DEADLY DELIVERY

THE MATERNAL HEALTH CARE CRISIS IN THE USA

ONE YEAR UPDATE
SPRING 2011
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
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

50 YEARS
AMNESTY INTERNATIONAL
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.

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.

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.

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.

Women living in low-income areas across the US were twice as likely to suffer a maternal death as women in high income areas.

The US cesarean rate rose for the 13th consecutive year to reach an all-time high of 32.9% in 2009, more than double the WHO recommended range of 5% to 15%.

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%.

“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
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.¹

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.

“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.

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

HIGH LEVEL GLOBAL EVENTS IN 2010 SIGNALLED 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. 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.

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, 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. Statistics released in 2010 demonstrate that when governments invest in improving maternal health, women’s lives can be saved. 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.\textsuperscript{17} The vast majority of maternal deaths occur in developing countries, and the vast majority are preventable.\textsuperscript{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\textsuperscript{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.\textsuperscript{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.\textsuperscript{21} Of all the MDGs, MDG 5 is considered one of the least likely to be met.\textsuperscript{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.\textsuperscript{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.\textsuperscript{24}

**Magnitude and Cost of Maternal Health Care**

\begin{itemize}
  \item 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.\textsuperscript{25}
  \item 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.\textsuperscript{26}
\end{itemize}

*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\textsuperscript{27}
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. 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.

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.

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“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

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
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\textsuperscript{11} 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,\textsuperscript{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:

\begin{itemize}
\item 10 states had 18.5 or more maternal deaths per 100,000 live births.\textsuperscript{33}
\item Only 5 states met the Healthy People 2010 goal of 4.3 deaths per 100,000 live births.
\item 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.
\item 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.\textsuperscript{34}
\end{itemize}

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.\textsuperscript{35} Although partly a result of improvements in data collection, this substantial increase remains a concern.\textsuperscript{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.\textsuperscript{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.\textsuperscript{38}
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.

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.
“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

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

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

States 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,
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.

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

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.” This new analysis supports the need for increased attention to the rising rates of cesarean section and induction of labor.

Recent data shows that the cesarean rate rose for the 13th consecutive year to reach an all-time high of 32.9% in 2009. 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 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, while eight states had maternal mortality ratios that were at least 50% lower than the average for the US. demonstrat[53]ing the magnitude of this variation.

“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

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.’”

“The rising trend in cesarean rates may have contributed to the apparent increase in maternal mortality during the past decade.”

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MATERNAL HEALTH IS A HUMAN RIGHT
Amnesty International Spring 2011
and policymakers collaborate to reduce or eliminate current barriers to VBACs.63

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
“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 groups70 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.22

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’ 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.23
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 UKIPKƂECPVICRUCPFQDUVCENGUTGOCKP75 Moreover, these expected improvements are at risk of not ever being fully implemented due to legal, legislative, and financial challenges.

Efforts are ongoing at the state level to increase the number of states that use 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. 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.

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.”
## IMPACT OF 2010 HEALTH CARE REFORM ON MATERNAL HEALTH

### FINANCIAL BARRIERS TO CARE

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<tr>
<th>FINDINGS FROM DEADLY DELIVERY</th>
<th>IMPACT OF HEALTH CARE REFORM</th>
<th>GAPS REMAINING AND NEXT STEPS</th>
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<tr>
<td>» An estimated 52 million people were uninsured in the US in 2009, including approximately 13 million women of reproductive age.</td>
<td>» 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.</td>
<td>» Government estimates indicate that 23 million people will remain uninsured even after full implementation of health care reform.</td>
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<td>» Many women were uninsured prior to becoming pregnant. Uninsured women are:</td>
<td>» 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.</td>
<td>» 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).</td>
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<td>› more likely to enter into pregnancy with untreated chronic medical conditions that pose risks for them and their babies.</td>
<td>› 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.</td>
<td>› 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.</td>
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<td>› more likely to face bureaucratic hurdles and delays, resulting in delayed prenatal care.</td>
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<td>› Undocumented immigrants remain ineligible for Medicaid, and subsidized insurance programs (“insurance exchanges”). The US government should lift this restriction immediately.</td>
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### INSURANCE GENDER-EQUITY

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<td>» Women could be charged more than men for the same insurance coverage, a practice called “gender rating.”</td>
<td>» “Gender rating” is prohibited.</td>
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<td>» Women could be excluded from obtaining insurance based on “pre-existing conditions,” including pregnancy or a prior cesarean.</td>
<td>» Insurance companies cannot exclude people based on pre-existing conditions.</td>
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<td>» Some insurance plans (approximately 88% of individual insurance plans) did not include coverage for care related to pregnancy.</td>
<td>» Prenatal, maternity and newborn care, as well as primary care and preventive services, are among “essential benefits” that all insurance plans must cover.</td>
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## IMPACT OF 2010 HEALTH CARE REFORM ON MATERNAL HEALTH (CONTINUED)

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<td><strong>PROVIDER SHORTAGES</strong></td>
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<td>» 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.</td>
<td>» 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. (^{a1})</td>
<td>» 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. (^{a2})</td>
</tr>
<tr>
<td>» 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.</td>
<td>» 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).</td>
<td>» Private insurance should include payment for services that women may choose through qualified midwives or birth centers.</td>
</tr>
</tbody>
</table>
| » 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. \(^{a4}\) | » 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%. |
| » Women’s need for publicly funded family planning services and supplies was not being met:  
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  › 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%. |
| FAMILY PLANNING \(^{a3}\) | | » 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)

<table>
<thead>
<tr>
<th>FINDINGS FROM DEADLY DELIVERY</th>
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<th>GAPS REMAINING AND NEXT STEPS</th>
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<td></td>
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<td>» essential preventive services that must be covered by all plans. Decision to be announced by the Institute of Medicine in August 2011.</td>
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</table>

### 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 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.
<table>
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<tr>
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<tr>
<td>CULTURAL COMPETENCY AND DIVERSITY</td>
<td>» 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.</td>
<td>» 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)</td>
</tr>
<tr>
<td>LANGUAGE BARRIERS</td>
<td>» 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.</td>
<td>» Promotes language services and community outreach within health exchanges</td>
</tr>
<tr>
<td>QUALITY CARE IMPROVEMENT INITIATIVES</td>
<td>» 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.</td>
<td>» 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)</td>
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<td>» Women do not always receive comprehensive care that includes nutrition and smoking counseling due to limited time and payments for prenatal visits.</td>
<td>» Ensures coverage without copayment for evidence-based preventive measures including smoking cessation counseling and treatment during pregnancy (§§2713, 4107)</td>
<td>» 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.</td>
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<td>POSTPARTUM CARE</td>
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<td>» 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.</td>
<td>» Expands maternal, infant, and early childhood home visiting programs for high-risk communities (§2952)</td>
<td>» 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.</td>
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<td>» 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</td>
<td>» Includes funds for post-partum depression research and treatment (§2952)</td>
<td>» 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</td>
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<td>ACCOUNTABILITY</td>
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<tr>
<td>» 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.</td>
<td>» 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)</td>
<td>» Maternal care should be prioritized and efforts must be coordinated in order to reduce preventable maternal mortality and complications in the US, including by:</td>
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<tr>
<td></td>
<td>» Enhance collection and reporting of health care data by race, ethnicity, sex, primary language, disability, and rural residence. (§4302)</td>
<td>› establishing an office of maternal health with a mandate to improve maternal health care, outcomes, and disparities;</td>
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**IMPACT OF 2010 HEALTH CARE REFORM ON MATERNAL HEALTH (CONTINUED)**
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<tr>
<td>» Assists with health information technologies and electronic medical records that can improve care coordination ($1561)</td>
<td>» 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.</td>
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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.

<table>
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<tr>
<th>DEADLY DELIVERY FOUND:</th>
<th>THE MATERNAL HEALTH ACCOUNTABILITY ACT WOULD:</th>
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<td>» Accountability for maternal health outcomes was lacking at the federal and state level.</td>
<td>» Help establish a maternal mortality review board in every state.</td>
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<tr>
<td>» 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.</td>
<td>» Fight disparities with new research and pilot programs.</td>
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<tr>
<td>» 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.</td>
<td>» Develop definitions of severe maternal morbidity (complications) to improve data collection and maternal health research.</td>
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“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)"
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)\(^{83}\)
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:**

- A need for increased data collection on performance and quality measures for maternal care, in order to reduce high rates of complications and deaths.
- 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.
- 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.
- Beneficial, comprehensive care services were often not available, including counseling on nutrition, domestic violence, mental health, and stopping smoking.

**THE PARTNERING TO IMPROVE MATERNITY CARE QUALITY ACT WOULD:**

- Ensure development of national, evidence-based quality measures for maternity care in Medicaid, as well as a process to collect this data;
- Create and implement a national patient survey of women to assess their experience of maternal care;
- Establish a demonstration project to develop effective alternative payment models aimed at simultaneously improving health outcomes and reducing costs; and
- 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)\(^{16}\)

“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)\(^{16}\)
On 28 September 2010, Capps introduced the Maternity Care Improvement Act which would take the following steps to improve US maternal health:

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<tr>
<td>» Fragmented oversight of health care financing and delivery leading to a lack of coordination of efforts to improve maternal care and outcomes.</td>
<td>» Increase government accountability and coordination of efforts related to maternal health by designating a national coordinator of programs related to maternal health;</td>
</tr>
<tr>
<td>» A lack of comprehensive data collection, a lack of standardization of data, and inadequate data on complications.</td>
<td>» 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;</td>
</tr>
<tr>
<td>» Significant need to increase evidence-based care practices; inadequate programs to foster cultural competence; and a lack of collaborative care.</td>
<td>» 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;</td>
</tr>
<tr>
<td>» 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.</td>
<td>» Improve the diversity of the maternity care workforce by awarding grants to increase recruitment of underrepresented minorities into the maternity care workforce.</td>
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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)
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.
39 The Joint Commission. Sentinel Event Alert: Preventing mater-

nal death.
40 CJ Berg, “Overview of Maternal Morbidity During Hospitaliza-
ation for Labor and Delivery in the United States 1993–1997 and
41 Institute of Medicine, Women’s Health Research: Progress,
iom.edu/Reports/2010/Womens-Health-Research-Progress-
Pitfalls-and-Promise.aspx, last visited 7 April 2011.
42 Institute of Medicine, Women’s Health Research: Progress,
Pitfalls, and Promise.
44 Institute of Medicine, Women’s Health Research: Progress, Pit-
falls, and Promise.
46 Linda Kramer “Global maternal health gets 2nd big checkup” Women’s 
org/story/reproductive-health/100669/global-maternal-health-
guts-2nd-big-checkup.
49 Because death certificates are the primary source of mater-
nal mortality data, but lack socioeconomic data, it has been dif-
ficult to assess the impact of income on risk of maternal mortality. The 
MCHB report combined census data on income level with death cer-
tificate data grouped by county. MCHB compared maternal mortality 
ratios between 1969 and 2007 in low-poverty level areas (less than 
5% of families in the county had incomes below the poverty level), 
mid-poverty level areas (between 5 and 15% of family incomes 
below the poverty level), and high poverty areas (15% or more fam-
ily incomes below the poverty level). GK Singh, Maternal Mortality in 
51 GK Singh, Maternal Mortality in the United States, 1935–2007, 
cdc.gov/mortsql.html.
55 See also N Johnson, “More women dying from pregnancy 
complications; state holds on to report,” California Watch, February 
more-women-dying-pregnancy-complications-state-holds-report. 
Last visited 7 April 2011
cdc.gov/nchs/data/nvsr/nvsr59/nvsr59_03.pdf. Last visited 7 April 
2011.
nsr59_03_tables.pdf. Last visited 7 April 2011.
59 CA Russo et al, Hospitalizations Related to Childbirth, 2006, 
Statistical Brief No.71, April 2009, p, 7, Table 1, available at http:// 
www.hcup-us.ahrq.gov/reports/statbriefs/sb71.pdf, and N Johnson, 
“For-profit hospitals performing more C-sections,” California Watch, 
September 11, 2010, available at http://californiawatch.org/health-
and-welfare/for-profit-hospitals-performing-more-c-sections-4069.
Last visited 7 April 2011.
60 Childbirth Connection, United States Maternity Care Facts and 
Figures, February 2011, available at http://www.childbirthconncet-
National Institute of Health Consensus Development Conference 
Statement, Vaginal Birth after Cesarean: New Insights, Volume 27, 
gov/2010/images/vbac/vbac_statement.pdf. Last visited 7 April 
2011.
61 National Institute of Health Consensus Development Confer-
ence Statement, Vaginal Birth after Cesarean.
Statistics Reports, Hyattsville, MD. National Center for Health Sta-
States: impact of labor induction,” American Journal of Obstetrics 
and Gynecology, 2010; 203:124, el-72.
63 SL Clark, et al., “Neonatal and maternal outcomes associated 
with elective term delivery,” American Journal of Obstetrics 
and Gynecology, 156, February 2000, el-44.
64 Leapfrog Group, Fact sheet: Early Elective Deliveries: Between 
37 and 39 Completed Weeks of Gestation, 18 February 2011, avail-
able at http://www.leapfroggroup.org/media/file/FactSheet_Elec-
College of Obstetricians and Gynecologists. Late preterm infants. 
2008 Committee Opinion, no.404, Induction of labor. 1999 Practice 
Bulletin no 10, and Assessment of fetal lung maturity, 1996 Techni-
cal Bulletin no 230.
65 Leapfrog Group, Fact sheet: Early Elective Deliveries: Between 
37 and 39 Completed Weeks of Gestation.
66 SL Clark et al., “Reduction in elective delivery at <39 weeks 
of gestation: comparative effectiveness of 3 approaches to change 
and the impact on neonatal intensive care admission and stillbirth,” 
American Journal of Obstetrics & Gynecology, 2010, 203:449, el-6, 
available at http://download.journals.elsevierhealth.com/pdfs/jour-
nals/0002-9378/PHS00029378180060794.pdf. Last visited 7 April 
2011.
67 Leapfrog Group Press Release, Newborn Deliveries are 
Scheduled Too Early According to Hospital Watchdog Group. 26 
release/478210. Last visited 7 April 2011.
68 Groups include the Leapfrog Group, National Quality Forum, 
The Joint Commission, March of Dimes, and Childbirth Connection.
69 SL Clark et al. Reduction in elective delivery at <39 weeks 
of gestation; US Dime, Improving maternity outcomes and cutting costs 
in Washington State, available at http://www.acog.org/department-
ments/dept_notice.cfm?recono=5&bulletin=5430. Last visited 7 
April 2011.
70 Cynthia Berg et al “Pregnancy-Related Mortality in the United 
States, 1998 to 2005” (2010) 116(6), Obstetrics & Gynecology 1302-
1309, at 1309.
71 Correspondence on file with Amnesty International USA.
72 Correspondence on file with Amnesty International USA.
73 This is not a comprehensive assessment of health care reform 
legislation. The provisions set forth here are intended only as a 
sample of key provisions affecting maternal health outcomes. Many 
other provisions that are not listed here will undoubtedly affect 
maternal health. In addition, this document does not reflect an 
arbitrary assessment of the human rights impact of health care 
reform. The entire text of the Patient Protection and Affordable Care 
Act, Public Law 111-148, March 23, 2010, the health care reform 
legislation is available at http://democrats.senate.gov/reform/
information on health care reform is available online, including from 
the following resources: http://www.healthcare.gov/law/infocus/
org/reformmatters/, http://www.guttmacher.org/pubs/journals/. 
health.
76 Findings from Deadly Deliver-can be found in that document. 
Amnesty International, Deadly Delivery: The Maternal Health Care 
77 Unless otherwise indicated, citations for this column are to the 
text of the Act. Patient Protection and Affordable Care Act, Public 
Last visited 7 April 2011.
78 Congressional Budget Office. Cost estimate for the amendment 
in the nature of a substitute for H.R. 4872, incorporating a proposed 
manager’s amendment made public on March 20, 2010, available at 
Last visited 7 April 2011.
79 Congressional Budget Office. Cost estimate for the amendment 
in the nature of a substitute for H.R. 4872.
80 National Women’s Law Center, Reform Matters, What Women 
Need to Know about Health Reform: Medicaid, August 2010, 
available at http://www.nwlc.org/sites/default/files/pdfs/medic-
81 National Association of Community Health Centers, Community 
Health Centers Lead the Primary Care Revolution, August 2010, 
available at http://www.nachc.com/client/documents/Primary_Care_
Deady Delivery
The Maternal Health Care Crisis in the USA: One Year Update

82 National Association of Community Health Centers, Community Health Centers Lead the Primary Care Revolution.


