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Maternal Mortality and Severe Maternal Morbidity

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Foreword

The maternal mortality rate has been and continues to be a key indicator of a nation's health and health care delivery system. During the 20th century the United States had a dramatic decrease in the risk of death associated with pregnancy and childbirth, largely attributed to improved living standards and the modernization of maternity care. However, as we approached the millennium there was evidence of increasing maternal mortality and that trend continued into the 21st century. Although there remains controversy about how to count maternal deaths and what deaths should be counted, some of which is discussed in this symposium, it is clear that US maternal mortality is not headed in the desired direction; our best estimates indicate that about 700 women die each year during or shortly after the end of pregnancy due to causes specific to or aggravated by the physiology of pregnancy. Moreover, deaths are the tip of an iceberg, with estimates of another 75 to 100 women experiencing severe complications for every woman who dies as a result of being pregnant. As someone who has been studying and thinking about these tragic events at the national level, I am honored to edit this symposium on maternal mortality and severe maternal morbidity. Although it is tempting to focus on the numbers and rates, it is my hope that focusing a lens on maternal morbidity and mortality reminds all of us that behind the numbers are our mothers, sisters and daughters, and the events we count are individual human tragedies we are seeking to prevent.

A consistent theme running through this symprosium is that of identification and review of maternal deaths and cases of severe maternal morbidity for the purpose of informing clinical care, with an eye toward promoting a culture of continuous quality improvement. While there has been a flurry of initiatives recently such as state-based perinatal quality collaboratives and the Alliance for Innovation in Maternal Health, there is much more that needs to be done. In the short time since the inception of this symposium, the Association for Maternal Child Health Programs in partnership with the CDC Foundation and CDC's Division of Reproductive Health have provided resources (www.ReviewtoAction.org) to further enhance the capacity and standardize processes for states to identify, review and take action to prevent maternal deaths.

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The author declares that there is nothing to disclose.

I sincerely thank the authors of this set of papers for taking the time to put their thoughts and ideas on paper. They represent the very best of a relatively small group of professionals who have been genuinely concerned about the problems we see in maternal health. Their collective vision has been to identify and understand the problems and then take the necessary steps to reduce maternal deaths and severe pregnancy complications. They are to be congratulated for leading the charge to protect the women and families that we all serve.

Acknowledgments

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