facilitator runs a discussion on a topic relevant to the current stage of pregnancy. These women learn from each other and support one another. There also is no mention of the impact of doulas on outcomes. Doulas have been shown to shorten labors and reduce the number of c-sections and interventions. It would seem that there would be an overall impact on outcomes for these reasons alone. If Community-Based doulas are studied, there should be better outcomes for BIPOC in these communities. Link to The Role of Culturally Congruent Community-based Doula Services in Improving Key Birth Outcomes in Kansas City by Ria Hegde, BA; H. Ellis McCormick, BA; Hakima Payne, MSN, RN;	Thank you for your comment. Our focus was on risk factors for maternal health. As such, efficacy or effectiveness studies of interventions to improve maternal health were not in scope. We also appreciate your sharing the reference with us. However, the outcomes examined were neonatal, rather than maternal health, outcomes.
Public Commenter #17 Qing Li University of Mississippi Medical Center	Introduction	I read the report and attended the three-day Pathways to Prevention meeting. Thanks for this important work on this report. I found the major limitation in this report is the lack of a clear justification on excluding protective factors but only the focus on the risk factors in the introduction section.	Thank you for the comment. We did not explicitly exclude studies of protective factors, if they had been approached as such. We did not find any such studies that met all inclusion criteria based on the population, exposures, or outcomes in Table 2.1. We did specify that interventional research examining efficacy or effectiveness of an intervention was outside the scope of the review.

Reviewer	Section	Comment	Response
Public Commenter #9 Anonymous	Methods	I downloaded the appendix to look at the search strategy and methods. I noticed only 3 databases were searched. I was wondering why the database Embase wasn't included since it's one of the largest biomedical research databases. A comprehensive evidence map should search more databases than 3. It also says the literature search was updated, but the process for how it was updated is not reported. The new PRISMA-S requires more transparency regarding search updates. It also says you limited the search to published studies, evidence maps should also search the unpublished literature to avoid bias. Also, will the librarian who worked on the search be included as an author, properly credited? Another comment that I have is the search terms for the different populations could be expanded, I see some Mesh headings that were then not listed as keywords. Should the term Black* be included in line 17 of Medline? That is just one example. Many missing for Hispanic/Latinos too. I see many keywords for the US, but I also don't see Puerto Rico listed as part of the US population. The Hispanic Americans Mesh term has also been updated, if you do a future search update.	Thank you for the comment. Because the review was focused on US-based studies, we focused our search strategy on the bibliographic databases most likely to contain US-based research. Embase is an excellent bibliographic database but is often used to capture non-US based studies that Medline does not index. Given the difficulty of writing specific search algorithms to identify risk factor research, we determined that the resource cost of screening references from additional databases was too high for the potential of finding one additional study, which was also highly likely to be high risk of bias. Further, given the already noted issues of publication bias for observational studies of this nature, any additional searches of unpublished literature that had not undergone peer review would likely have only added to the challenges. Thank you for your suggestions for future search strategies. We agree that our medical librarian deserves proper credit as a co-author and have always proudly done so. Our medical librarian is a valued member of our team.

Reviewer	Section	Comment	Response
Public Commenter #10 Anonymous	Methods	The Methods section is clear.	Thank you for the comment.
Public Commenter #11 Tammy Hall	Methods	The methods of structural maternal development growth and bias is a very important approach and should be addressed. You did well explaining and expressing your points, it important women goes thru postpartum and some goes thru it in silence saying nothing suffering alone .	Thank you for the comment.
Public Commenter #12 Marsha Walker, National Lactation Consultant Alliance	Methods	Studies accessed did not appear to consider the lactation status of the reported populations. Such an omission could have altered the results, implications, and conclusions of the review.	Thank you for the comment. The populations of interest were people during pregnancy and people at the time just prior to, during, and immediately after delivery. These periods would have included people in the first stage of lactogenesis by default. No identified studies noted lactation status as a variable of interest. Studies may have noted breastfeeding behavior as maternal/infant outcome, but breastfeeding is not an outcome directly related to, or measuring, maternal health or poor maternal outcomes, and thus was not an outcome of interest.
Public Commenter #14 L.F. Ellington	Methods	I would suggest that for the next stage of systematic review the following additions are made: 1. Key Questions 1 and 2 be expanded to include Key Questions 1b and 2b: To what extent did these patterns of predictors of poor postpartum health outcomes vary by the person's gender identify/self-expression? 2. Tables listing confounding variables, covariates, propensity scores and resulting matching scores. 3. Support redesign into cohort, case-control and/or cross-sectional studies following Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) guidelines.	Thank you for your suggestions. If or when future systematic reviews use this current review as a starting point, this document of public comments will remain as supplementary material that future reviewers may use.

Reviewer	Section	Comment	Response
Public Commenter #15 Amy Fox	Methods	I found the alluvial graphs to be somewhat confusing with so much information and so many links between SDoH and outcomes. I also felt that some of the outcomes could have been grouped together differently. For instance, anxiety and anxiety symptoms should be grouped with depression outcomes. Anxiety and depression are closely related. They are often experienced together with some women not realizing that anxiety is a part of postpartum depression. I understand the reasoning behind the alluvial graphs, but it might be better to have different types of charts to display the relationships in different ways.	Thank you for your comment. The alluvial graphs are a newer way of visualizing complex data. As noted in our Discussion section, we agree that our approach to grouping the studies is somewhat subjective and that other researchers may have other approaches that would be similarly reasonable.
Public Commenter #10 Anonymous	Results	The organization and structure of this section generally worked well, but the figures (e.g., Figure 4.1) are very hard to read and interpret. I am not sure that they would pass 508 compliance even with the lengthy paragraph required to explain the figure, which introduces another accessibility issue.	Thank you for the comment. The commenter is also correct that relatively lengthy alternative text for the alluvial graphs were needed. It is very challenging to summarize complex data without losing appropriate or necessary nuance.
Public Commenter #11 Tammy Hall	Results	The more you keep doing what your doing and involving others allowing others to engage sharing knowledge and letting others share there feed back and voice The less the risks will be.	Thank you for your comment.
Public Commenter #13 American Psychological Association	Results	Please clarify for the following sentence, does this mean that a women's risk of morbidity is based on the hospital alone or are there underlying mechanisms explaining the difference? Put simply, would giving birth at a different hospital reduce morbidity (e.g., is something inherent in the hospital causing the issue) or would the morbidity be the case irrespective of hospital? "In one study, Hispanic birthing women were more likely to deliver at hospitals with higher risk adjusted severe maternal morbidity, contributing up to 37 percent of ethnic disparity in severe maternal morbidity in New York City."	Thank you for the question. We have clarified the sentence to note that delivery location may contribute up to 37 percent of ethnic disparity.

Reviewer	Section	Comment	Response
Public Commenter #17 Qing Li University of Mississippi Medical Center	Results	This limitation of the lack of a clear justification on excluding protective factors has narrowed the scope of findings to inform future research and practice. Several studies looked at the protective and risk factors together. However, “protect” only appeared once in the report. The result section only included one study reference 133 with "protective" in the title. Copied from Page 26 “Two studies examined associations between neighborhood greenness and hypertensive disorders131 and how greenspace may positively impact pregnancy health for racially and economically minoritized populations.133” Copied from Page 27 “One study found that those with the lowest access to publicly available and accessible greenspace had an increased risk for mental disorders, depressive disorders, and gestational diabetes.133” Copied from Page 51 “133. Runkle JD, Matthews JL, Sparks L, et al. Racial and ethnic disparities in pregnancy complications and the protective role of greenspace: A retrospective birth cohort study. Science of The Total Environment. 2022;808:152145.”	Thank you for the comment. We did not explicitly exclude studies of protective factors, if they had been approached as such. We did not find any such studies that met all inclusion criteria based on the population, exposures, or outcomes in Table 2.1. We did specify that interventional research examining efficacy or effectiveness of an intervention was outside the scope of the review.
Public Commenter #3 David Gregory, Carilion Clinic	Discussion	With increasing Hospital L&D closures, and growing maternity care and prenatal care deserts, somewhat connected with efforts to consolidate resources and experience, we have become more aware of the risks to maternal mortality related to patients being rural. Still, we have very little else to clarify why, and I think it worth considering if the following have any relationship: - Deliveries at home or enroute to a delivery center - Distance from home to a source of prenatal care -Distance from home to specialized care of high risk pregnancies (perinatology) - Distance from home to initially intended delivering center - Distance from home to eventual delivering center - The level of care for the eventual delivering center - Differences in death rates between deliveries occurring at an unintended center, vs when it occurs at an intended center	Thank you for the suggestion. We have added a paragraph to the section on Exposure that briefly discusses healthcare delivery and rurality as exposures that will require future research to understand mechanisms.
Public Commenter #3 David Gregory, Carilion Clinic	Discussion	See above (Hospitals may not be able, well resourced or interested to seek data related to rural-ness risk factors, and public health has opportunity to seek this data and by engaging primary care in improved death certificate reporting of all female birth assigned patients of childbearing age.	Thank you for the suggestion. We have added a paragraph to the section on Exposure that briefly discusses healthcare delivery and rurality as exposures that will require future research to understand mechanisms.

Reviewer	Section	Comment	Response
Public Commenter #5 Patricia Bartels, Mount Sinai South Nassau	Discussion	Pregnant patients need continuity of care. Those patients receiving care at one place and following up for birth at another facility with no familiar provider with the patient's OB background is the greatest risk and one that is not being explored. Patients with comorbidities are more at risk, yes, but what we should be looking into is the antepartum care provided vs delivery care provided and was there any continuity. Patients are at a greater risk when they are delivered by a provider that does not have intimate knowledge of their background.	Thank you for the suggestion. We have added a paragraph to the section on Exposure that briefly discusses healthcare delivery and continuity of care as exposures that will require future research to understand mechanisms.
Public Commenter #10 Anonymous	Discussion	Same comment as Chapter 4.	Thank you for the comment.
Public Commenter #10 Anonymous	Discussion	The Discussion is generally clear. No substantive comments.	Thank you for the comment.
Public Commenter #11 Tammy Hall	Discussion	The risk is major	Thank you for the comment.
Public Commenter #11 Tammy Hall	Discussion	Depending on the pregnant women health and condition	Thank you for the comment.
Public Commenter #11 Tammy Hall	Discussion	Well expressed. I needed it . It help me and I'm a women , a mother of 4 a mother of 7 step children too . I went thru post partum twice. It was terrible for me honestly. I overcomed. I have lost 6kids . DNC 5 of them and barried 1 step son of 20 yrs old . 4 of those d n c fact was mis carriage. Most women with postpartum does not always get treated or bc of belief s do not go forth with treatment s or anything else. Some may not need treatment n that's ok . Theres more factors that comes with postpartum as well .	Thank you for the comment.
Public Commenter #13 American Psychological Association	Discussion	While we understand that a qualitative search was outside the scope of the review, we invite you to refer to Levitt and colleagues' (2018) reporting standards for qualitative primary, qualitative meta-analytic, and mixed methods research in psychology should researchers decide to conduct a qualitative synthesis of the literature on maternal morbidity and mortality.	Thank you for the comment.

Reviewer	Section	Comment	Response
Public Commenter #14 L.F. Ellington	Discussion	This section provides knowledge and discussion of social -structural determinants of health. Next stage review might examine health equity across specific intersections of subpopulation and comparator groups (e.g., nonbinary presenting people and/or BIPOC x geography x health care system level).	Thank you for the comment. We did note in the "Population and Data Sources" and the "Exposures" section a need to understand diverse populations including trans- and gender diverse populations, and intersectionality.
Public Commenter #15 Amy Fox	Discussion	The final paragraph of this section mentions that in a North Carolina study, "receipt of any prenatal care was associated with a decreased risk for pregnancy-related mortality." Interventions that focus on ensuring all expectant people receive prenatal care, early and often, with other resources besides just Obstetrician or Midwife scheduled visits, should be considered. Other resources could be having a maternal health nurse come to their home, community-based doula programs where trained doulas could provide more education and emotional support in the prenatal period, in addition to support during the birth and in the postpartum period.	Thank you, we have slightly revised the Exposures section to note the need to examine access to prenatal care provided from sources beyond obstetrics as risk or protective factors.
Public Commenter #15 Amy Fox	Discussion	The section on Hospital and Healthcare Use Factors refers to hospitals with "higher risk-adjusted severe maternal morbidity." This was confusing because it was not clear if the Hispanic women were more likely to deliver there because they had conditions that required them to, or because it was the closest to where they live. It would be interesting to know if any of these are teaching hospitals because that can make a difference in care when a lot of new doctors are trying to learn skills on patients who may not be advocating effectively for themselves because they don't speak English or don't understand what is going on or if they have had many negative experiences with hospitals and are just trying to get things over with as best they can.	Thank you for the question. We have clarified the sentence to note that delivery location may contribute up to 37 percent of ethnic disparity.
Public Commenter #16 Tory Lowy	Discussion	In the Future Research section, a line is given to state the need for a "mixed studies review", i.e. future studies that rely on both quantitative and qualitative data. The review notes instances where multiple studies were difficult to compare, based on an inability to assess methodological rigor. Mixed methods studies won't eliminate that issue, but inclusion of mixed-methods studies in the future could help even the playing field and present a fuller and more complete picture, with additional anecdotal data. Further into the 'Discussion' section, under "Other Research Approaches", the benefits of qualitative research are mentioned, with the review suggesting that the inclusion of qualitative research would be "valuable to explore this subset of the literature." The mention of the need for a mixed-methods approach to future research should be more clearly stated, as a call to action. The finding of a need for mixed-method research needs to be fully explained earlier on in the Discussion section, under Future Research.	Thank you for the suggestion. We agree the qualitative and mixed-methods research are likely to be important contributors to future research in maternal outcomes. Since this review did not examine qualitative research, we feel the level of discussion in the report related to that body of literature is appropriate.

Reviewer	Section	Comment	Response
Public Commenter #17 Qing Li University of Mississippi Medical Center	Discussion	This limitation of the lack of a clear justification on excluding protective factors has narrowed the scope of inclusion and discussions on protective factors to inform future research and practice. For example, resilience in the individual or family level has been the focus on interventions but was not mentioned in this report. “Hear*” was not mentioned in this report. Only “listen” was mentioned once on page 41: “Qualitative research provides rich data based on listening to the experiences of birthing people.”	Thank you for the comment. We did not explicitly exclude studies of protective factors, if they had been approached as such. We did not find any such studies that met all inclusion criteria based on the population, exposures, or outcomes in Table 2.1. We did specify that interventional research examining efficacy or effectiveness of an intervention was outside the scope of the review.
Public Commenter #10 Anonymous	References	A regular page format (rather than column format) would be easier to read.	Thank you for the suggestion. The report follows a required style guide.
Public Commenter #3 David Gregory, Carilion Clinic	General	We know more than ever that more deaths occur after 6 wks postpartum. Our data on maternal deaths being derived from vital statistics tabulated from death certificate completion, it should be considered that more deaths past 6 weeks are completed by primary care physicians, who are likely not to be shared information (be aware) of a pregnancy within 12 months. The data is also possibly more reliably collected when pts present via hospitals, and less reliably collected with home deliveries, only coming to care weeks or months later via a primary care type source. Based on these possible confounders, maternal death data likely under represents issues that occur away from hospital care (both temporally and geographically).	Thank you for the comment.

Reviewer	Section	Comment	Response
Public Commenter #4 Anna Grizzard	General	Read the summary, not the full report. I do not see mentioned the structure of how prenatal care is provided to women. I am a nurse midwife who reluctantly gave up practice due to the expectations imposed by the reimbursement system we suffer under. In order to keep a practice open, it is necessary to see patients every 10-15 minutes. Included in that time is not only your assessment of the woman, the fetus, answering her questions & providing anticipatory guidance, but often doing that in a language other than your own first language & also documenting in an electronic medical record. Any practitioner will agree that this is extremely difficult if not impossible, with the possible exception of if your client speaks English, has a totally normal, uneventful pregnancy course, is multiparous & has few questions or concerns. As a result of this structure, practitioners are frustrated, overworked, and mistake and oversights occur. Then when a woman is in labor, she is in hospital & her provider is often in the office, so the nurse is actually managing the labor. Continuous fetal monitoring is usually ordered, which has been long known to provide no improved outcome, but does prevent the woman from experiencing a physiologic labor & birth. She is often tied to an IV pole & kept without oral hydration & nutrition, again, which has been proven by research to be safe & important for the proper functioning of her body. The availability of a setting in which physiological birth is possible, home & birth centers, are not available to the majority of woman experiencing a normal pregnancy due to her lack of knowledge of the safety & availability of this option, the legality in her state of residence or restriction due to inability to use her insurance for these services. For those women who are known to be high risk, a collaboration between a perinatologist & nurse midwife can provide excellent care for a woman, taking into consideration her physical as well as psychosocial needs.	Thank you for the comment. We did not explicitly exclude studies of protective factors, if they had been approached as such. We did not find any such studies that met all inclusion criteria based on the population, exposures, or outcomes in Table 2.1. We did specify that interventional research examining efficacy or effectiveness of an intervention was outside the scope of the review.
Public Commenter #5 Patricia Bartels, Mount Sinai South Nassau	General	We need to do a retrospective study on patients with poor outcomes in relation to their prenatal care and delivery providers during the intrapartum and postpartum course.	Thank you for the comment.
Public Commenter #6 Basia Delawska-Elliott, Providence (Medical Librarian)	General	Please include your librarians as authors or acknowledge them by name. Systematic review searching is labor-intensive and a substantial intellectual contribution to the reviews. For more information, please refer to the article by Amanda Ross-White: Ross-White A. Search is a verb: systematic review searching as invisible labor. J Med Libr Assoc. 2021 Jul 1;109(3):505-506. doi: 10.5195/jmla.2021.1226. PMID: 34629983; PMCID: PMC8485967. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8485967/	We agree whole-heartedly that our medical librarian deserves proper credit as a co-author and have always proudly done so. Our medical librarian is a valued member of our team.

Reviewer	Section	Comment	Response
Public Commenter #7 Healthy Nourishments, LLC	General	These inequities will continue and will worsen until USA quits pushing women, in general, to the back of the bus and, in particular, pushing women of colour off the bus, by the refusal of adequate supports such as guaranteed and and effective health care, national paid leave and equitable breastfeeding support. Our abilities as women to Bear, Birth and Breastfeed become vicious disabilities due to the lack of support from our country and health care system. Not only will maternal/infant morbidity and mortality continue to soar, but infertility and birth strikes will radically decrease our birth rates if women do not receive the righteous support they need and deserve.	Thank you for the comment.
Public Commenter #8 Katy Kozhimannil, University of Minnesota	General	The term "maternity care desert" is used throughout the report. I generally do not recommend use of this term. One concern is that the word "desert" implies "lack." From an Indigenous perspective, specifically, this belies a settler (extractive) perspective on land, and does not respect a desert as a complex and abundant landscape. I do not use the term "maternity care desert" to describe places where people lack access to obstetric services, and try to encourage others not to use the term as well.	Thank you for the comment. The review included a single study that used the term “maternity care desert.” As noted in our Terminology section in the Introduction, we tried to use study author terms, with the rare exception of “perceived discrimination”, to allow for shifting terminology and to avoid confusion. We appreciate the intention of comment and will also encourage the change in language where opportunities arise.

Reviewer	Section	Comment	Response
Public Commenter #10 Anonymous	General	This report does not meet plain language standards. It contains extensive jargon and offensive terms to refer to women - the phrase "potential pregnant person" is deeply reductive and dehumanizing, as if women are no more than vessels who should be thought of as pre-pregnant or post-pregnant at all times in their lives. The phrase also does not include women who cannot get pregnant, but who experience sex- and pregnancy-related discrimination that may impact their health (e.g., being passed over for promotion on the basis of perceived pregnancy potential). Women have fought for decades to be considered full humans, to be seen as something other than pregnancy incubators. It is also offensive to refer to women as "birthing persons" when many women who get pregnant will not give birth. I can't imagine that a woman suffering preventable morbidity from a denied abortion or a woman who has experienced a miscarriage would enjoy being called a "birthing person." The language in this report is a big step back. It's unfortunate that so many leading organizations have finally turned their attention to maternal mortality, but cannot seem to discuss it in a normal way that most people can understand and empathize with. I would suggest that the report remove instances of "potential pregnant person" and reduce instances of "birthing person." Other options that reflect language people actually use would make the report less offensive, more readable, and more applicable in a wider variety of settings.	Thank you for the comment. The draft report has undergone several revisions based on internal and peer review, with the intention to write to a relatively broad audience yet retain a certain level of academic presentation. The Terminology section of the Introduction was included to address the concern about the shifting use of language. We have revised this section to incorporate: “We likewise acknowledge that there are women who may object to what may be felt as an erasure of a long history of advocating for women’s rights, and that finding the language balance is fraught.
Public Commenter #11 Tammy Hall	General	Working together makes the Team work . Being Bias is not the answer. Bias I would say is higher now then what it was just watch the news its terrible. Reference? ????????	Thank you for the comment.
Public Commenter #11 Tammy Hall	General	I am a twin to a boy , I can tell you has a female what you started I support and am on board . I will tell you this with the mentranal structural postpartum dominant independent movement women who deals with bias or is bias some may have went thru trama and that should be acknowledged and if so when you do all your research and studies I think honestly maybe that should be considered concluded in there some where . Because bias thinks others is against them some of them may have had been dealt a bad card in life or had bad experiences or whatever causing them to act the way they do . They dont have the courage to express the truth . Anyways . The risk into me is higher then it's ever been and Page 29/46 All Submissions for Webform -- Draft Comment Form for Social an as a women in general even a mother It scares me . Its frightening, I have daughters , neices and sisters were all females	Thank you for the comment.

Reviewer	Section	Comment	Response
Public Commenter #13 American Psychological Association	General	These comments were developed by members and staff of the American Psychological Association (APA) who have expertise on the topic, but they are not an official statement of the APA. Thank you for the opportunity to comment on AHRQ's draft systematic review Social and Structural Determinants of Health Risk Factors for Maternal Morbidity and Mortality: An Evidence Map. We commend AHRQ on undertaking this review of a very important and timely topic. We also commend AHRQ on the attention given to social and structural determinants of health in this review as well as to the important role of intersectionality in maternal morbidity and mortality.	Thank you for the comment.
Public Commenter #13 American Psychological Association	General	Further, we appreciate the efforts to use inclusive language throughout this review, for example referring to pregnant persons. For any questions about inclusive language, please refer to APA's (2021) Inclusive Language Guidelines as a helpful resource.	Thank you for the comment.
Public Commenter #3 David Gregory, Carilion Clinic	Report Purpose	Yes	Thank you for the comment.
Public Commenter #4 Anna Grizzard	Report Purpose	No, see below	Thank you for the comment.
Public Commenter #5 Patricia Bartels, Mount Sinai South Nassau	Report Purpose	Yes	Thank you for the comment.
Public Commenter #10 Anonymous	Report Purpose	Sometimes. The report does not reflect the language that most women use and would be hard to understand for anyone who did not attend an elite school (and for anyone with less literacy or English proficiency). For example, I'm not sure that most people would understand the phrase "we committed to individual and team reflexivity" in the Author Statement or "Importantly, an interacting framework allows us to examine how people and their health are affected by multiple intersecting social forces. Such a framework also shifts away from examining these comorbidities as inherent and one-directional, opting instead to view the interactions as a multidimensional feedback loop that compounds risk" in the Background. I can see that intentions are good, but execution is poor - and that is a real problem when discussing understudied issues like maternal morbidity and mortality.	Thank you for the suggestion. The draft report has undergone several revisions based on internal and peer review, with the intention to write to a relatively broad audience yet retain a certain level of academic presentation.

Reviewer	Section	Comment	Response
Public Commenter #11 Tammy Hall	Report Purpose	Mostly I got distracted in the middle and had to stop reading some of it . To be honest. Its important to me and I take it just as ser6 as you do .	Thank you for the comment.
Public Commenter #3 David Gregory, Carilion Clinic	Report Clarity	Yes	Thank you for the comment.
Public Commenter #4 Anna Grizzard	Report Clarity	Read the summary & it was not clearly stated	Thank you for the comment.
Public Commenter #5 Patricia Bartels, Mount Sinai South Nassau	Report Clarity	Yes, but I think we are overlooking other mitigating factors.	Thank you for the comment.
Public Commenter #10 Anonymous	Report Clarity	Yes, but only because I am a health policy researcher myself. If I were a member of the general public, I think I would find this report quite hard to understand. Revising or simplifying the figures in the body chapters would possibly help increase understanding throughout.	
Public Commenter #11 Tammy Hall	Report Clarity	I absolutely agree , it took me a minute to fully understand at first .	Thank you for the comment.
Public Commenter #11 Tammy Hall	Report Clarity	Yes	Thank you for the comment.
Public Commenter #15 Amy Fox	Report Clarity	I can find and understand the results and conclusions. However, I felt like there were too many alluvial graphs and I think the conclusion was basically “we reviewed a lot of studies and do not see a clear cut answer on what specific SDoHs impact maternal mortality and morbidity.” I think it might be valuable to set up a pilot study where specific SDoHs are evaluated in a geographic location that is diverse in demographics as well as populous enough to have many birth experiences to analyze.	Thank you for the comment.