**South Carolina General Assembly**

124th Session, 2021-2022

**H. 4801**

**STATUS INFORMATION**

General Bill

Sponsors: Rep. J. Moore

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Currently residing in the House Committee on **Medical, Military, Public and Municipal Affairs**

Summary: South Carolina Dignity in Pregnancy and Childbirth Act

**HISTORY OF LEGISLATIVE ACTIONS**

Date Body Action Description with journal page number

1/13/2022 House Introduced and read first time

1/13/2022 House Referred to Committee on **Medical, Military, Public and Municipal Affairs**

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**VERSIONS OF THIS BILL**

[1/13/2022](file:///p:\pprever\2021-22\4801_20220113.docx)

**A** **BILL**

TO AMEND THE CODE OF LAWS OF SOUTH CAROLINA, 1976, TO ENACT THE “SOUTH CAROLINA DIGNITY IN PREGNANCY AND CHILDBIRTH ACT” BY ADDING CHAPTER 42 TO TITLE 44 SO AS TO REQUIRE PERINATAL HEALTH CARE PROVIDERS TO IMPLEMENT AN EVIDENCE‑BASED IMPLICIT BIAS PROGRAM TO TRAIN HEALTH CARE STAFF, TO ESTABLISH REQUIREMENTS FOR THE PROGRAM, AND FOR OTHER PURPOSES.

Be it enacted by the General Assembly of the State of South Carolina:

SECTION 1. This act shall be known and may be cited as the “South Carolina Dignity in Pregnancy and Childbirth Act”.

SECTION 2. Title 44 of the 1976 Code is amended by adding:

“CHAPTER 42

South Carolina Dignity in Pregnancy and Childbirth Act

Section 44‑42‑10. The General Assembly hereby finds and declares all of the following:

(1) Every person should be entitled to dignity and respect during and after pregnancy and childbirth. Patients should receive the best care possible regardless of their race, gender, age, class, sexual orientation, gender identity, disability, language proficiency, nationality, immigration status, gender expression, or religion.

(2) Among developed nations, the United States has the highest maternal mortality rate, which refers to the death of a woman during her pregnancy or up to a year after her pregnancy has terminated but only including causes related to her pregnancy and excluding accidental causes. About 700 women die each year in the United States from childbirth, and another 50,000 suffer from severe complications.

(3) According to the Centers for Disease Control and Prevention (CDC), in 2017, the maternal morbidity rate for African American women in the United States was 43.5 for every 100,000, a rate three to four times higher than for any other race. For every thirteen white women, there are forty‑four black women who die from pregnancy complications.

(4) South Carolina’s maternal mortality rate is the eighth highest in the country with 26.5 mothers dying from pregnancy complications for every 100,000 births, compared to the national average of 20.7.

(5) From 2011‑2015, non‑Hispanic black women had a maternal mortality rate nearly four times greater than white woman, and the majority of pregnancy‑related deaths in the State occurred in a hospital.

(6) Severe bleeding, cardiovascular conditions, and hypertension are a few of the most common causes of maternal morbidity in this State, and more than half of these deaths have been deemed preventable by the CDC.

(7) Access to prenatal care, socioeconomic status, and general physical health do not fully explain the disparity seen in black women’s maternal mortality and morbidity rates. There is a growing body of evidence that black women often are treated unfairly and unequally in the health care system.

(8) Implicit bias is a key cause that drives health disparities in communities of color, which must be addressed. At present, health care providers in South Carolina are not required to undergo any implicit bias testing or training. Nor does there exist any system to track the number of incidents where implicit prejudice and implicit stereotypes have led to negative birth and maternal health outcomes.

(9) It is the intent of the General Assembly to reduce the effects of implicit bias in pregnancy, childbirth, and postnatal care so that all people are treated with dignity and respect by their health care providers.

Section 44‑42‑20. For the purposes of this chapter:

(1) ‘Implicit bias’ means a bias in judgment or behavior that results from subtle cognitive processes, including implicit prejudice and implicit stereotypes that often operate at a level below conscious awareness and without intentional control.

(2) ‘Implicit prejudice’ means prejudicial negative feelings or beliefs about a group that a person holds without being aware of them.

(3) ‘Implicit stereotypes’ means the unconscious attributions of particular qualities to a member of a certain social group. Implicit stereotypes are influenced by experience and are based on learned associations between various qualities and social categories, including race or gender.

(4) ‘Perinatal care’ means the provision of care during pregnancy, labor, delivery, and postpartum and neonatal periods.

(5) ‘Pregnancy‑related death’ means the death of a person while pregnant or within three hundred sixty five days of the end of a pregnancy, irrespective of the duration or site of the pregnancy, from any cause related to, or aggravated by, the pregnancy or its management, but not from accidental or incidental causes.

Section 44‑42‑30. (A) A hospital, as defined in Section 44‑7‑130, that provides perinatal care, a birthing center, as defined in Section 44‑89‑30, and any primary health care clinic in the State delivering perinatal care services, shall implement an evidence‑based implicit bias program for all health care providers involved in the perinatal care of patients within those facilities.

(B) An implicit bias program implemented pursuant to subsection (A) must include all of the following:

(1) identification of previous or current unconscious biases and misinformation;

(2) identification of personal, interpersonal, institutional, structural, and cultural barriers to inclusion;

(3) corrective measures to decrease implicit bias at the interpersonal and institutional levels, including ongoing policies and practices for that purpose;

(4) information on the effects including, but not limited to, ongoing personal effects, of historical and contemporary exclusion and oppression of minority communities;

(5) information about cultural identity across racial or ethnic groups;

(6) information about communicating more effectively across identities, including racial, ethnic, religious, and gender identities;

(7) discussion on power dynamics and organizational decision making;

(8) discussion on health inequities within the perinatal care field, including information on how implicit bias impacts maternal and infant health outcomes;

(9) perspectives of diverse local constituency groups and experts on particular racial, identity, cultural, and provider‑community relations issues in the community; and

(10) information on reproductive justice.

(C)(1) A health care provider described in subsection (A) shall complete initial basic training through the implicit bias program based on the components described in subsection (B).

(2) Upon completion of the initial basic training, a health care provider shall complete a refresher course under the implicit bias program annually in order to keep current with changing racial, identity, and cultural trends and best practices in decreasing interpersonal and institutional implicit bias.

(D) A facility described in subsection (A) shall provide a certificate of training completion to another facility or a training attendee upon request. A facility may accept a certificate of completion from another facility described in subsection (A) to satisfy the training requirement described in subsection (C) from a health care provider who works in more than one facility.

(E) Notwithstanding subsections (A) through (D), if a physician involved in the perinatal care of patients is not directly employed by a facility, the facility shall offer the training to the physician.”

SECTION 3. This act takes effect six months after approval by the Governor.

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