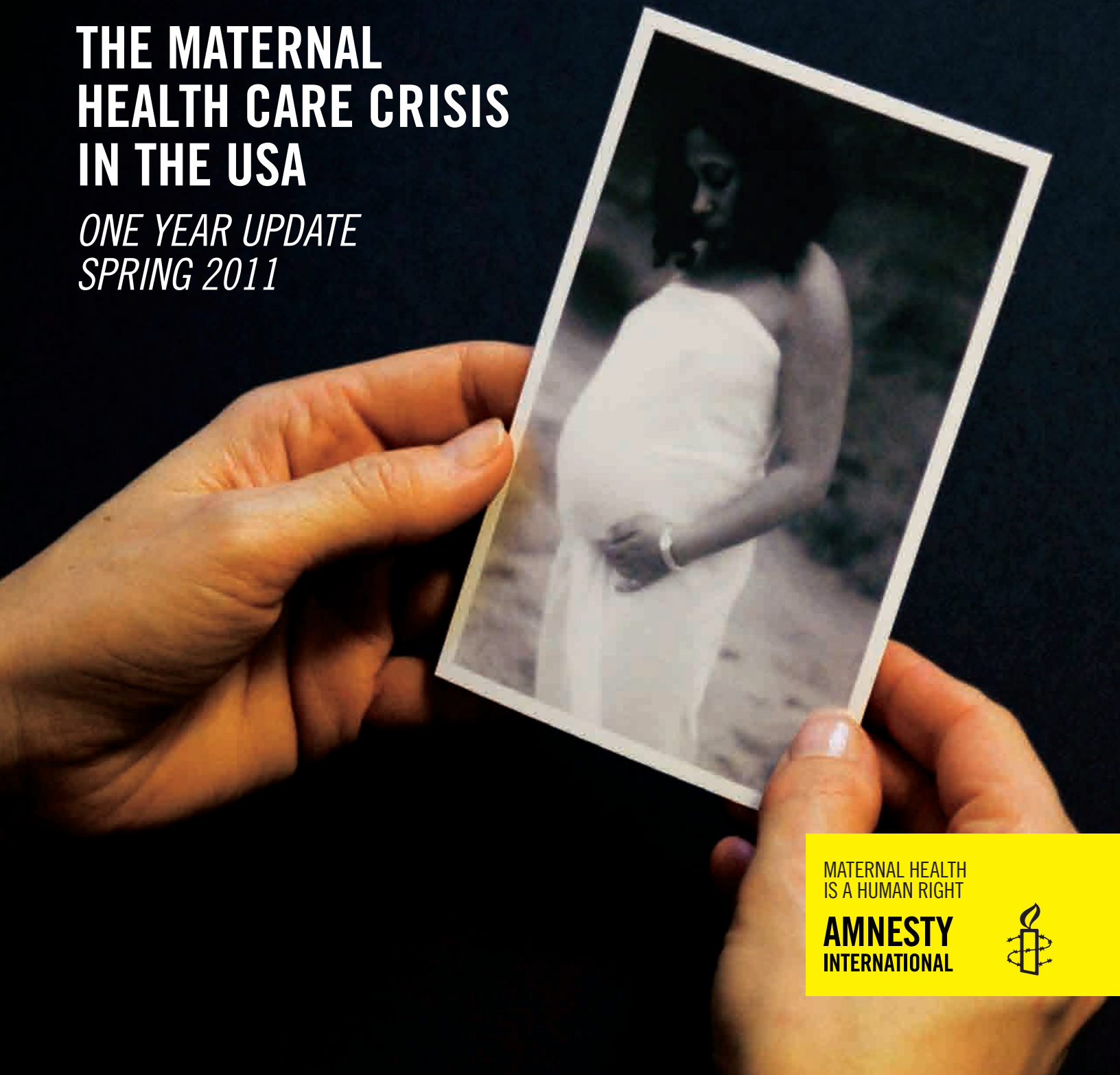
DEADLY DELIVERY

THE MATERNAL HEALTH CARE CRISIS IN THE USA

ONE YEAR UPDATE
SPRING 2011



MATERNAL HEALTH
IS A HUMAN RIGHT

AMNESTY INTERNATIONAL

This document updates the report *Deadly Delivery: The Maternal Health Care Crisis in the USA* (Index: AMR 51/007/2010) which contains full citations and should be consulted for further information.

Cover photo, front:
Tatia Oden French and her baby daughter, Zorah, died in 2001 after an induced labor. Her mother has since set up a foundation to prevent similar deaths. Photo of Tatia Oden French taken by Joseph B. French and used by kind permission of Maddy Oden and Joseph B. French. © Amnesty International

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DEADLY DELIVERY

THE MATERNAL HEALTH CRISIS IN THE USA
ONE YEAR UPDATE, SPRING 2011

"It keeps startling me that at the beginning of this 21st century, at a time when we can . . . explore the depths of the seas and build an international space station, we have not been able to make childbirth safe for all women around the world. . . . This is one of the greatest social causes of our time."

Thoraya Obaid, Executive Director of the United Nations Population Fund[1]

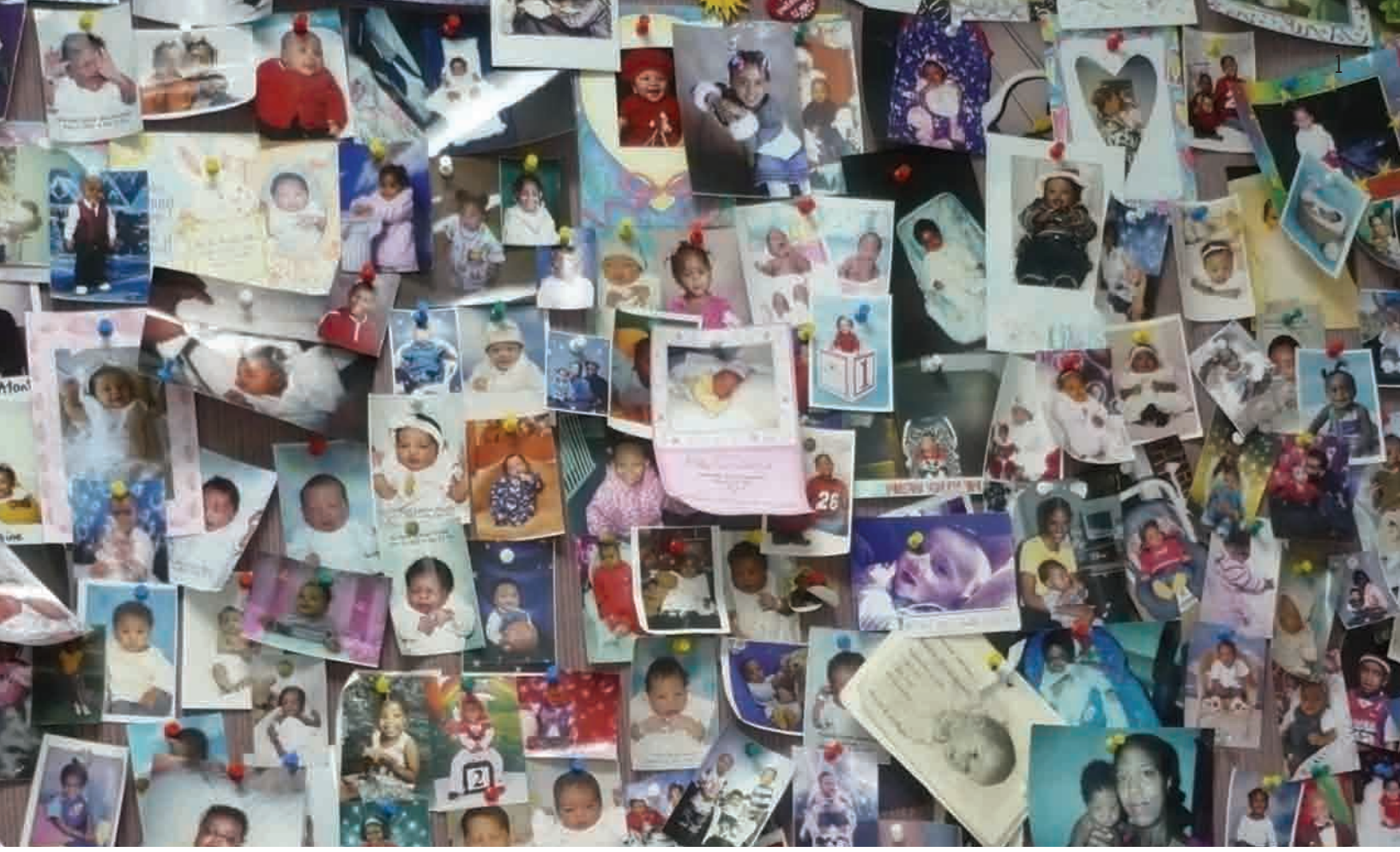
50 YEARS
AMNESTY
INTERNATIONAL

"Amnesty International brought the issue of maternal mortality and morbidity front and center as a human rights issue. For the first time in twenty years, I felt the American people come to understand the jeopardy of pregnancy and birth right here at home, understanding that the statistics, perhaps unknown until now, are populated by our neighbors."

Jennie Joseph, Midwife, Winter Garden, Florida, 8 February 2011

KEY DATA RELEASED IN 2010

See Page 3	According to new UN data, maternal mortality in the US has worsened, falling from 41st to 50th in the world. In other words, women in the US face a greater risk of maternal death than in 49 other countries.[2]
See Page 3	Over 4 million women in the US give birth each year, and the hospital bills for this care reached $98 billion. International Federation of Health Plans data indicated that the US spends twice as much as any other country surveyed on the fees charged by maternal health care providers.[3]
See Page 5	The US maternal mortality ratio, at 12.7 (deaths per 100,000 live births), was 3 times as high as the Healthy People 2010 goal, a national target set by the US government.[4]
See Page 5	The maternal mortality ratio for American Indian/Alaska Native women was 4 times higher than the 2010 target and for African American women was 8 times higher than the 2010 target.[5]
See Page 7	Women living in low-income areas across the US were twice as likely to suffer a maternal death as women in high income areas.[5]
See Page 8	The US cesarean rate rose for the 13th consecutive year to reach an all-time high of 32.9% in 2009,[6] more than double the WHO recommended range of 5% to 15%.
See Page 8	New analysis shows that the states reporting higher than average cesarean rates (over 33% of births) had a 21% higher risk of maternal mortality than states with cesarean rates less than 33%.[7]



"She never got to hold her baby. That is one of the hardest things for me."

Matt Logelin, whose wife, Liz, died of a pulmonary embolism (blood clot) one day after giving birth by cesarean section to their daughter Madeline, now 3 years old[8]

Above: **A bulletin board at the Developing Families Center, a birth center in a medically under-served community in Washingon, DC, covered with photos of the babies born to women who received maternal health care at the center.** ***© Amnesty International***

BACKGROUND

On March 12, 2010, Amnesty International issued a report entitled *Deadly Delivery*: *The Maternal Health Care Crisis in the USA*, which documented that although the United States spends more on health care than any other country, it ranked 41st (at the time of publication) in terms of maternal death. As the report demonstrated, this is not just a matter of public health, but a human rights issue. Half of these deaths are preventable, and the report clearly demonstrated many barriers women face in accessing high quality maternal care.[9]

2010 has been a watershed year for maternal health issues, both globally and in the US. In 2010, new studies and data were released and new legislation and initiatives developed that promise to improve maternal health. Throughout 2010, Amnesty International has been campaigning to end preventable maternal deaths in the US and around the globe. Despite some progress, more work remains to be done in order to ensure that the work of the last year will have a lasting impact. This update will examine the developments and new data on maternal health in the United States, address the expected impact on maternal health and health care of some key provisions in health care reform, the Patient Protection and Affordable Care Act, which passed on 23 March 2010, and cover some of the progress and successes that have been accomplished during the last year. All data and developments cited in this update have been released in 2010 or 2011, except where indicated.

MATERNAL HEALTH IS A HUMAN RIGHTS ISSUE

Preventable maternal mortality can result from or reflect violations of a variety of human rights, including the right to life, the right to freedom from discrimination, and the right to the highest attainable standard of health. Governments have an obligation to respect, protect and fulfill these and other human rights and are ultimately accountable for guaranteeing a health care system that ensures these rights universally and equitably.

The US has ratified two key international human rights treaties that guarantee these rights: the International Covenant on Civil and Political Rights and the International Convention on the Elimination of All Forms of Racial Discrimination. It has also signed two international treaties that address these rights—the International Covenant on Economic, Social and Cultural Rights and the Convention on the Elimination of All Forms of Discrimination against Women—and so has an obligation to refrain from acts that would defeat the object and purpose of these treaties.

According to human rights principles, the health care system must provide health care services that are available, accessible, acceptable and of good quality. In addition, the health care system must be accountable, free from discrimination, and ensure the active participation of women in decision-making.

In June 2009, the UN Human Rights Council (HRC) issued a resolution explicitly recognizing preventable maternal mortality as a human rights issue.[10] The UN Office of the High Commissioner on Human Rights followed the resolution with a report further elaborating on the application of a human rights-based approach to maternal mortality including: the need to focus on equality and non-discrimination; obligations regarding accountability; and such elements as participation, transparency, empowerment, sustainability, and international assistance. The report made recommendations on how a human rights analysis can add value to existing maternal health initiatives.[14]

HIGH LEVEL GLOBAL EVENTS IN 2010 SIGNALED UNPRECEDENTED ATTENTION TO MATERNAL HEALTH.

In September 2010, at the United Nation's Millennium Development Goal Summit, the UN launched its Global Strategy for Women's and Children's Health, to identify and implement critical interventions to improve maternal health and save the lives of over millions of women and children by establishing a roadmap to improve maternal and child health.[11]

As part of this effort, a new UN Commission on Information and Accountability for Women's and Children's Health has been established to create a framework to monitor global commitments for maternal, newborn and child health and to ensure that resources are used effectively, in order to save as many lives as possible. The Commission will propose a framework for global reporting, oversight and accountability on women's and children's health.[12]

Other high level global leadership efforts to reduce maternal mortality in 2010 included initiatives of the the G-8, the African Union summit, and the UN MDG summit. Human rights bodies issued several resolutions and reports focused on maternal mortality and human rights, including a report by the Office of the High Commissioner of Human Rights, a Human Rights Council resolution,[13] and a resolution of the Inter-American Commission on Human Rights. In addition, Women Deliver, a global advocacy organization, held its second conference on reducing maternal death with 3,400 participants from 146 countries, including UN and national government leadership.

GLOBAL UPDATE

Around the world, a woman dies from complications of pregnancy and childbirth every ninety seconds, nearly 1,000 women every day.[15]

Statistics released in 2010 demonstrate that when governments invest in improving maternal health, women's lives can be saved.[16] Yet, as reported by Countdown to 2015 (a global initiative to track progress on maternal and child health), maternal mortality remains unacceptably high and

much more work remains to be done.[17] The vast majority of maternal deaths occur in developing countries, and the vast majority are preventable.[18]

"The new evidence [of a decline in global maternal deaths] is encouraging, but must not be allowed to undermine the urgency of addressing maternal mortality and health as a basic human right."

Mary Robinson, President, Realizing Rights, former President of Ireland and United Nations Commissioner for Human Rights[19]

New UN data show that between 1990 and 2008, 146 of 172 countries reduced their maternal mortality ratios, for a global decrease of 34% to 358,000 deaths a year. Some low and middle income countries have been able to make significant progress reducing maternal mortality by prioritizing the issue.[20] Yet despite progress, the overall decline is less than half of that needed to meet the United Nations Millennium Development Goal 5 target: reducing maternal mortality by 75% by 2015. According to UN analysis, only 10 countries are considered to be "on track" to meet MDG 5.[21] Of all the MDGs, MDG 5 is considered one of the least likely to be met.[22]

UNITED STATES UPDATE

OVERVIEW US MATERNAL MORTALITY

In *Deadly Delivery*, Amnesty International documented that women in the US face a range of obstacles in obtaining the services they need, and documented multiple failures in the health care system, including: discrimination; financial, bureaucratic and language barriers to care; lack of information about maternal care and family planning options; lack of active participation in care decisions; inadequate staffing and quality protocols; inadequate postpartum care; and a lack of accountability and oversight.

Previous UN reports showed that women in the US have a greater risk of dying of pregnancy related causes than in 40 other countries. In 2010, UN data showed that the United States had slipped from 41st to 50th, with a higher maternal mortality ratio than 49 other countries.[23]

Women in the US face a greater risk of maternal death than nearly all European countries, as well as Canada and several countries in Asia and the Middle East. Despite the 34% decrease in global maternal mortality between 1990 and 2008, with 147 countries experiencing a decline in maternal death rates, the US was among just 23 countries to see an increase in maternal mortality.[24]

MAGNITUDE AND COST OF MATERNAL HEALTH CARE

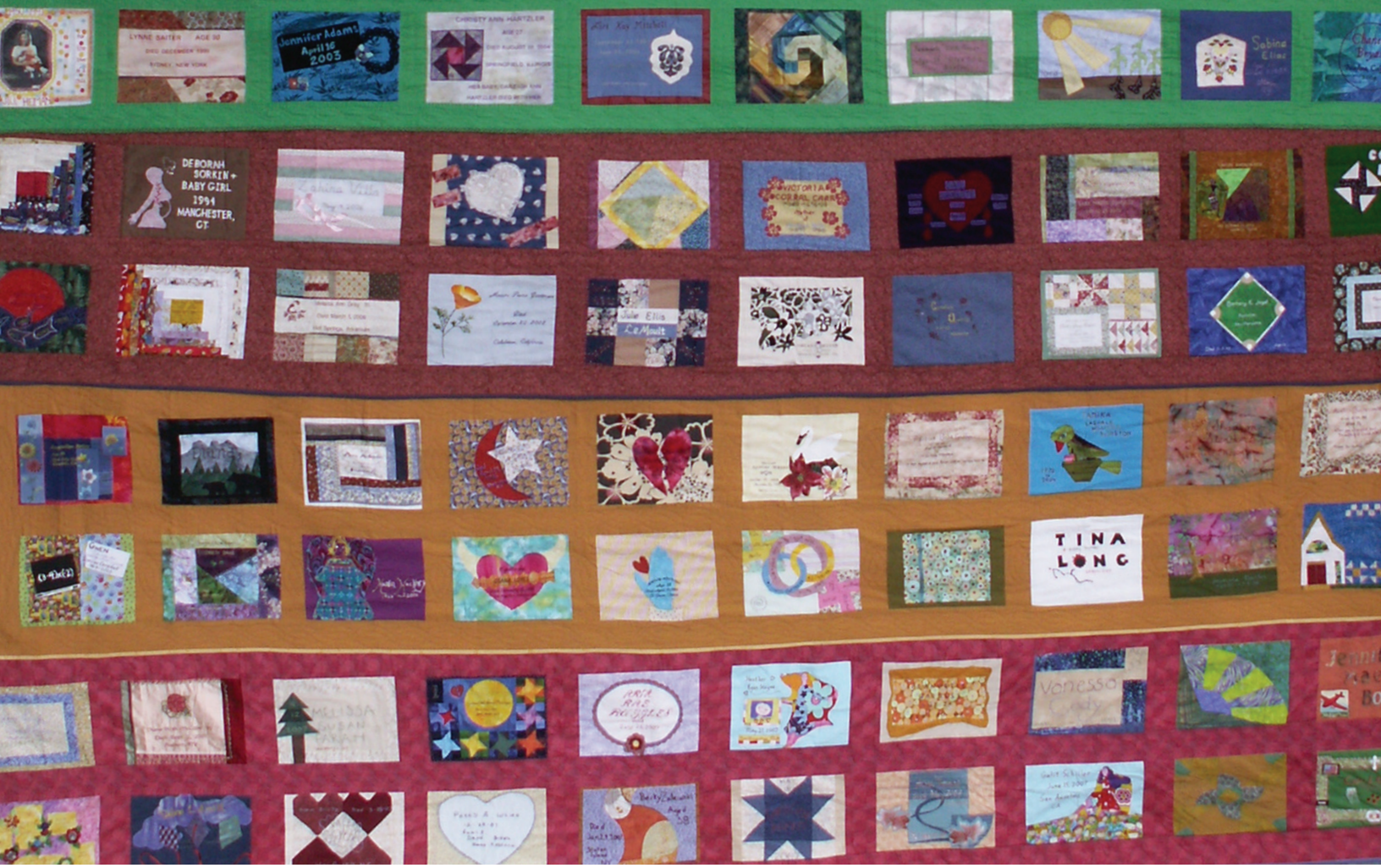
With over 4 million women giving birth each year in the US, at a total cost of $98 billion, childbirth and newborn care is by far the most common, and most expensive, reason for hospitalization.[25]

The International Federation of Health Plans data reported in 2010 shows that the US spends twice as much as any other country surveyed on the fees charged by maternal health care providers.[26]

Deadly Delivery found that cost was a significant barrier preventing women from

"While the decrease in the [global] maternal mortality ratio … is a victory, it is anything but a 'mission accomplished'. We are not off the hook … The US … still has a responsibility to prevent maternal death. No woman should die giving birth, in the US or abroad. We have the technology and medical knowledge to prevent it. It's just a question of making sure everyone has access to it, which is, irrefutably, a basic human right."

Serra Sippell, President of the Center for Health and Gender Equity[27]



Above: **The Safe Motherhood Quilt Project, a national initiative developed by midwife and author Ina May Gaskin to honor women who have died of pregnancy-related causes since 1982. *© Safe Motherhood Quilt Project***

"History will show that 2010 was a year of new, decisive action—a year when the world decided that no woman should die giving life and no child should die when we know how to save them."

Ban Ki-moon, UN Secretary-General[28]

accessing health care, with consequences including women entering pregnancy with untreated health conditions, facing delays receiving prenatal care and inadequate post-partum care. Having a baby is the most costly health event families are likely to encounter during their childbearing years. Prior to health care reform, approximately 13 million women of reproductive age had no health insurance. Uninsured women are less likely to be in good health when becoming pregnant, and if they have chronic health conditions, they are less likely to have obtained treatment, which increases their risks during pregnancy. Once becoming pregnant, women eligible for Medicaid (government funded health insurance for low income families) faced bureaucratic hurdles and delays obtaining Medicaid coverage, which resulted in delays obtaining prenatal care. In addition, many physicians do not accept payment by Medicaid because of low reimbursement rates, which has created a shortage of providers for women paying with Medicaid. The high cost of maternal care means that many women cannot afford to pay for care without insurance.

Approximately 99 percent of women give birth in hospitals where facility fees alone average between $8,900 and $11,400 for a vaginal delivery, and between $14,900 and $20,100 for a cesarean, depending on whether complications occur.[29] This does not include the health professional fee which was reported in *Deadly Delivery* to add an additional $4,350 to $6,000. Medicaid pays for over 40% of births in the US, and costs related to pregnancy and birth account for over one quarter of all hospital charges billed to Medicaid.[30]

"The release of Deadly Delivery *was a clarion call to action to reduce maternal death and improve maternal care in the US. It put a human face on our horrible statistics and struck an emotional chord among readers. It helped to mobilize us all!"*

Maureen Corry, Executive Director, Childbirth Connection, 14 February 2011

MATERNAL MORTALITY DATA

Deadly Delivery found that maternal mortality in the US had not decreased in over 20 years, and in fact, may be increasing.

The maternal mortality ratio[31] in the US continues to lag far behind the Healthy People 2010 goal, established by the US government, to reduce maternal mortality to 4.3 deaths per 100,000 live births. According to data released in 2010, the maternal mortality ratio was 12.7,[32] three times as high as the Healthy People goal.

Despite the Healthy People Goal of reducing maternal mortality to 4.3 deaths per 100,000 live births:

- **10 states had 18.5 or more maternal deaths per 100,000 live births.[33]**
- **Only 5 states met the Healthy People 2010 goal of 4.3 deaths per 100,000 live births.**
- **Maternal mortality ratios for American Indian/Alaska Native women and non-Hispanic black women were 4 and 8 times higher than the 2010 target, respectively.**
- **No racial or ethnic group met the Healthy People goal: The ratios for White women, Latinas, and Asian American/Pacific Islander women were all approximately 2 ½ times higher than the 2010 goal.[34]**

Between 2003 and 2007, the average maternal mortality has been 13 deaths per 100,000 live births, approximately double the low of 6.6 deaths per 100,000 live births recorded in 1987.[35] Although partly a result of improvements in data collection, this substantial increase remains a concern.[36]

In 2010, the Joint Commission (the primary health care facility accreditation organization) recognized "that maternal mortality rates may be increasing" and issued a Sentinel Event Alert on preventing maternal death, which recommended participation in state-level maternal mortality review processes and other actions to prevent maternal deaths.[37]

A report issued by the Centers for Disease Control and Prevention (CDC) in 2010 found that pregnancy-related deaths (deaths related to pregnancy or childbirth in the year following pregnancy or birth) had reached their highest level in a 20 year period.[38]

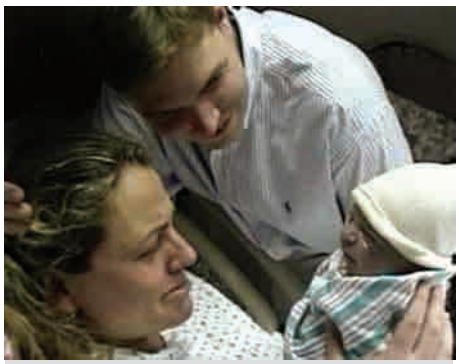


Photo:* Julie LeMoult holds her baby boy shortly before her death in April 2003. *© Private

JULIE LEMOULT died on 4 April 2003 after giving birth to a healthy baby boy – Logan Donnelly. She was given two epidurals during labor. After giving birth, she complained of an intense headache, but her family could not find anyone to help. When the headache worsened and she developed a fever, the obstetrician ordered an antibiotic over the telephone. Her husband says it was not administered. She started to have a seizure and was rushed to intensive care, where doctors discovered she had meningitis brought on by an infection—which led to massive brain damage. Faced with the prognosis that Julie would never recover from her coma, her husband chose to take her off life support. Her family filed a lawsuit against the hospital, charging that her death was the result of a "failure to maintain a sterile environment." The hospital now requires physicians (and anybody else in the room) to wear a mask while administering an epidural.

MATERNAL COMPLICATIONS ("MORBIDITY")

Deadly Delivery found that little data is available on maternal morbidity (complications), despite its frequency. "Near misses," complications so severe the woman nearly dies, have increased by over 25% between 1998 and 2005 to 34,000 a year – one woman every fifteen minutes. Over 1 million women a year experience some complication of pregnancy that has a negative effect on her health. Yet currently, researchers report that there is not enough data available to study how to reduce these complications. Systems to measure quality of care need to be put in place to ensure that more research can be done to reduce maternal complications.

"Maternal deaths are the tip of the iceberg for they are a signal that there are likely bigger problems beneath – some of which are preventable. It is important to consider the women who get very, very sick and do not die, because for every woman who dies, there are 50 who are very ill, suffering significant complications of pregnancy, labor and delivery."[39]

Dr. William M. Callaghan, Senior Scientist, Division of Reproductive Health, Centers for Disease Control and Prevention

Currently, nearly 30% of women experience complications related to childbirth, and this has not improved.[40] The Institute of Medicine, in a 2010 report requested by Congress, determined that maternal mortality and morbidity were among the conditions for which recent scientific research had achieved "little progress."[41] The Institute of Medicine concluded that future research in this area should address "the promotion of wellness and quality of life in women," and that research on conditions that have high morbidity should be increased."[42]

RACIAL AND ETHNIC DISPARITIES

New government data shows that for 2005-2007, the maternal mortality ratio (deaths per 100,000 live births) was highest among non-Hispanic black women (34.0), followed by American Indian/ Alaska Native women (16.9), Asian/Pacific Islanders (11.0), non-Hispanic whites (10.4), and Hispanics (9.6).[43]

Deadly Delivery found that women of color are more likely to die in pregnancy or childbirth than women from other sections of the population, reflecting disparities in access to health care and information, discrimination and inappropriate treatment, and socioeconomic disparities.

New analysis conducted by the US government's Maternal Child Health Bureau has confirmed and added to what is known about disparities based on income, race, ethnicity, and indigenous status.

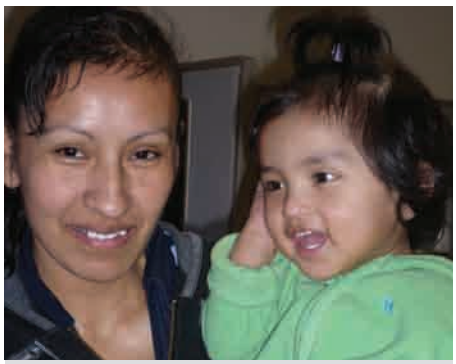


Photo: **Maria and her one-year-old daughter, 3 February 2009. *© Private***

MARIA (not her real name) did not have access to public assistance during any of her five pregnancies because of her immigration status and so was unable to afford prenatal care. In 2008, when she went into labor with her last baby, the hospital she went to turned her away because she had not received prenatal care. The second hospital she visited admitted her. After six hours waiting to be seen "I spoke to an interpreter via the phone because they wanted to check my insurance. I asked him 'Please, please send someone… please tell them the baby is coming.' Everyone spoke English. I was so afraid. At last a nurse came in and examined me". Maria gave birth to her daughter, but soon after she began to feel unwell. "I started crying out and screaming, 'I can't breathe!'… Then I [passed out]." Maria was discharged after three days, but no one ever explained what had happened. She did not receive any follow-up care or get any of the recommended medications: "I had no way to pay, so I never got any."

"Every effort should be made to ensure that the outcome of each and every labor and delivery in the United States is a healthy newborn-mother tandem … Determining the best ways to reduce maternal mortality and morbidity should have high priority in research."

Institute of Medicine, 2010[44]

The risk of maternal mortality has remained 3 to 4 times higher among black women than white women during the past 6 decades. Racial disparities were also seen in all income groups, with black women facing approximately three times higher maternal mortality risk compared to white women at low, middle, and high income levels.[45]

"I think the U.S. was shocked by what they read [in Amnesty International's report]."

Jill Sheffield, President of Women Deliver, a global advocacy organization calling for action against maternal death[46]

SOCIOECONOMIC DISPARITIES

In 2003-2007, women living in the lowest-income areas were twice as likely to suffer a maternal death, and women in the middle income areas faced a 58% higher risk, compared with women in the highest-income areas.[47]

States with high rates of poverty (18% or more of people living below the poverty level) were found to have 77% higher maternal mortality ratios than states in which fewer residents had incomes below the federal poverty level.[48]

Deadly Delivery found that low-income women faced barriers to accessing care beyond difficulty paying for care, including difficulty obtaining transportation, child care, and leave time from work, as well as shortages of health care providers and specialists in their area.

For the first time in 2010, government data has been analyzed to show clear evidence of socioeconomic disparities in maternal mortality, by linking maternal mortality statistics to census data on income level.[49] Higher poverty rates increased the risk of maternal mortality for both white and black women.[50]

GEOGRAPHIC DISPARITIES IN MATERNAL MORTALITY

State maternal mortality ratios varied from lows of 1.4 deaths per 100,000 live births for Maine, and 4.3 deaths per 100,000 live births for Indiana (lowest MMR for a larger state) yet reached as high as 26.0 for Michigan, and 41.6 for the District of Columbia.[51]

Deadly Delivery found that maternal mortality ratios vary considerably across the US, which may reflect the significant differences in health care access, funding,

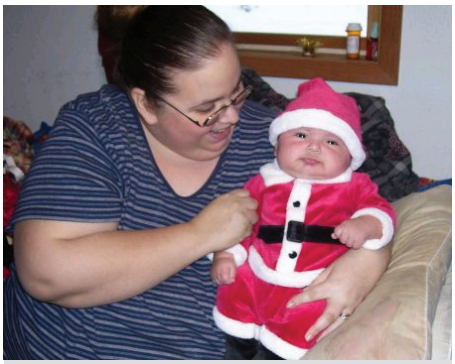


Photo: **Trudy LaGrew, a Native American woman, died in Wisconsin in January 2008, three months after giving birth, following severe complications.** ***© Joseph LaGrew***

TRUDY LAGREW, a Native American woman living on the Red Cliff reservation in Wisconsin, died on 7 January 2008 from an undiagnosed heart problem, months after giving birth to her second child. Although her pregnancy was considered high risk because of complications during her first pregnancy and obesity, Trudy LaGrew did not see an obstetrician or high risk specialist for prenatal care because the closest one was a two-hour drive away.

Photo: **Inamarie Stith-Rouse died in a Boston hospital in June 2003 after giving birth to her daughter. Warning signs of her decline were ignored. *© Private***

INAMARIE STITH-ROUSE, a 33-year-old African-American woman, delivered a healthy baby girl, Trinity, by c-section at a hospital in Massachusetts in June 2003. Her husband, Andre Rouse, said that after the birth she was distressed and struggling to breathe, but that staff dismissed their requests for help. Andre Rouse told Amnesty International he felt race played a part in the staff's failure to react.

According to court papers filed by her family, it was hours before appropriate tests and surgery were undertaken, and by then it was too late. Inamarie Stith-Rouse had suffered massive internal bleeding, and slipped into a coma. She died four days later. Andre Rouse said, "Her last words to me were, 'Andre, I'm afraid.'"

policies and staffing in different areas.

Seven states and Washington, D.C. had maternal mortality ratios at least 50% higher than the national average of approximately 13 deaths per 100,000 live births,[52] while eight states had maternal mortality ratios that were at least 50% lower than the average for the US,[53] demonstrating the magnitude of this variation.

INFORMATION AND QUALITY OF CARE

While cesarean births can be life-saving procedures when needed, in the US, *Deadly Delivery* reported that cesarean births carry greater risks of death and severe complications, compared with vaginal births. For example, cesareans have been shown to increase a woman's risk of infection, hysterectomy, and kidney failure, and have been associated with an increased risk of developing a life threatening blood clot (pulmonary embolism). Cesareans also result in greater risks for future pregnancies. US experts and institutions including the Institute of Medicine and the CDC agree current rates are too high. The US government's Healthy People 2010 initiative set a goal of reducing the c-section rate to 15 percent for low risk, first-time mothers. However, there is no nationally-implemented, evidence-based set of protocols or guidelines for the use of medical procedures in childbirth.[54]

New analysis shows that states with high cesarean rates (over 33%) were associated with a 21% higher maternal mortality risk.[55]

Deadly Delivery found significant variation from hospital to hospital and state to state in obstetric practice and the use of medical procedures across the country.

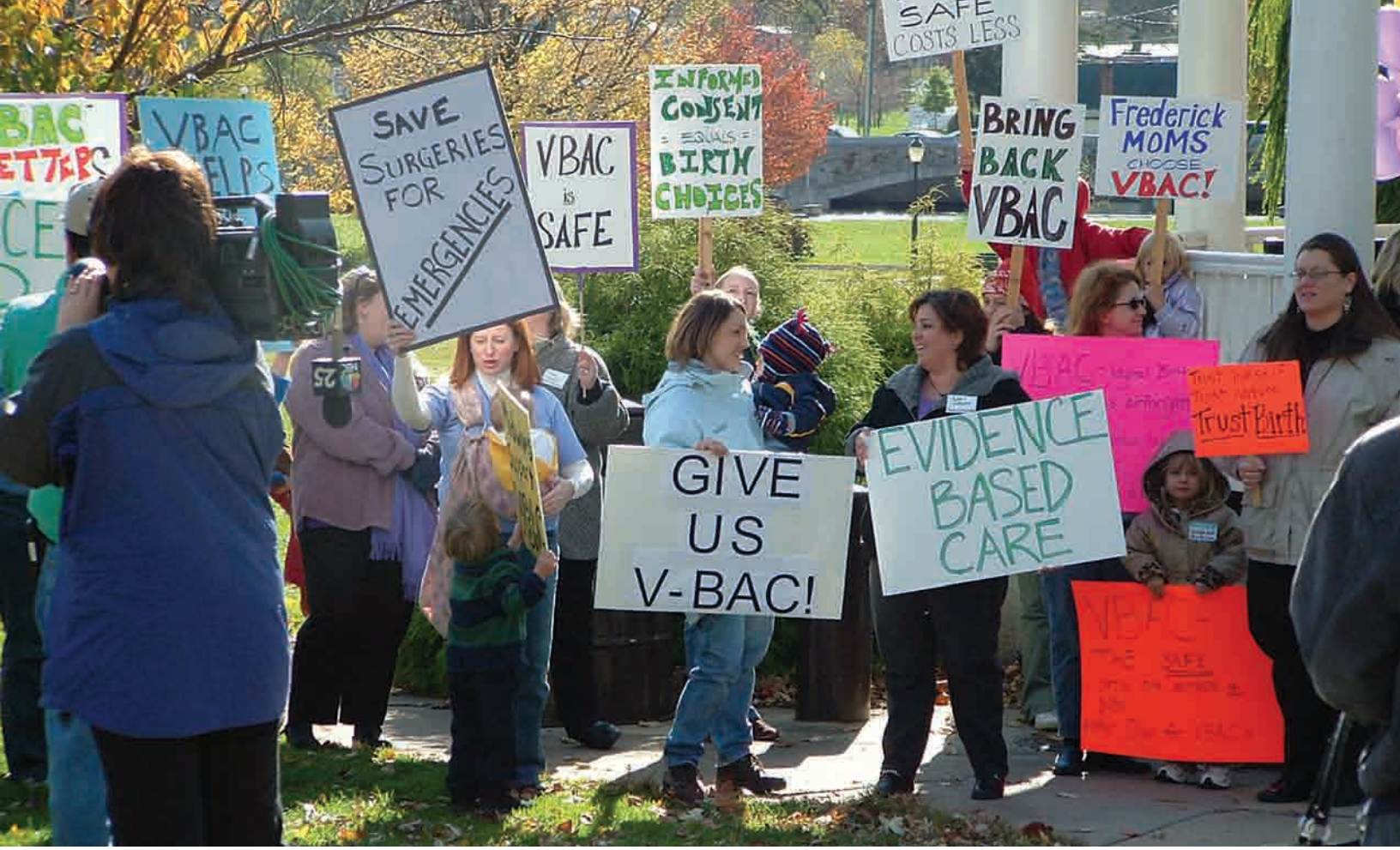
In December 2010, the Maternal Child Health Bureau reported that "The rising trend in cesarean rates may have … contributed to the apparent increase in maternal mortality during the past decade."[56] This new analysis supports the need for increased attention to the rising rates of cesarean section and induction of labor.[57]

Recent data shows that the cesarean rate rose for the 13th consecutive year to reach an all-time high of 32.9% in 2009.[58] The cesarean rate is now more than double the WHO recommended range of 5% to 15%.

The cesarean rate has increased every year since 1996, when it was 20.7% of all

"Blaming women for the rise in maternal mortality, e.g., they need to take better care of themselves, will not solve the current issues. Indeed, the bulk of the solutions that will have the greatest impact are those solutions that occur at the system-level beyond the control of the individual woman."

Debra Bingham, Former Executive Director of the California Maternal Quality Care Collaborative, 28 February 2010



births, for a total increase of nearly 60%. Cesareans remained the most common operating room procedure in the US and were performed on 1.4 million women in 2009.[59] The cesarean rate varied widely across states, from 22.8% in New Mexico to 39.6% in Louisiana, and 48.0% in Puerto Rico, in 2009.[60] On average, costs are higher for cesareans though they take much less time than a vaginal delivery, and recent studies have found that the rate of cesareans varies by type of facility and payer: for-profit hospitals in California had 17% higher cesarean rates than not-for profit hospitals, and the cesarean rates highest for private insurance at 34%, somewhat lower for Medicaid at 30%, and lowest for uninsured women at 25%, suggesting the need for research to investigate if payment structures influence care decisions.[61]

Among the factors contributing to increasing cesarean rates is the decline in VBACs (vaginal birth after cesarean). Significant barriers prevent many women from having access to clinicians and facilities that are able and willing to offer a VBAC. Among women who have had a cesarean in the past, the rate of VBAC was only 9.7% in 2006, a decrease of 73% from 1997 rates of 35.3%, and new data for 19 states suggests it may now be as low as 8%.[62] In March 2010, in response to the high cesarean rates and because multiple cesareans pose an added risk of complications, the National Institute of Health held a conference on VBAC, which found that "given the available evidence, [VBAC] is a reasonable option for many pregnant women," and that when it is a safe option, "whenever possible, the woman's preference should be honored." The panel recommended that facilities, providers, consumers, insurers and policymakers collaborate to reduce or eliminate current barriers to VBACs.[63]

Photo: **A rally in 2004 in Frederick, Maryland, calling for the reversal of a recent hospital decision to ban vaginal births after a prior c-section (VBAC). After 18 months of activism, the hospital changed its policy and permitted VBACs to be offered again.** ***© Amnesty International***

QUALITY INITIATIVES

*** Rates of labor induction and cesareans that are performed without any medical reason increased dramatically between 1990 and 2006, and have grown even faster than the rates of medically indicated inductions.[64] An estimated $1**

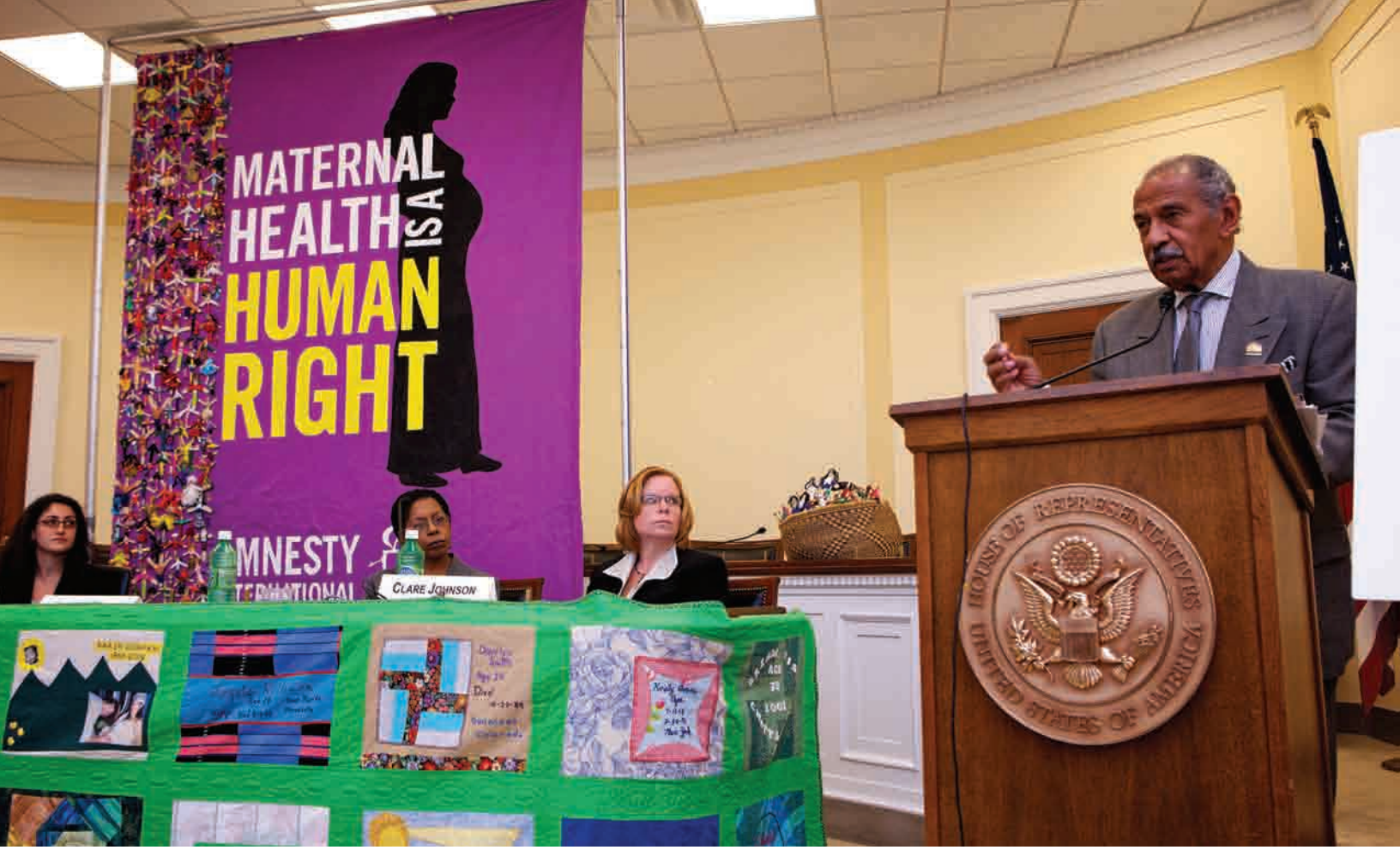


Photo: **Representative John Conyers (D-MI) (at podium) addresses a standing-room-only briefing on maternal health on Capitol Hill, May 6, 2010. L-R are Amnesty International researcher Nan Strauss, midwife Jennie Joseph, and maternal health advocate Clare Johnson.** ***© Shawn Duffy***

billion could be saved annually – mostly by reducing neonatal intensive care unit admissions – if early elective deliveries were reduced.[65]

Deadly Delivery found that there are no comprehensive, nationally implemented, evidence-based protocols for promoting safe and quality maternal care and for preventing, identifying and managing obstetric emergencies. The failure to establish and implement such standards can result in increased risk of error, preventable complications and deaths.

One area of quality improvement that could have a significant impact on maternal health is reducing the frequency of "early elective deliveries" (inductions and cesareans planned before 39 weeks of pregnancy, with no medical indication), because they result in unnecessary risks for mothers and babies. The prevalence of "early elective deliveries," despite evidence of their risks, has been a primary concern among quality of care advocates in 2010 and 2011. The American College of Obstetricians and Gynecologists (ACOG) guidelines have long indicated that elective early delivery is not acceptable medical practice.[66] Risks of elective deliveries between 37 and 38 weeks include, for the woman, a significantly greater risk of c-section and serious

"The release of the Leapfrog Group's survey data of US hospital rates of elective delivery before 39 weeks gestation, called out wide variation … among reporting hospitals. This is powerful information and critical to women's informed decision-making on where to give birth. Now let's demand the same data from all maternity care providers. That's when we'll see change."

Maureen Corry, Executive Director, Childbirth Connection, 14 February 2011

complications including anemia, infections, and sepsis; and for babies, a higher risk of death, respiratory problems, and admission to neonatal intensive care units. Elective deliveries also result in longer hospital stays and significantly higher costs (17.4%).[67] However, this practice remains common and may account for 10-15% of all births.[68] One survey found rates ranging from well under 5% to over 60% at some hospitals.[69] The frequency of "early elective deliveries," despite the evidence of their risks indicates a need for performance measures to better evaluate this practice and the implementation of protocols to ensure that all women have access to safe and effective care.

Deadly Delivery urged that all women should receive balanced information about the risks associated with medical interventions and procedures.

Many women do not have sufficient information regarding the risk of giving birth prior to 39 weeks of pregnancy. Several leading advocacy and quality improvement groups[70] are working to ensure that women receive appropriate information regarding risks and benefits of early deliveries, that hospitals and providers report their early delivery rates, and that this information is publicly available. Efforts are also underway to develop of strong policies to prevent elective early deliveries, which new studies have demonstrated to be effective at reducing rates of early deliveries to as low as 2%.[71]

ACCOUNTABILITY

"A pregnancy-related death is a sentinel event that demands investigation of the factors that lead to the tragic outcome… . [W]omen continue to die as a result of pregnancy, and these deaths are not random events. State-based maternal death reviews and maternal quality collaboratives have the potential to identify deaths, review the factors associated with them, and take action with the findings."

Cynthia Berg and William Callaghan, Centers for Disease Control and Prevention.[72]

Deadly Delivery found a lack of comprehensive and accurate data on maternal mortality, morbidity, and health care practices; a lack of coordinated oversight needed to improve the maternal care system and research; inadequate review of data; and a lack of concerted efforts to eliminate disparities. Some effective steps that can be taken to improve accountability include improving data collection by ensuring that all states use the CDC recommended death certificates and train personnel filling out those certificates to do so accurately; creating maternal mortality review boards in every state to identify patterns and trends in maternal deaths and to make recom-

WHAT MATERNAL MORTALITY REVIEW CAN ACCOMPLISH: ILLINOIS'S MATERNAL MORTALITY REVIEW COMMITTEE

Illinois is one of only a few states to routinely review maternal morbidity, as well as mortality. All Illinois birthing hospitals are required to report any obstetrics patient admitted to the ICU or who receives more than 3 units of blood. Quality Improvement standards for case review are in place in all birthing hospitals.

In 2010, Illinois's Maternal Mortality Review Committee (MMRC) completed their Statewide Obstetric Hemorrhage Education Program. Based on the cases they reviewed, the MMRC developed and implemented a comprehensive education program – including lecture, hands-on skills training to evaluate volume of blood loss, simulation and debriefing sessions – which was completed by over 35,000 physicians, midwives, and obstetric nurses between July 2008 and December 2009. The program was mandatory and reportedly very well received by participants and hospitals. A final hospital assessment in 2010 found that all Illinois birthing hospitals now have Rapid Response Teams (RRT) trained to respond to hemorrhage, and many hospitals have expanded the RRT to include all obstetric emergencies.

Preliminary data supports great improvement in the statewide response to hemorrhage and allows the MMRC to focus efforts on assessing preventability of near miss or severe morbidity, which can ultimately reduce the number of maternal deaths.[73]

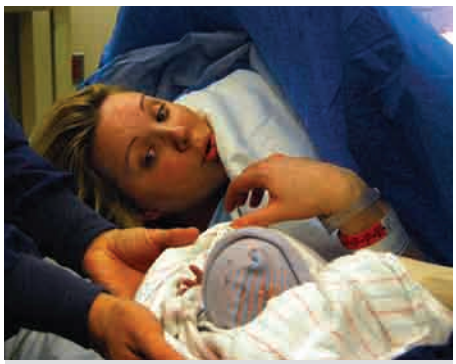


Photo: **Liz Logelin passed away soon after she gave birth to her baby daughter Madeline.** ***© Matthew Logelin***

LIZ LOGELIN died on 25 March 2008 as a result of a blood clot (pulmonary embolism). She had been placed on bed-rest for five weeks prior to giving birth to her baby girl, Madeline, via c-section. Staff told her that she needed to stay in bed for the following 24 hours. The next day her husband, Matthew Logelin, and a nurse came in to take her to see her baby daughter. As Liz went to sit in her wheelchair, she said, "I feel light-headed," and then passed out. Doctors and nurses rushed her to the bed, but it was too late. Matthew Logelin told Amnesty International that his wife was at heightened risk of pulmonary embolism because of her prolonged bed-rest and a genetic condition and that he does not know whether she was given medication or compression stockings to prevent blood clots from developing. He decided not to file suit against the hospital, and told Amnesty International, "What good would money be to me? Liz was already dead and there was nothing that could bring her back. I don't blame anyone for her death."

mendations to improve maternal health; and improving the federal government's coordination and prioritization of maternal health within the Department of Health and Human Services.

Efforts are ongoing at the state level to increase the number of states that use the standard birth and death certificates recommended by the CDC to enhance the ability to identify maternal deaths, and the number of states with effective maternal mortality review boards. However, funding shortages and implementation challenges continue to hamper progress. For example, new legislation was passed in Delaware in 2008, yet as of March 2011, the board has not yet begun to review deaths.[74] Although New York's Safe Motherhood Initiative was previously considered one of the leading maternal mortality review committees in the US, the governor eliminated its funding in the spring of 2010, effectively shutting it down. Currently, the state department of health is working to establish a new process to review maternal deaths, yet because it will collect and review more limited data in a less in-depth process, the changes have raised serious concerns regarding its effectiveness. This is of particular concern because, as reported in *Deadly Delivery*, the maternal mortality ratio in New York was the fourth highest in the US.

State and federal agencies should track, assess and publicly report on maternal mortality and morbidity trends. Data collection and analysis should be improved to better identify and respond to maternal health issues, including those contributing to maternal deaths and complications.

KEY LEGISLATIVE DEVELOPMENTS IN 2010

HEALTH CARE REFORM

On 23 March 2010, President Obama signed into law the Patient Protection and Affordable Care Act of 2010, the most sweeping health care reform to be enacted in the US in decades, which promises to substantially improve health coverage. A number of provisions begin to address barriers to obtaining quality health care documented in *Deadly Delivery*, though significant gaps and obstacles remain.[75] Moreover, these expected improvements are at risk of not ever being fully implemented due to legal, legislative, and financial challenges.

Even after steps taken by health care reform, more work must be done to ensure that all women have access to healthcare throughout their lives, that health disparities are addressed and eliminated, and that the government is accountable for ensuring specific improvements in the quality, safety, and effectiveness of maternal care for all women in the US. This will require prioritization and coordination of efforts specifically targeted to improve the quality of maternal health care and outcomes.

IMPACT OF 2010 HEALTH CARE REFORM ON MATERNAL HEALTH

FINDINGS FROM *DEADLY DELIVERY*[76]	IMPACT OF HEALTH CARE REFORM[77]	GAPS REMAINING AND NEXT STEPS
FINANCIAL BARRIERS TO CARE		
» An estimated 52 million people were uninsured in the US in 2009, including approximately 13 million women of reproductive age.	» The Congressional Budget Office has estimated that by 2019 approximately 32 million more people will be covered by health care insurance after full implementation of the reform.[78]	» Government estimates indicate that 23 million people will remain uninsured even after full implementation of health care reform.[79]
» Many women were uninsured prior to becoming pregnant. Uninsured women are: › more likely to enter into pregnancy with untreated chronic medical conditions that pose risks for them and their babies. › more likely to face bureaucratic hurdles and delays, resulting in delayed prenatal care.	» Medicaid eligibility will be expanded to all citizens and legal residents with incomes under 133% of the federal poverty level ($24,645 for a family of three in 2011). (§2001) As a result, 4.5 million more women are expected to become eligible for Medicaid, allowing them to address chronic health issues prior to pregnancy, and reducing delays in beginning prenatal care.[80] » States will establish private insurance exchanges, starting in 2014, and citizens and legal residents with income between 133% and 400% of the poverty level will be eligible for federal subsidies to make coverage more affordable.	» State governments should ensure that pregnant women who become eligible for Medicaid after becoming pregnant have temporary access to Medicaid while their permanent application is pending (presumptive eligibility). » Medicaid should be available for as long as needed during the post-partum period, and should not be terminated at 6 weeks, when women have ongoing health care needs. » Undocumented immigrants remain ineligible for Medicaid, and subsidized insurance programs ("insurance exchanges"). The US government should lift this restriction immediately.
INSURANCE GENDER-EQUITY		
» Women could be charged more than men for the same insurance coverage, a practice called "gender rating."	» "Gender rating" is prohibited.	
» Women could be excluded from obtaining insurance based on "pre-existing conditions," including pregnancy or a prior cesarean.	» Insurance companies cannot exclude people based on pre-existing conditions.	
» Some insurance plans (approximately 88% of individual insurance plans) did not include coverage for care related to pregnancy.	» Prenatal, maternity and newborn care, as well as primary care and preventive services, are among "essential benefits" that all insurance plans must cover.	

IMPACT OF 2010 HEALTH CARE REFORM ON MATERNAL HEALTH (CONTINUED)

FINDINGS FROM *DEADLY DELIVERY*	IMPACT OF HEALTH CARE REFORM	GAPS REMAINING AND NEXT STEPS
PROVIDER SHORTAGES		
» 64 million people were living in areas designated as health professional shortage areas. Federally qualified health centers (FQHCs) served only about 20 percent of areas with shortages.	» Doubles funding for Federally Qualified Health Centers (FQHCs) which operate in areas and communities with provider shortages. (§10503) The expansion of community health centers could mean that an additional 40 million people every year get affordable access to health care.[81]	» Even with the proposed increase to FQHC funding, community health centers are expected to only reach 1/3 of those living in areas with shortages of health care providers.[82] » Shortages of maternal health care providers should be addressed to ensure adequate numbers and a broader range of health care facilities and services are available in all areas, particularly in medically under-served areas.
» Women who want to explore the option of having a midwifery model of care face a number of barriers, including the refusal of insurance plans to reimburse for care by midwives.	» Makes midwives and birth centers more available, particularly in medically underserved communities by ensuring Medicaid reimbursement for services and facility fees, and increases Medicaid reimbursement rates (§2301).	» Private insurance should include payment for services that women may choose through qualified midwives or birth centers. » State governments should revise current legal restrictions on appropriately trained and qualified midwives. » Decisions by women to choose a midwife or a physician as her maternity care provider should be respected.
FAMILY PLANNING[83]		
» Women's need for publicly funded family planning services and supplies was not being met: › Half of all pregnancies in the US are unplanned. › An estimated 8 million women who needed publicly funded family planning were unable to access it. › Public funding for family planning is cost effective, saving as much as $4 of public funds on the cost of unintended births for every $1 spent on family planning.	» Greatly simplifies the process for a state to provide expanded access to family planning under Medicaid, creating the opportunity for states to save significant amounts of public funds.[84]	» Federal and state governments should ensure that all women in need of publicly funded family planning and reproductive health services can receive them, including by: › Removing cost sharing for these services › Expanding the Title X clinic program (a US government program to provide family planning services) to increase the percentage of women whose need for services is being met to 100%. » Legislation before Congress to eliminate all public funding for family planning clinics (Title X funding) should be opposed.

IMPACT OF 2010 HEALTH CARE REFORM ON MATERNAL HEALTH (CONTINUED)		
FINDINGS FROM *DEADLY DELIVERY*	IMPACT OF HEALTH CARE REFORM	GAPS REMAINING AND NEXT STEPS
		» essential preventive services that must be covered by all plans. Decision to be announced by the Institute of Medicine in August 2011.
DISPARITIES		
» Gender, race, ethnicity, immigration status, Indigenous status or income level can affect a woman's access to health care, the way she is treated by health care providers, and the quality of health care she receives, resulting in appalling health disparities.	» Elevates the Office of Minority Health to report directly to the Secretary of Health and Human Services; » Establishes National Institute on Minority Health and Health Disparities as part of the National Institute of Health. (§10334) » Seeks to reduce health disparities by improving and expanding the collection, analysis, and reporting of data by race, ethnicity, sex, primary language, disability, and rural residence to detect and monitor trends in health disparities (§4302) » Funds research on disparities (§6301)	» Egregious disparities in maternal mortality have persisted over the last 6 decades[85] and the elimination of these disparities should be a specific priority. » The Office of Civil Rights in the Department of Health and Human Services should undertake investigations to assess where laws, policies, and practices are obstacles to equal access to quality health care, including maternal health care.
» Native American and Alaska Native women face particular barriers to care, and were 3.6 times as likely as white women to receive late or no prenatal care. » The Indian Health Service (IHS) has suffered from severe, long-term underfunding and lack resources and staff.	» Cost sharing has been removed for Native Americans and Alaska Natives with an income under 300% of the federal poverty level for coverage provided through an insurance exchange or through Indian Health Services.	» Congress should rectify the chronic budgetary shortfalls affecting women receiving care through IHS, and insure that public funding levels do not discriminate on the basis of race or indigenous status. Indian Health Service funding should be made more secure to eliminate annual fluctuation by making its funding parallel to that of Medicaid.

IMPACT OF 2010 HEALTH CARE REFORM ON MATERNAL HEALTH (CONTINUED)

FINDINGS FROM *DEADLY DELIVERY*	IMPACT OF HEALTH CARE REFORM	GAPS REMAINING AND NEXT STEPS
CULTURAL COMPETENCY AND DIVERSITY		
» Women of color reported inappropriate behavior and care in a variety of health care settings. » *Deadly Delivery* recommended increasing the linguistic and cultural diversity of staff and leadership that reflect the demographic characteristics of the area they service, as one way of reducing discriminatory attitudes that prevent or discourage women from accessing health care.	» Seeks to improve workforce diversity, training, and support (§§5404, 5507) » Supports increasing cultural competence, including developing model training programs and curricula and researching effective programs. (§5307)	» Training in culturally appropriate and gender sensitive provision of services and treatment should be incorporated into the basic training curriculum of all health care professionals, as well as in their continuing education and licensing requirements. » The government should ensure greater compliance with Culturally and Linguistically Appropriate Services (CLAS), developed by the Office of Minority Health.
LANGUAGE BARRIERS		
» Language barriers compromise access to maternal health care services for women with limited English, affect the quality of care they receive, and may be compounded by discriminatory attitudes.	» Promotes language services and community outreach within health exchanges	» Federal and state governments should enforce requirements that all women receive adequate interpretation and translation services when seeking and receiving medical care. » Public and private insurance should be required to adequately reimburse for translation and interpreter services.
QUALITY CARE IMPROVEMENT INTIATIVES		
» The lack of implementation of evidence-based guidelines and protocols for promoting effective, safe, quality care leads to significant unwarranted variation in obstetric practice and quality of care.	» Promotes evidence-based care and effective care generally (though not specifically maternal care): › Establishes of a national health care quality strategy, an Inter-agency Working Group on Health Care Quality and a process to support the development of health care quality measures. (§§3011, 3012, 3013, 3014). › Promotes evidence-based community preventive health activities (§§4201, 4301)	» General quality improvement initiatives must be expanded to maternity care, the most common and most costly type of hospital care. » The Department of Health and Human Services should work in collaboration with a variety of stakeholders to expand the development, dissemination, and implementation of evidence based guidelines and protocols to address the most common causes of maternal deaths and complications, and the appropriate use of medical procedures such as c-sections.

IMPACT OF 2010 HEALTH CARE REFORM ON MATERNAL HEALTH (CONTINUED)		
FINDINGS FROM *DEADLY DELIVERY*	IMPACT OF HEALTH CARE REFORM	GAPS REMAINING AND NEXT STEPS
		» Providers should ensure all women receive balanced, comprehensive information about risks and benefits of potential medical procedures so they can make informed decisions.
» Women do not always receive comprehensive care that includes nutrition and smoking counseling due to limited time and payments for prenatal visits.	» Ensures coverage without copayment for evidence-based preventive measures including smoking cessation counseling and treatment during pregnancy (§§2713, 4107)	» More should be done to expand access to alternative and potentially more cost effective models of care for low-risk pregnancies that could help improve the availability, accessibility, acceptability, and quality of maternal care.
POSTPARTUM CARE		
» Home visits following pregnancy are not a routine component of postpartum care, despite the fact that they could significantly improve access to healthcare and could improve prevention and treatment of postpartum complications.	» Expands maternal, infant, and early childhood home visiting programs for high-risk communities (§2952)	» Home visits should be a routine part of postpartum care for all women, not only those considered to be at-risk, and should be included in public and private insurance coverage.
» Limited postpartum care often fails to meet women's needs, including by not following recommendations to screen for postpartum depression, which affects 10-25% of women	» Includes funds for post-partum depression research and treatment (§2952)	» The payment scheme to compensate providers for postpartum care and the time allotted for postpartum visits should be adequate to encourage screening for postpartum health issues, including depression, as well as appropriate referrals and treatment
ACCOUNTABILITY		
» The failure to meet targets for improving maternal health in the US, is linked to a fundamental breakdown in accountability, including an increased need for coordinated oversight; more accurate and comprehensive data collection and review; and improved attention to disparities.	» Improves and expands the collection, analysis, and reporting of data to detect and monitor trends in health disparities including for federal research agencies, Medicaid and CHIP, and other federally supported programs (§4302) » Enhance collection and reporting of health care data by race, ethnicity, sex, primary language, disability, and rural residence. (§4302)	» Maternal care should be prioritized and efforts must be coordinated in order to reduce preventable maternal mortality and complications in the US, including by: › establishing an office of maternal health with a mandate to improve maternal health care, outcomes, and disparities;

IMPACT OF 2010 HEALTH CARE REFORM ON MATERNAL HEALTH (CONTINUED)		
FINDINGS FROM *DEADLY DELIVERY*	IMPACT OF HEALTH CARE REFORM	GAPS REMAINING AND NEXT STEPS
	» Assists with health information technologies and electronic medical records that can improve care coordination (§1561)	› improving data collection and analysis of maternal deaths and complications at state and federal levels, including requiring reporting of maternal deaths; › improving data collection and research on maternal complications; and › establishing maternal mortality review processes in all states.

HEALTH CARE PROGRAMS AT RISK

Various challenges put expanded access and other improvements promised by health care reform at risk of not being implemented. Legal challenges to the health care reform act are ongoing, and are likely to be decided ultimately by the US Supreme Court. Legislation has been introduced by Congress in 2011 to repeal health care reform, and although it is considered unlikely to pass, it reflects efforts to limit the effectiveness of health care reform. Proposed deep budget cuts would also render many provisions of health care reform meaningless by eliminating or drastically cutting their funding. Funding for existing health care programs as well as planned expansions are also currently facing the threat of significant funding cuts, and include eliminating all funding for publicly funded family planning clinics, and significantly reducing funding for community health centers, maternal child health grants made to the states, and the CDC. The proposed funding cuts could have a devastating impact on maternal health.

As efforts to reform the US health care system are developed and implemented, it will be imperative that human rights standards are applied, so that all have equal access to affordable, quality health care, including maternal health care, and so that backsliding is avoided.

"We greatly appreciate Amnesty International's efforts to raise awareness and suggest solutions to the important issue of maternal mortality. Our international ranking . . . on this vital measure is a tragic illustration of why we need rapid and sustained improvement. . . . We hope that this heightened awareness will help both the public and policymakers to support appropriate investments and policy change."

Dr. Michael Fraser, CEO, Association of Maternal and Child Health Programs [86]

FEDERAL MATERNAL HEALTH LEGISLATION

Amnesty International has seen significant steps taken by elected officials since the release of *Deadly Delivery* in March 2010 to improve maternal health in the US. Several pieces of federal legislation have been introduced in Congress to address US maternal mortality and maternal health, each of which reflect key recommendations made in *Deadly Delivery*: increasing government accountability for improving maternal health; addressing maternal health disparities; improving the workforce by addressing provider shortages, diversity, and training; and establishing performance measures and payment reform provisions that would focus on improving the quality of maternal care. Key provisions of each bill, matched against the findings of *Deadly Delivery*, are listed below.

MATERNAL HEALTH LEGISLATION INTRODUCED IN 2011

One bill, the Maternal Health Accountability Act of 2011, has been introduced in 2011, in the 112th Congress.

REPRESENTATIVE JOHN CONYERS (D-MI)
THE MATERNAL HEALTH ACCOUNTABILITY ACT OF 2011, HR 894
INTRODUCED 3 MARCH 2011

DEADLY DELIVERY FOUND:	THE MATERNAL HEALTH ACCOUNTABILITY ACT WOULD:
» Accountability for maternal health outcomes was lacking at the federal and state level.	» Help establish a maternal mortality review board in every state.
» Huge disparities in maternal health outcomes—with African-American women being nearly four times as likely to die, and women living in poverty, immigrant and indigenous women also facing particular barriers to care.	» Fight disparities with new research and pilot programs.
» Deaths are only the tip of the iceberg of the U.S. maternal health crisis, with one woman suffering a "near miss" (nearly dying from pregnancy-related complications) every 15 minutes, or 34,000 women a year.	» Develop definitions of severe maternal morbidity (complications) to improve data collection and maternal health research.

"Improving maternal health care should be a key priority for our federal and local governments. . . . Women cannot afford for this matter to be neglected any longer. . . [W]ithout a uniform state-level data collection, it is extremely difficult to investigate causes of maternal deaths and develop cost-effective interventions to prevent these tragedies."

Representative John Conyers (D-MI)[87]

MATERNAL HEALTH LEGISLATION INTRODUCED 2010

Three bills were introduced in 2010, in the 111th Congress and must now be reintroduced in the new 112th Congress in 2011 in order to move forward.

REPRESENTATIVE LUCILLE ROYBAL-ALLARD (D-CA)
THE MAXIMIZING OPTIMAL MATERNITY SERVICES (MOMS) FOR THE 21ST CENTURY ACT OF 2010, HR 5807
INTRODUCED 21 JULY 2010

The MOMS for the 21st Century Act creates a coordinated national focus on evidence-based maternity care practices to help achieve the best possible maternity outcomes for women and babies.

DEADLY DELIVERY FOUND:	THE MOMS FOR THE 21ST CENTURY ACT WOULD:
» Significant variation in obstetric practice across the US and a lack of implementation of evidence-based protocols promoting safe quality maternal care.	» Expand federal research on best maternity care practices;
» Women did not receive adequate information about risks and benefits associated with medical interventions and procedures, about care options, or about warning signs to recognize complications.	» Authorize a public awareness media campaign to educate the public about the best proven maternity care practices;
» Shortages of maternal care providers and nurses, particularly in rural and inner-city areas.	» Pinpoint areas with shortages of maternity care providers and create incentives for providers to fill those gaps; and;
» That health care providers should recruit and promote linguistically and culturally diverse staff and leadership that reflect the demographic characteristics of the area they service.	» Improve the maternity care workforce by developing interdisciplinary core curriculum for training and increasing workforce diversity.

"Tragically, in spite of all the money we spend, the United States continues to rank far behind nearly all developed countries in perinatal outcomes, with childbirth continuing to present significant risks for mothers and babies, particularly in communities of color. The MOMS for the 21st Century Act, which I introduced, addresses these disparities in our nation's maternity health care system by making key reforms to improve the health and well-being of mothers and their babies in our country while bringing down maternity care costs … The fact is we have a maternity care system in the United States that has not traditionally adhered to evidence-based practices."

Representative Lucille Roybal-Allard (D-CA)[88]

REPRESENTATIVES ELIOT ENGEL (D-NY) AND SUE MYRICK (R-NC)
THE PARTNERING TO IMPROVE MATERNITY CARE QUALITY ACT OF 2010, HR 6437
INTRODUCED 18 NOVEMBER 2010

The Partnering to Improve Maternity Care Quality Act would improve the quality of maternal care services, improve health outcomes for women and children, and ensure better value and efficiency for patients and health providers.

DEADLY DELIVERY FOUND:	THE PARTNERING TO IMPROVE MATERNITY CARE QUALITY ACT WOULD:
» A need for increased data collection on performance and quality measures for maternal care, in order to reduce high rates of complications and deaths.	» Ensure development of national, evidence-based quality measures for maternity care in Medicaid, as well as a process to collect this data;
» Violations of key principles of autonomy and informed decision-making, including the failure to be provided with adequate information, a lack of opportunity to participate in care decisions, being treated inappropriately, and a lack of care options.	» Create and implement a national patient survey of women to assess their experience of maternal care;
» Payment structures may influence care decisions in ways that do not maximize women's health, including by discouraging transfers to high risk facilities and incentivizing medical procedures.	» Establish a demonstration project to develop effective alternative payment models aimed at simultaneously improving health outcomes and reducing costs; and
» Beneficial, comprehensive care services were often not available, including counseling on nutrition, domestic violence, mental health, and stopping smoking.	» Authorize an Institute of Medicine report to identify a package of essential evidence-based services for childbearing women and newborns.

"Every single person alive has been affected in one way or another by maternity care… Maternity care has significant health care consequences—in both the short and long term—for the more than 80 percent of women who give birth."

Rep. Eliot Engel (D-NY)[89]

"Responsible maternity care can prevent childbirth-related health problems for mothers. Evidence-based reforms to the maternity care payment process could save healthcare dollars and improve quality of care."

Representative Sue Myrick (R-NC)[90]

REPRESENTATIVE LOIS CAPPS (D-CA)
THE MATERNITY CARE IMPROVEMENT ACT OF 2010, HR 6318
INTRODUCED 28 SEPTEMBER 2010

On 28 September 2010, Capps introduced the Maternity Care Improvement Act which would take the following steps to improve US maternal health:

DEADLY DELIVERY FOUND:	THE MATERNITY CARE IMPROVEMENT ACT WOULD:
» Fragmented oversight of health care financing and delivery leading to a lack of coordination of efforts to improve maternal care and outcomes.	» Increase government accountability and coordination of efforts related to maternal health by designating a national coordinator of programs related to maternal health;
» A lack of comprehensive data collection, a lack of standardization of data, and inadequate data on complications.	» Create a national registry of maternal and infant health data, and ensure that data is collected in a way that is standardized and disaggregated by race;
» Significant need to increase evidence-based care practices; inadequate programs to foster cultural competence; and a lack of collaborative care.	» Improve the maternity care workforce by enhancing education and training for nurses, creating an interdisciplinary maternity care core curriculum to promote best practices in evidence based, woman-centered, culturally competent, collaborative care, that will prevent complications and reduce disparities;
» That health care providers should recruit and promote linguistically and culturally diverse staff and leadership that reflect the demographic characteristics of the area they service.	» Improve the diversity of the maternity care workforce by awarding grants to increase recruitment of underrepresented minorities into the maternity care workforce.

Earlier in 2010, Rep. Capps introduced the "Improvements in Global Maternal and newborn health Outcomes while Maximizing Successes Act" or "The Global MOMS Act," which would strengthen U.S. global maternal health efforts by creating a comprehensive strategy to combat maternal mortality, authorizing new assistance, and better aligning existing programs.

"… there is also work to be done here at home. The United States ranks well below other industrialized nations in maternal mortality rates despite the incredible advances made in our overall medical care. … as a nation, we still have work to do to improve data collection, encourage wider adoption of best practices and train additional providers in reproductive and obstetric care."

Rep. Lois Capps (D-CA)[91]

STATE LEVEL DEVELOPMENTS

Deadly Delivery documented the substantial variation among the states regarding both maternal health outcomes and the ways the health care systems operate in different states. Efforts to ensure that all women have access to good quality care must include a focus on state legislation and policy in addition to the federal level. While state level advocacy has been ongoing in a number of states, including the introduction of bills in several states to establish maternal mortality reviews or to improve data collection efforts, following are two examples of successful advocacy efforts that promise to improve maternal health at the state level.

TEXAS

Texas Representative Armando Walle Introduced *An Act Relating to the Creation of a Review Board to Study Maternal Mortality and Severe Maternal Morbidity, Texas HB 1133*, 3 February 2011

Texas has approximately 400,000 births every year. Yet among the five states with the largest population and highest number of births each year, Texas is the only state to lack a maternal mortality review board. The maternal mortality rate in Texas currently exceeds the national average. Legislation introduced by Rep. Walle calls for the creation of a maternal mortality and morbidity task force to study and make recommendations to reduce maternal mortality and severe maternal complications. The maternal mortality task force would identify trends and implement quality improvements that could significantly improve Texas maternal care among diverse segments of the population to ensure that all women's needs are being met.

NEW YORK

Midwifery Modernization Act, A8117B// S5007A, Signed into law 30 July 2010

New York's maternal mortality ratio is the 4th highest in the US, and many parts of the state, both rural and urban face shortages of health care providers, including obstetric providers. New legislation, New York's Midwifery Modernization Act, will improve access to quality maternal care, particularly for women in medically underserved areas, by allowing licensed midwives to practice to the full extent of their training. The new legislation, which passed the New York State Senate unanimously, eliminated a technical requirement that limited the ability of fully licensed midwives to practice in many parts of New York State, including in areas with provider shortages.

CONCLUSION

Amnesty International has documented a number of positive developments in 2010 and early 2011 which suggest that with concerted effort, progress can be made in reducing maternal mortality, improving maternal health, improving access to care, and eliminating health disparities. Yet more work remains to be done on all of these fronts before all women will have equal access to good quality health care throughout their lives and around pregnancy and childbirth. The recommendations and campaign goals identified in *Deadly Delivery* remain relevant, and signal the need for additional legislation and policy changes to ensure women's right to a safe and healthy pregnancy and birth in the US.

KEY RECOMMENDATIONS

1. The US government should ensure that health care services, including sexual and reproductive health care services, are available, accessible, acceptable and of good quality throughout an individual's lifetime.

2. The US government should ensure that all women have equal access to timely and quality maternal health care services, including family planning services, and that no one is denied access to health care services by policies or practices that have the purpose or effect of discriminating on grounds such as gender, race, ethnicity, age, Indigenous status, immigration status or ability to pay.

3. The Office of Civil Rights, within the Department of Health and Human Services, should undertake investigations into laws, policies and practices that may impact on equal access to quality health care services, including maternal health care services.

4. State governments should ensure that pregnant women have temporary access to Medicaid while their permanent application for coverage is pending (presumptive eligibility) and that Medicaid provides timely access to prenatal care. In cases where a woman receives prenatal care before eligibility is confirmed, states should ensure that Medicaid reimburses retroactively for services provided.

5. Federal, state and local governments should ensure that an adequate number of health service facilities and health professionals, including, nurses, midwives, and physicians, are available in all areas. Particular emphasis should be given to medically underserved areas, including by expanding community health care center programs, such as the Federally Qualified Health Center (FQHC) program.

6. The Department of Health and Human Services should, in collaboration with affected communities and the medical community, develop and implement comprehensive, standardized, evidence-based guidelines and protocols for maternal health care services.

7. Health care providers should ensure that sufficient, accessible information is available to all women so that they can make informed decisions about their health care.

8. The US Congress should direct and fund the Department of Health and Human Services to establish an Office of Maternal Health with a mandate to improve maternal health care and outcomes and eliminate disparities.

9. Washington DC and each of the 29 states that do not currently have a maternal mortality review committee should establish one. Committees should receive ongoing funding to collect, analyze and review data on all pregnancy-related deaths and address disparities. Efforts at state level should be coordinated nationally by the CDC in order to identify and implement best practice.

10. State and federal authorities should devise and implement programs to improve data collection and analysis in order to better identify and develop responses to issues contributing to maternal deaths and complications. This may include requiring all states to report maternal deaths and morbidity to federal agencies, including the CDC, on an annual basis and standardizing data collection tools.

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