

**ASSOCIATION OF WOMEN'S HEALTH, OBSTETRIC AND
NEONATAL NURSES**

**STATEMENT ON
SAFE MOTHERHOOD**

**HEALTH, EDUCATION, LABOR AND PENSIONS COMMITTEE
PUBLIC HEALTH SUBCOMMITTEE
UNITED STATES SENATE**

APRIL 25, 2002

The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) appreciates the opportunity to comment on the comprehensive Women's Health bill with specific emphasis on the Safe Motherhood legislation and its impact on the health of the nation's pregnant women and their infants. AWHONN, a membership organization of 22,000 nurses, promotes the health of women and newborns. AWHONN nurses work in a variety of fields that support the care of women across the lifespan, pregnant women and their newborns. AWHONN members are registered nurses, nurse practitioners, certified nurse midwives, and clinical nurse specialists who work in hospitals, physicians' offices, universities, and community clinics across North America as well as in the Armed Forces around the world.

Childbirth Has Lifelong Impact

The birth of a child is one of the most significant events in a woman's life. The attitudes and implications surrounding each pregnancy are colored by each woman's complex cultural and sociological attitudes as well as their physical conditions. While pregnancy is an everyday occurrence and Agency for Healthcare Research and Quality (AHRQ) data reveals that childbirth is the number one reason for hospital admissions, each birth is a major family event with lifelong implications. Most women can recount with great clarity almost every detail of their childbirth experience, even when many years have passed since the event.

The Power of Nursing Care

Studies suggest that a woman's most vivid recollections of the birthing experience usually include her interactions with the health care provider who generally stays with a laboring woman throughout the entire birthing process – the nurse. The registered nurse facilitates the childbirth process in collaboration with the laboring woman. The nurse's expertise and therapeutic presence influence patient and family satisfaction with the labor and delivery experience. Women who are provided with continuously available support during labor usually experience improved labor and delivery outcomes compared with those who labor without a skilled support person. Such care can lead to shorter labors, decreased use of analgesia/anesthesia, decreased operative vaginal delivery or cesarean section, decreased need for oxytocin, and increased satisfaction with the childbirth experience.

AWHONN views labor care and labor support as powerful nursing functions, and therefore believes that any successful efforts to improve maternal health outcomes and improve health care disparities will have to include collaboration with registered nurses as integral members of the health care team. Only the registered nurse combines adequate formal nursing education and clinical patient management skills with experience in providing physical, psychological and sociocultural care and support to laboring women; therefore AWHONN encourages the committee to support continued research efforts to further document the essential role of professional nursing labor support on maternal-newborn outcomes, as well as the potential financial benefits of such support for the health care system.

Childbearing is a Natural Life Process

The U.S. Agency for Healthcare Research and Quality reports that childbirth accounts for 3.8 million admissions annually; each day in the United States over 10,000 women give birth. The large majority of these births are low risk and clinically uncomplicated; 8 out of 10 women have no serious complications during childbearing. The nursing community views childbirth not as an illness or medical condition that requires intervention; rather, as a natural life process that provides opportunities to empower women and families.

Exploring the Costs of High-Tech Care

It is widely noted in the nursing community that the current environment of care encourages the use of unnecessary technologic interventions on laboring women that increase the cost of care and may well increase the risk of certain complications for the mother and infant. By approaching pregnancy-related conditions from the perspective that pregnancy is a natural phenomenon, we can target research priorities to critically examine the mysteries of normal pregnancy and the high-tech interventions that may interfere with that process. In addition, there are a number of routine interventions that are commonly used during labor for which there is little evidence of effectiveness in preventing adverse outcomes, and may actually lengthen labor and/or increase the risk for complications during labor.

Such interventions include the routine use of continuous electronic fetal monitoring (EFM) despite good evidence that intermittent fetal auscultation of fetal heart rate is equivalent to continuous electronic monitoring in the assessment of fetal condition for the low risk laboring woman; an ever-increasing rate of cesarean sections, which now account for more than 20% of all births nation-wide; the potentially adverse effects of elective induction of labor; the indiscriminate use of fundal pressure during second stage labor; routine use of epidurals and episiotomies; and the negative affects of bed rest for preterm labor and restrictive policies regarding ambulation and nutrition during labor. We applaud the bill sponsors for including the Agency for Healthcare Research and Quality (AHRQ) research on the quality of maternal health care from a patient-centered, woman's perspective, and we encourage the committee to include specific language for additional research mechanisms into the physical, emotional and financial impact of all types of routine interventions that are implemented during the labor and delivery processes.

While the AHRQ study will provide some important information regarding the issues surrounding the normal birth process and the other options women may choose for their birth experience, it is the only one indicated. This one study that provides opportunity for research related to a low tech, natural birth is overshadowed by the substantial discussion of pregnancy as an illness or medical condition in other sections of the bill. Increased focus and attention on birth as a natural process instead of a disease state could unveil important information about preventing complications by avoiding unnecessary interventions; therefore, we recommend the Coordinating Committee instruct the Director of NIH to make recommendations for additional studies to measure the efficacy of regularly utilized interventions during pregnancy and delivery.

Maternal Well-Being

There are times, however, when there is a breakdown at some point during the childbearing process, and the Safe Motherhood bill addresses some of these complications. For the wealthiest country in the world with arguably the most sophisticated medical system, we must identify and explore some fundamental problems before we can change the fact that the United States has an unreasonably high maternal morbidity rate for an industrialized country.

We Need Answers for Even the Most Common Problems

Each year in the United States, almost 1,000 women die of pregnancy-related complications; there has been no decrease in the maternal mortality ratio during the last 20 years. For every woman who dies of a pregnancy-related cause, several thousand suffer morbidity related to pregnancy – before, during or after delivery. Each year six million women become pregnant, almost four million give birth, and over one million experience pregnancy-related complications. The most common complications are miscarriage, ectopic pregnancy, excessive vomiting, diabetes, hemorrhage, infection, pre-eclampsia, premature labor, and the need for a surgical (caesarean) delivery. While some progress has been made in each of these areas, the fact that maternal and infant mortality rates have not improved much over the last ten years suggest that urgent attention should be given to fighting these most common problems.

We should have more and better answers for the most prevalent causes of maternal morbidity and mortality; and infant mortality, and this bill takes important steps to find those answers and attempt solutions. The bill's requirement that the Interagency Coordinating Committee on Safe Motherhood develop a coordinated Federal research and strategic action plan for safe motherhood will likely result in important first steps that will finally provide meaningful insight into the most common causes of maternal and infant health complications during pregnancy and childbirth.

The Effects of Chronic and Acute Health Conditions and Pharmacological Agents on the Childbearing Process

More research is needed on the impact of chronic health conditions, such as cardiovascular disease, asthma, diabetes, and hypertension, on the childbearing process. We are hopeful that this bill's provision to study the impact of chronic conditions, physical impairments, or mental health conditions on pregnant women's health will reveal important information on how underlying medical conditions and their symptoms influence pregnancy; and also on how pregnancy affects existing health problems.

Not only must additional research focus on management of chronic health conditions; priority must also be given to creating a body of evidence related to the special treatment needs of pregnant women who experience unexpected trauma and require emergency care and interventions. The effects of anesthesia and the physical trauma associated with surgical procedures such as acute appendicitis and conditions such as cardiovascular failure can be more life threatening when a woman is pregnant or in labor. These considerations may become even more critical as increased opportunities for maternal-fetal surgery arise.

Not only do the symptoms of some conditions threaten the reproductive process, but also the treatment for such illnesses must be examined. There is a paucity of reliable information on the

impact of most medications on pregnant and lactating women, with only 1 percent of drugs having been shown in controlled studies to be without risk to pregnant women. The bill findings include information that an additional 80 percent of approved drugs lack scientific evidence about their use in pregnancy. The average woman under 35 takes 3 prescriptions while pregnant; women over 35 take an average of 5 prescriptions. Despite the overwhelming need for additional research into the impact of such medicines on developing fetuses and how they affect a woman's physiology while she is pregnant, the research into the effects of most pharmaceutical agents are woefully inadequate.

The establishment of registries and databases of safe drugs and dosing information for pregnant and lactating women will assist health providers in prescribing appropriate pharmacological treatments to their patients. Additionally, we need improved information about drug efficacy and safety and the provision to improve drug labeling for pregnant women is an important first step in creating both an educated healthcare workforce and consumer market.

The Particular Concerns of Lactating Women

We applaud the bill's authors for expanding the sections in the bill that refer to medical devices, drugs and drug labeling to specifically include the consideration of lactating women.

Healthy People 2010 goals aim for 75% of women to breastfeed. In addition to the well-known newborn health benefits of breastfeeding, breastfeeding facilitates the immediate postpartum recovery. Maternal health benefits of breastfeeding include the promotion of uterine involution and a decrease in postpartum bleeding. Breastfeeding has been shown to reduce the risk of premenopausal breast and ovarian cancers, and breastfeeding mothers usually experience an earlier return to prepregnant weights.

There is no telling how many women do not initiate or sustain breastfeeding efforts out of fear that needed medications they must take to maintain health, may enter their breast milk and impact their infants. For example, anti-depressive medications may be contra-indicated for breastfeeding, but mothers who suffer from depression prior to childbirth face increased risk of postpartum depression and may therefore be in even greater need for anti-depressants following childbirth. This is only one example of the dilemma that many women face when deciding whether to provide their infants with optimal nutrition (breastfeeding) or to formula feed and continue their medications to protect their own health.

The strong provisions in Title II – Pregnant and Lactating Women - that require identification, study, potential marketing limitations, establishment of dosing recommendations, and investigation on the safe use of drugs and biological products for pregnant and lactating women are critical first steps to improve the quality of information available to health care providers and consumers about the safe use of medications while pregnant and lactating, and will enable women to work with health care providers to make evidence-based decisions regarding needed medical treatments.

On Environmental Health

We are grateful to see the small section on environmental health concerns included in this legislation; however, we would like to note that while we recognize that medical devices made from plastics and other potential environmental toxins represent a risk to the mother and her fetus, we maintain that it may be more beneficial to focus this section the safety of medical devices more broadly on phthalates as endocrine disrupters, a general class of toxins posing significant risks to fetal development and maternal health. Because phthalates are present in many often-used products, including nail polish, throw rugs and shower curtains, a broader research priority studying the effects of these toxins on maternal health is appropriate and necessary.

We applaud the inclusion of the study of pregnant women in the longitudinal Children's Study sponsored by the National Institute of Children's Health and Human Development. This inclusion allows researchers to access a large pool of women preconception through their pregnancies. By studying this crucial period, researchers can determine environmental risk factors that lead to negative health outcomes for the mother and her child.

Environmental health is research area that needs still further attention, particularly as it relates to maternal and fetal health. Infertility, complications in pregnancy, birth defects and developmental disorders all have been shown to have links to environmental exposure. A recent NIEHS study that found that low birth weight may in part be attributed to maternal lead burdens. Low birth weight is among the leading causes of neonatal death and is associated with long-term disabilities such as cerebral palsy, mental retardation and vision and hearing impairments. Infants born to women of color disproportionately suffer from low birth weight making it a significant pregnancy related health disparity. Costs associated with the care of low birth weight babies total more than half of the costs of care for all newborns. This research finding identifies a controllable environmental component to this health problem and reveals another possible benefit from the national remediation efforts to reduce environmental lead.

Further, by including research on environmental health impacts on pregnant women and their children, we can begin to explain the unexplainable. Why do 1 out of every 125 male infants suffer from hypospadias? Why do some children have unexplainable developmental disorders? How does exposure to massive amounts of toxins impact pregnant women with chronic disease? How does the environment interact with a pregnant woman's genes and altered hormonal state? How would a biochemical terrorist attack impact a pregnant woman and her child? As a nation we know so little about how our environment affects us, we should be particularly concerned about vulnerable populations like pregnant women and their children.

On Disparities and Culturally Competent Care

One of the most alarming aspects of maternal mortality rate in this country is the highly disproportionate rate at which minorities are affected. We know that pregnancy-related mortality ratios continue to be three to four times higher for black women than for white women and that black women have a higher risk than white women of dying from every pregnancy-related cause of death, including hemorrhage, pregnancy-induced hypertension, and embolism. Other populations suffer disproportionately from various disorders; for example, the leading cause of

pregnancy-related death for Hispanic women is pregnancy-induced hypertension. Native Americans are at greater risk for alcohol abuse during pregnancy.

Black women in this country are much more likely to experience preterm labor, which leads to low birth weight and very low birth weight babies. The most recent data from the National Center for Health Statistics confirms that 13 percent of all births to black mothers resulted in low birth weight babies. For infants of black mothers, mortality rate for infants with low birth weight was four times that for white mothers. Averting preterm labor in the minority population should be a key component of efforts to achieve safe motherhood.

More research into the complex inter-relationship of genetics, lifestyle choices, access to health care, and cultural expectations related to childbirth is needed to begin to understand why some women survive certain complications during the childbearing process while others may die from the same disorder. The bill's provisions to expand research activities related to disparities, especially the creation of Prevention Research Centers through CDC grants for the purpose of conducting research to improve maternal outcomes and eliminate racial disparities, should yield important new information that will help policy makers and health care providers address disparity issues.

Part of the disparity problem is unequal access to prenatal care and health care coverage. According to a recent Centers for Disease Control article, infant mortality rates were higher for mothers who began prenatal care late or not at all. Prenatal care and preconception counseling can be immensely helpful as they allow for early identification of risks, advice on consuming folic acid to prevent birth defects, initiation of appropriate and effective health promotion interventions, education stressing the advantages of planned pregnancies, and the importance of the earliest weeks of pregnancy. Minorities are less likely to have timely, quality prenatal care and late or no prenatal care is associated with lower birth weights and a higher rate of preterm births.

AWHONN recognizes the importance of addressing disparities in the delivery of health care, and applauds the inclusion of key sections in this legislation that would target research and community-based strategies to improve maternal morbidity and mortality in diverse populations. We would like to emphasize the importance of providing grants to health care providers working in the field, as well as to facilities that are educating future health care professionals to support education offerings that would promote culturally proficient services to pregnant women in diverse communities.

Training a Culturally Competent Health Care Workforce

Another piece of the puzzle is providing culturally appropriate care that not only provides access to the health care system and basic, standard medical and nursing care, but maximizing the birth experience according to cultural expectations and norms for optimal care in the perinatal period. Health care providers should take into account different worldviews that surround the childbirth experience, including knowledge of cultural issues, barriers and perspectives that influence care during preconception, labor and delivery, and postpartum phases. Providing culturally competent care commands that health care professionals demonstrate an awareness and

acceptance of, as well as a respect for, cultural and religious norms, patterns, beliefs and differences.

While support of a nursing delivery model that integrates culturally competent care is critical to quality health care in all specialties and practice settings, it is especially important in efforts to improve birth outcomes. At the National Institutes of Health, Office of Racial and Minority Health Conference, “Challenges in Health Disparity in the New Millennium: A Call to Action,” culturally competent care delivery was emphasized throughout the conference. Minority health advocates urged that cultural sensitivity training be included in health care education. Participants recounted stories where women or infants have died in childbirth due to problems as simple as a language barrier, or where a laboring woman traveled hours farther than the nearest health care facility to seek a caregiver familiar with her cultural beliefs. Birth is a richly cultural experience that is best supported by a nurse workforce that represents the ethnic diversity of the population it serves and has a comprehensive understanding of the impact of cultural components on the outcome and satisfaction of the birth experience. Achieving cultural competence should be an integrated part of training for all health care professionals.

There are thousands of health care professionals working in the field who may not have had cultural competence as part of their training, or whose training in years past did not reflect the current state of the science in this area. Continuing efforts to reach existing providers and enhance their skills in this area, as well as taking steps to ensure that future practitioners are well prepared, should be included in the SMART Motherhood bill. We cannot afford to wait for the next generation of health care providers to create a health care climate that will be comfortable for all Americans.

Increased Minority Representation in Health Care Professions

There is evidence to show that minority health care professionals are more likely to provide care to their own racial/ethnic population, yet there remains a dearth of providers that reflect the changing demographics of the U.S. population. The health care system has not kept pace with the health care needs of an increasingly diverse consumer market. Census data reveal that the growth of minority populations, including African Americans and Hispanic populations, will continue to increase at higher rates than the majority population, while there is no indication that minority representation in the health care work force is poised to expand at similar rates. The disparities between the health care workforce and the population it serves contribute to the continuing problems of access to culturally competent care available to minority populations. Racial/ethnic minorities comprise about 12.3% of the current RNs, compared to about 28% in the U.S. population. (Division of Nursing, HRSA, 2000).

We encourage the Committee’s continuing efforts to diversify the health care work force in the U.S., and welcome the opportunity to work toward diversification, especially related to increased minority representation in specialty areas of nursing, such as labor and delivery.

Access to Prenatal Care

Twenty-five percent of American women do not receive adequate prenatal care, even though it has been demonstrated that late entry into prenatal care or a lack of prenatal care results in higher infant mortality rates. Health experts agree that most pregnancy-related infant and maternal deaths are preventable.

Once women become pregnant, prenatal care is critical for monitoring the health of the pregnant woman and the developing fetus to avoid known dangers that might result in maternal mortality. It is important for women to collaborate with health care providers during pregnancy, particularly if they are managing chronic health issues such as heart disease, hypertension, or diabetes.

The prenatal period is the ideal time to screen for any health conditions or lifestyle behaviors that may influence maternal/fetal health. Screening for depression during pregnancy can help identify women at risk for postpartum depression. Identification of women who are experiencing domestic abuse is critical during childbearing, as new evidence from a long term study in the District of Columbia shows that women are not only more likely to experience intimate partner abuse during pregnancy, but they are more likely to be victims of homicide during pregnancy as well. Prenatal care also allows for opportunities for health care providers to educate clients as to the benefits of breastfeeding – both for the mother and the infant.

Women are also often highly motivated in these periods to alter risky behaviors such as smoking or alcohol consumption, so the prenatal period is an ideal time for health care providers to encourage women to quit smoking, as evidence shows that cessation rates increase with intervention from health care providers encouraging smokers to quit.

Women who do not have access to appropriate prenatal care do not receive the benefits of physical and psychological assessments, screening for disorders or risky lifestyle behaviors that could be altered, or education about parenting. It is no wonder that these women who are outside of the health care system experience higher rates of maternal and infant mortality.

More Than Safe Motherhood

Preventing maternal mortality is the most pressing critical aim for any initiative that calls itself SAFE motherhood, but there is also tremendous opportunity to not only avert disasters, but to optimize and improve the childbearing experience and improve the overall health of women and newborns through discovering what types of behaviors and activities will make the experience of motherhood the best it can be. Optimal maternal health outcomes would consider the benefits of access to an individualized, culturally sensitive plan of care for all childbearing women that will maximize a woman's opportunities for health during the complete phase of childbearing - from preconception, through labor and delivery, with supportive early postpartum hospital or birthing facility care, to follow up care and support in postpartum health management.

We have a responsibility to protect the health of mothers, infants and children in both in their own right as a large segment of the population and as a predictor of the health of the next generation. We can achieve not just SAFE Motherhood – but SMART Motherhood.

Thank you for the opportunity to submit testimony on this critical area of women’s health.

Contact:

Melinda Mercer Ray, RN, MSN, Director, Health Policy/Legislative Affairs

Lisa M. Greenhill, MPA, Legislative Manager

Association of Women’s Health, Obstetric and Neonatal Nurses

2000 L St. NW, Suite 740, Washington, DC 20036

(202) 261-2400