VIA ELECTRONIC TRANSMISSION

January 20, 2026

Jeffrey M. Zirger
Information Collection Review Office
Centers for Disease Control and Prevention
1600 Clifton Road NE, MS H21-8
Atlanta, Georgia 30329.

Re: Proposed Data Collection Submitted for Public Comment and Recommendations (CDC-2025-0750)

Dear Mr. Zirger,

The Center for Reproductive Rights ("the Center") submits this comment in response to the Notice by the Centers for Disease Control and Prevention's ("CDC's" or the "agency's"), "Proposed Data Collection Submitted for Public Comment and Recommendations," issued on November 21, 2025 ("Notice") which invites comment on a proposed information collection project titled Pregnancy Risk Assessment Monitoring System ("PRAMS").[1]

Since 1992, the Center has used the power of law to advance reproductive rights as fundamental human rights worldwide. Our litigation and advocacy over the past 33 years have expanded access to reproductive health care around the nation and the world. We have played a key role in securing legal victories in the United States, Latin America, Sub-Saharan Africa, Asia, and Eastern Europe on issues including access to life-saving obstetrics care, contraception, safe abortion services, and comprehensive sexuality information. We envision a world where every person participates with dignity as an equal member of society, regardless of gender; where every person is free to decide whether or when to have children and whether or when to get married; where access to quality reproductive health care is guaranteed; and where everyone can make these decisions free from coercion or discrimination. In addition, the Center's Maternal Health & Rights Initiative promotes the human rights of pregnant, birthing, and postpartum people in the United States. Harnessing the power of law, policy, and strategic advocacy, the Initiative seeks to improve access to safe and respectful maternal health care for all who need it, and to ensure that all people have an opportunity to attain the highest standard of maternal health possible for themselves.

As an organization committed to advancing policies that uphold reproductive rights as fundamental human rights, including the right to available, high quality, accessible, acceptable reproductive health care,[2] we believe PRAMS is a vital data collection tool necessary to address

[1] Proposed Data Collection Submitted for Public Comment and Recommendations, 90 Fed. Reg. 52,666 (Nov. 21, 2025) [hereinafter "Notice"].
[2] Committee on Economic, Social and Cultural Rights (ESCR Committee), General Comment No. 14: The right to the highest attainable standard of health (Art. 12), (22nd Sess., 2000), in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at 80, para.12 (a)-(d), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008); ESCR Committee, General Comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social, and Cultural Rights), U.N. Doc.

and improve maternal health outcomes in the United States. For almost four decades, PRAMS has allowed researchers, advocates, and policymakers to monitor and address various clinical factors that contribute to the United States' maternal mortality and morbidity crisis in real time.[3] The Center believes this data collection effort must continue and supports the CDC's effort to seek approval for an extension of PRAMS.

I. Background

PRAMS is a long standing, population-based data collection system designed to collect critical information on maternal behaviors, experiences, and health before, during, and shortly after pregnancy.[4] Established in 1987, PRAMS has been conducted annually for nearly four decades and remains the only national, long term dataset specifically designed to capture maternal experiences and health indicators across time and geography in the United States. Data is collected by states, territories, tribes and local health departments through a standardized questionnaire sent to a randomly selected set of people who recently gave birth. CDC then plays a central role in harmonizing survey datasets, ensuring methodological consistency, and maintaining data comparability across states and over time. This federal coordination is essential to PRAMS' value as a national public health data collection system, but the Trump administration's reductions in the federal workforce have put the program in jeopardy.[5]

In a typical year, more than 40 states participate in PRAMS. While participation is voluntary and not all states take part,[6] PRAMS nonetheless represents the most comprehensive national source of maternal self-reported data available. The CDC's role in analyzing and releasing PRAMS data enables researchers, policymakers, and public health officials to assess trends, identify disparities, and evaluate policy and programmatic interventions across jurisdictions.[7]

II. PRAMS is Necessary to Address the U.S. Maternal Mortality Crisis

The U.S. has the highest rate of maternal mortality among wealthy nations.[8] Although rates have increased over the last two decades for all women, Black women are around three times more likely to die from a pregnancy-related cause than White women, while Indigenous women are

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E/C.12/GC/22 (2016).

[3] Amy Roeder, *With federal maternal health database in limbo, a risk to mother and infant health*, HARV. T.H. CHAN SCH. OF PUB. HEALTH (Oct. 16, 2025), https://hsph.harvard.edu/news/with-federal-maternal-health-database-in-limbo-a-risk-to-mother-and-infant-health/.

[4] PRAMS, CTRS. FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/prams/index.html (last visited Jan. 13, 2026); Holly B. Shulman et al., The Pregnancy Risk Assessment Monitoring System (PRAMS): Overview of Design and Methodology, 108 Am. J. of Pub. Health 1305, 1305-1313 (Sep. 12, 2018) *available at* https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2018.304563.

[5] Jackie DeFusco and Marissa Mizroch, *After mass layoffs, questions remain about CDC pregnancy survey*, WCVB5 ABC (Nov. 30 2025, 10:38 AM) https://www.wcvb.com/article/mass-layoffs-cdc-pregnancy-survey-health/69584103.

[6] For example, California does not participate and instead conducts its own Maternal and Infant Health Assessment (MIHA).

[7] Emily Oster, *The Pregnancy Dataset We Can't Afford to Lose*, PARENTDATA (Oct. 9, 2025) https://parentdata.org/the-pregnancy-dataset-we-cant-afford-to-lose/.

[8] What is the U.S. Maternal Health Crisis, CTR. FOR REPROD. RTS. (Oct. 9, 2025) https://reproductiverights.org/resources/what-is-the-u-s-maternal-health-crisis/.

two to three times as likely compared to White women and, overall, Black, Indigenous, Hispanic, and Asian women experience higher rates of severe maternal morbidity than White women.[9] High rates of maternal mortality are universal for all Black women in the U.S., regardless of socioeconomic background.[10] PRAMS is an indispensable tool for understanding and responding to the United States' maternal mortality and morbidity crisis, not only because of the breadth of its geographic coverage and longevity, but also in the type of information it captures, and that is simply not easily available through other sources.[11]

Data sources like birth and death certificates or claims data can provide helpful, factual information about a patient and the kind of care they received. However, unlike those sources, PRAMS provides insight into the quality of care and the experiences that directly shape maternal health outcomes but are otherwise difficult to measure. For example, PRAMS is one of the only accessible data sources that captures information on preventive care such as well-woman visits, maternal mental health, breastfeeding practices, and postpartum care utilization.[12] Equally important, PRAMS offers a rare opportunity to hear directly from birthing people about their experiences, including experiences of discrimination, mistreatment, or unmet needs within the health care system. This data is critical for identifying opportunities to improve quality of care, address bias, and advance health equity.[13]

PRAMS also serves as an early warning system, allowing public health officials to keep a finger on the pulse of emerging issues affecting pregnant and postpartum people. Because PRAMS data is collected annually and the survey can be customized, the system has proven responsive to evolving public health crises. In the past, PRAMS has been adapted to include questions related to Zika virus, H1N1, COVID-19, and other emergent threats, generating timely, actionable data to inform public health responses in support of pregnant people.[14]

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[9] Latoya Hill et al., *Racial Disparities in Maternal and Infant Health: Current Status and Key Issues*, KFF (Dec. 3, 2025) https://www.kff.org/racial-equity-and-health-policy/racial-disparities-in-maternal-and-infant-health-current-status-and-key-issues/.

[10] Eugene Declerq and Laurie C. Zephyrin, *Maternal Mortality in the United States, 2025*, THE COMMONWEALTH FUND (Jul. 29, 2025) https://www.commonwealthfund.org/publications/issue-briefs/2025/jul/maternal-mortality-united-states-2025.

[11] Pregnancy Risk Assessment Monitoring System– Informing Impact, Improving Lives, ASS'N OF MATERNAL AND CHILD HEALTH PROGRAMS (Apr. 2025) https://amchp.org/wpcontent/uploads/2025/04/AMCHPFundingSeries_PRAMS.pdf [hereinafter *AMCHP Factsheet*].

[12] R. Petersen et al., Preventive counseling during prenatal care: Pregnancy Risk Assessment Monitoring System (PRAMS), 20 Am. J. Preventative Med. 245, 245-50 (May 2001) https://pubmed.ncbi.nlm.nih.gov/11331111/; https://parentdata.org/the-pregnancy-dataset-we-cant-afford-to-lose/

[13] https://pubmed.ncbi.nlm.nih.gov/11331111/; Jillian McKoy, *CDC Responds to Professors' Call for Permanent Assessment of Racial Discrimination in Pregnancy Survey*, B.U. SCH. OF PUB. HEALTH (Feb. 17, 2022) https://www.bu.edu/sph/news/articles/2022/cdc-responds-to-professors-call-for-permanent-assessment-of-racial-discrimination-in-pregnancy-survey/; Sarojini Kanotra et al., Challenges faced by new mothers in the early postpartum period: an analysis of comment data from the 2000 Pregnancy Risk Assessment Monitoring System (PRAMS) survey, 11 Maternal Child Health J. 549, 549-58 (Jun. 12, 2007) https://pubmed.ncbi.nlm.nih.gov/17562155/; Oster, *supra* note 7.

[14] *See,* Special Projects: PRAMS and Zika, CTRS. FOR DISEASE CONTROL AND PREVENTION (May 14, 2024) https://www.cdc.gov/prams/php/projects/zika-postpartum-emergency-response-study-puerto-rico.html; Trina C. Salm Ward et al., Experiences of birthing people during the COVID-19 pandemic: Analysis of comments from the 2020 Wisconsin Pregnancy Risk Assessment Monitoring System (PRAMS), 51 Birth 738, 738-51 (May 27, 2024) https://pubmed.ncbi.nlm.nih.gov/38798170/.

State and federal public health agencies regularly rely on PRAMS data to guide the use of maternal and child health block grants and other public health investments. At the state level, PRAMS helps officials understand the lived realities of pregnant and postpartum people, identify gaps in care, and target interventions where they are most needed.[15] At the federal level, PRAMS has been used to assess block grant performance and outcomes, making it essential to accountability and evidence-based policymaking.[16]

III. Recommendations to Enhance the "Quality, Utility and Clarity of the Information to be Collected"

In response to the query in the proposed rule,[17] we believe the following additions to the PRAMS questionnaire would represent a beneficial expansion of the data needed to further the ability of stakeholders and policymakers to improve maternal health outcomes.

A. A recommendation to include questions on accessing care through telehealth.

The COVID-19 pandemic dramatically expanded access to and use of telehealth services, and pregnancy-related care is no exception. Research suggests that while there are both benefits and drawbacks to telehealth care, it is a novel tool that can bridge provider shortages in rural and underserved areas, ensure regular communication between patients and their providers, and potentially catch pregnancy-related complications early.[18]

We recommend including a question that assess whether the patient used telehealth before, during, and after their pregnancy, with a follow up list where they can share the types of care they received including, but not limited to, routine perinatal visits, visits with maternal-fetal specialists, remote monitoring of high-risk conditions like hypertension and diabetes, contraceptive counselling, mental health check-ups, and lactation support.

B. A recommendation to include a question to assess patients' access to midwives, doulas, lactation consultants, and other community birth workers.

The presence of community-based birth workers, such as doulas and midwives, has been shown to reduce adverse maternal health outcomes and postpartum complications.[19] We recommend adding a question that allows patients to report if they were able to utilize a doula, midwife, or other birth worker, such as a lactation consultant, before, during, or after their pregnancy.

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[15] Shulman, *supra* note 4.
[16] AMCHP Factsheet, *supra* note 11. https://amchp.org/wp-content/uploads/2025/04/AMCHPFundingSeries_PRAMS.pdf
[17] Notice, *supra* note 1, at 52666.
[18] Summer Sherburne Hawkins, Telehealth in the Prenatal and Postpartum Periods, 52 J. of Obstetric, Gynecologic, and Neonatal Nursing 264, 264-275 (Jul. 2023) https://www.jognn.org/article/S0884-2175(23)00173-9/fulltext; Amy G. Cantor et al., *PCORI Evidence Synthesis: Rapid Review No. 2— Telehealth Strategies for the Delivery of Maternal Health Care*, PATIENT-CENTERED OUTCOME RSCH. INST. (Jul. 2022) https://www.pcori.org/sites/default/files/PCORI-Rapid-Review-Telehealth-Strategies-for-the-Delivery-of-Maternal-Healthcare.pdf.
[19] https://www.commonwealthfund.org/publications/issue-briefs/2021/mar/community-models-improve-maternal-outcomes-equityn

C. A recommendation to include a question on factors surrounding patients' choice and satisfaction with their birth setting.

In order to better understand how patients' choice or lack thereof in selecting the setting where they give birth impacts their overall experience, we recommend including a question that allows the patients to report on the various factors that went into choosing their birth setting and their overall satisfaction. Factors like geographical proximity, insurance, a desire for fewer clinical interventions, or a desire to be seen by specific providers or specialists often determine patients' choices.[20] However, a lack of options due to provider shortages or limited options as a result of coverage restrictions may dramatically impact birthing experience and result in adverse health outcomes.[21]

D. A recommendation to identify active duty servicemembers and veterans, who face unique challenges throughout pregnancy.

Military service and veteran status can shape access to health care, insurance coverage, and continuity of care, including transitions between Department of Defense, Department of Veterans Affairs, and civilian health systems.[22] Additionally, veterans are a unique population that face increased health risks during pregnancy. For example, veterans of reproductive age have high rates of chronic medical and mental health conditions that may increase pregnancy risks, including conditions like severe hypertension and chronic renal disease.[23] Many veterans also experience severe post-traumatic stress disorder (PTSD) which can be exacerbated by pregnancy.[24] Collecting data on their experiences around pregnancy would enhance the ability of public health agencies to assess disparities in maternal morbidity and mortality, identify gaps in care coordination, and inform clinical interventions to support equitable, high-quality maternal health care for servicemembers, veterans, and their families.

For this reason, we recommend including a question or set of questions to identify whether a patient is an active-duty service member, a spouse of an active-duty service member, or a

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[20] Gregory Lang, et al., Out-of-Hospital Birth, 103 Am. Fam. Physician 672-679 (Jun. 1, 2021)https://www.aafp.org/pubs/afp/issues/2021/0601/p672.html; Alice Callahan, *Should You Give Birth at a Birth Center?*, N.Y. TIMES (Sep. 25, 2018) https://www.nytimes.com/2018/09/25/well/family/should-you-give-birth-at-a-birth-center.html.

[21] *See,* NAT'L ACAD. OF SCI., ENG'G, AND MED., COMM. ON ASSESSING HEALTH OUTCOMES BY BIRTH SETTINGS, BIRTH SETTINGS IN AMERICA: OUTCOMES, QUALITY, ACCESS, AND CHOICE 161-258 (2020) https://www.nationalacademies.org/read/25636/chapter/8.

[22] *See,* Erin Digitale, *For pregnant soldiers, recent deployment linked to higher risk of premature delivery*, STANFORD MED. (Mar. 1, 2018) https://med.stanford.edu/news/all-news/2018/03/recent-deployment-linked-to-higher-risk-of-premature-delivery.html; U.S. Gov't Accountability Off., GAO-24-106209, Veterans Health: VA Should Improve Its Monitoring of Severe Maternal Complications and Mental Health Screenings (2024) https://www.gao.gov/products/gao-24-106209; Cassandra Jaramillo, *Severe Complications for Pregnant Veterans Nearly Doubled in the Last Decade, a GAO Report Finds*, PROPUBLICA (Feb. 23, 2024, 10:45 AM) https://www.propublica.org/article/complications-pregnant-veterans-doubled-2011-2020.

[23] *See*, Joan L. Combellick, et al., *Severe Maternal Morbidity Among a Cohort of Post-9/11 Women Veterans*, 29 J. OF WOMEN'S HEALTH, 577–84 (Apr. 2020); Jonathan Shaw, et al., Post-traumatic Stress Disorder and Antepartum Complications: a Novel Risk Factor for Gestational Diabetes and Preeclampsia, 31 Paediatric and Perinatal Epidemiology, 185–194 (May 2017); David Jones & John P. Hayslett, Outcome of pregnancy in women with moderate or severe renal insufficiency, 25 New England J. of Med. 226–32 (Jul. 1996).

[24] Kristin M. Mattocks et al., Pregnancy and Mental Health Among Women Veterans Returning from Iraq and Afghanistan, 19 J. of Women's Health 2159 (2010), https://doi.org/10.1089/jwh.2009.1892 (study finding that "[v]eterans with a pregnancy were twice as likely to have a diagnosis of depression, anxiety, post-traumatic stress disorder (PTSD), bipolar disorder, or schizophrenia as those without a pregnancy.").

veteran. We also recommend including follow-up questions about the various aspects of their care including whether active-duty service members and spouses received obstetric services at a Military Treatment Facility or civilian facility, and whether veterans received care through a VA Medical Center, as well as their experience with a Maternity Care Coordinator.

IV. CDC Staffing Must be Restored in Support of PRAMS

Despite its proven value, PRAMS is facing significant challenges that threaten its integrity, accessibility, and future usefulness. Recent reductions in the federal workforce have resulted in the removal of nearly all staff who conduct the PRAMS survey at the CDC.[25] The lack of staffing means that access to PRAMS data has become increasingly constrained. Historically, researchers and advocates could request national PRAMS data from CDC at no cost. Currently, however, data requests, both multi-state and national, are not being processed, reportedly due to these federal staffing cuts.[26] While many states continue to provide access to their own PRAMS data, this piecemeal access undermines the purpose of PRAMS as a coordinated national data collection system and places additional burdens on states and researchers.

There are also growing concerns about data timeliness and completeness. As of now, PRAMS data for 2023 has not been released, despite earlier indications from the CDC that publication would occur in early 2025.[27] Looking ahead, there is significant uncertainty about data quality and availability for the 2024–2026 period, with reports suggesting uneven capacity across states.[28] This variability threatens the comparability and reliability of PRAMS data at precisely the moment when consistent, high quality- data collection is most needed.[29]

V. Conclusion

The Center believes this data collection effort must continue and supports the CDC's effort to seek approval for an extension of PRAMS data collection. The Center appreciates the opportunity to comment on this Notice. If you require any additional information about the issues raised in this letter, please contact Vandana Ranjan, Senior Federal Policy Adviser, Maternal Health at vranjan@reprorights.org.

Signed,
Vandana Ranjan
Center for Reproductive Rights

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[25] Anil Oza, *Gold-standard maternal mortality database in limbo as CDC staff placed on leave*, STAT NEWS (Apr. 1, 2025) https://www.statnews.com/2025/04/01/prams-maternal-mortality-cdc-layoffs/.
[26] Roeder, *supra* note 3.
[27] Madison Haiman and Emma Mairson, *Attacks on Data Accessibility Turn to Maternal Health: How States Can Help*, Academy Health (Apr. 17, 2025) https://academyhealth.org/blog/2025-04/attacks-data-accessibility-turn-maternal-health-how-states-can-help.
[28] *Id;* DeFusco and Mizroch, *supra* note 5.
[29] *The Landscape of Major Federal Health Survey Data Releases in 2025,* STATE HEALTH ACCESS DATA ASSISTANCE CTR. (Updated Dec. 18, 2025) *available at:* https://www.shadac.org/news/federal-health-survey-data-releases-landscape-2025