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The COVID-19 Pandemic is Exacerbating a Human RIghts Crisis in U.S. Maternal Health

Compiled over the first few months of the COVID-19 pandemic, this resource explores the pandemic's impact on the health and rights of people who experience pregnancy, birth, and postpartum recovery in the United States. It identifies: (1) the communities that government policy decisions have made most vulnerable to the overlapping risks presented by COVID-19 and the pre-existing human rights crisis in maternal health; (2) the various ways that COVID-19 may affect individual pregnant, birthing, and postpartum people and U.S. maternal health more broadly; (3) trends in maternal health that have emerged over the first few months of the COVID-19 pandemic; (4) human rights-based standards for ensuring respectful maternal health care during the pandemic; and (5) policy changes that government and health care decision makers can implement to mitigate the pandemics harms to pregnant, birthing, and postpartum people.

This document was drafted by the Center for Reproductive Rights. It expands upon information and recommendations set forth in a shorter, co-authored issue brief: Safeguarding Maternal Health and Rights in the United States during the COVID-19 Pandemic

As the COVID-19 pandemic surges across the United States(U.S.), pregnant and birthing people are facing new and escalating threats to their health and human rights.

The U.S. health care system is straining to meet the needs of the moment, and government officials and health care institutions are making difficult decisions about how to deliver care while curbing transmission of the virus. Resource constraints and public health emergencies can be precursors to human rights abuses in maternal health settings, including mistreatment of people giving birth, violations of informed consent and bodily autonomy, and restricted access to essential health care services. Women and gender minorities who are Black, Brown, Indigenous, low-income, young, LGBTQ, immigrant, or people with disabilities already experience substantial barriers to safe and respectful pregnancy-related care and will be at even greater risk for discriminatory treatment and inequitable outcomes under conditions shaped by scarcity and fear. To prevent harm to the hundreds of thousands of people who give birth in the U.S. every month, government and health care decision makers at every level must take steps to protect the human rights of pregnant people and ensure that the COVID-19 pandemic response includes access to quality maternal health care, free from discrimination.

1. THE COVID-19 PANDEMIC THREATENS TO DEEPEN RACIAL AND ETHNIC DISPARITIES IN MATERNAL HEALTH OUTCOMES

Before the arrival of COVID-19, the U.S. was only just beginning to confront decades of rising maternal mortality and morbidity and deeply entrenched racial and ethnic disparities in maternal health outcomes that disproportionately affect Black and Indigenous women of all socioeconomic backgrounds. The United States has the highest maternal mortality ratio among wealthy nations and is one of only thirteen countries that failed to reduce the proportion of maternal deaths occurring within its borders between 1990 and 2015. Additionally, life threatening pregnancy-related illnesses and injuries affect more than 50,000 pregnant people in the U.S. each year and disproportionately affect women of color. Black women are more than three times more likely to die from pregnancy complications as their white counterparts, and American Indian and Alaska Native women are twice as likely to die. The majority of these deaths are preventable, reflecting fatal gaps in our health care system and policy choices that entrench social, political, and economic inequalities along lines of gender and race.

Racism is a public health crisis in the United States, and people of color face multiple and intersecting forms of discrimination that threaten their health and bodily autonomy. The same structural, institutional, and interpersonal racism that drives disparate maternal health outcomes is at the root of inequitable COVID-19 outcomes as well. In communities with the highest burden of maternal mortality and morbidity, high rates of adverse COVID-19 outcomes are

already evident. Federal data—obtained by investigative journalists only after suing the Centers for Disease Control and Prevention (CDC)—show high rates of infection and death among people of color. Black and Latinx people are three times more likely than white people to become infected with the coronavirus and twice as likely to die from it. They are also significantly over-represented among pregnant people with COVID-19. In some parts of the country, Indigenous communities are also experiencing disparities. For instance, the Navajo Nation has one of the highest per capita rates of infection in the country, facilitated by a lack of access to water and electricity, chronic underfunding of the Indian Health Service, and delayed federal assistance.

Cumulative, systemic inequities deprive Black, Brown, and Indigenous communities of access to social determinants of health, making women of color more vulnerable during stressful events, such as pregnancy and disease outbreaks. Generation after generation, communities of color have been denied equal access to high quality medical care, education, employment, housing, food, transportation, infrastructure investments, and other resources that help prevent illness and promote health. Moreover, as Black communities suffer from COVID-19 and government inaction, they are simultaneously resisting other lethal expressions of racism, including endemic, state-sanctioned police violence. In the midst of a pandemic, Black women are leading what may be the largest social movement in U.S. history, in defense of Black lives.

Finally, for women and mothers of color, COVID-19's impacts are further amplified by societal expectations that they take on caregiving roles and other "essential" work in exchange for no or low wages and few labor protections. Essential workers are more likely to be women, people of color, and immigrants. Women of color are also over-represented in criminal and immigration detention facilities where crowded, inhumane conditions have fueled the spread of the virus. Indeed, the first known woman to die from COVID-19 in federal custody was an Indigenous mother who was pregnant when she became infected, gave birth while on a ventilator, and died weeks later. Her name was Angela Circle Bear. As a result of systemic inequities, Black, Brown, and Indigenous women like Circle Bear have fewer options for avoiding exposure to COVID-19 and less access to testing and effective treatment for it.

2. THE COVID-19 PANDEMIC THREATENS U.S. MATERNAL HEALTH IN MYRIAD WAYS

COVID-19 infections

The pandemic creates multiple sources of risk for individual pregnant people and U.S. maternal health more broadly. First, pregnant, birthing, and postpartum people may suffer direct harm from the coronavirus itself. The CDC has listed pregnant people among those who need "extra precautions" and those "at risk." Because of the inequities described above, racial and ethnic minority groups are also in this category. While early guidance from the CDC asserted that there is "no data showing that COVID-19 affects pregnant people differently than others," the agency also cautioned that pregnant people are typically at greater risk of harm from respiratory viruses than people who are not pregnant. In late June, the CDC updated its earlier guidance and now indicates that pregnant women may be at greater risk of becoming severely ill from COVID-19 than non-pregnant women.

In June 2020, a government study found that pregnant women with coronavirus are much more likely to be admitted to an intensive care unit and put on a ventilator than infected women who are not pregnant. Some pregnant people with COVID-19 infections have experienced miscarriage or preterm labor, more than 30 pregnant women died of COVID-19 between March and July, some witnessed their infant die, and others have been removed from mechanical ventilators to discover that their premature babies had already been delivered via emergency surgery. There are also emerging indications that the virus can be transmitted from a pregnant person to their fetus. More research is needed to understand the role of COVID-19 in these adverse outcomes and both pregnant people and their health care providers are anxiously awaiting better guidance. However, because racial and ethnic minorities and pregnant and/or breastfeeding women are often under-represented or excluded from research and therapeutic trials, best practices for treating COVID-19 may still leave pregnant and birthing people of color behind.

Strained health care systems

Second, pregnant, birthing, and postpartum individuals may be at increased risk of harm due to the strain COVID-19 infections are placing on the health care system. Before the pandemic, a majority of maternal deaths were deemed preventable, signaling systemic failures that include problems with quality care—especially in hospitals that primarily serve Black patients. As the health care system struggles to cope with the pandemic, pregnant people are expressing concern that the system will have even less capacity to meet their needs. Mistrust between communities of color and government and health care authorities may also deepen as pregnant people of color, particularly those with underlying conditions or disabilities, wonder whether their health and safety will be deprioritized.

Concerns about abuse and neglect in medical settings are grounded in history and routinely affirmed in modern practice. In particular, Black women have been

"COVID-19 is a test for our societies, and we are all learning and adapting as we respond to the virus. Human dignity and rights need to be front and centre in that effort, not an afterthought.

- UN High Commissioner for Human Rights and Medical Doctor, Michelle Bachelet

subjected to medical experimentation, denied pain medication, mistreated during childbirth, and ignored when communicating life-threatening symptoms. The pandemic is only amplifying those concerns. For instance, as NYC became an early "hot spot" for COVID-19, residents of poor, Black, and Brown neighborhoods were treated for the coronavirus in understaffed public hospitals with substandard equipment and less access to advanced treatments where they died at much higher rates than their wealthy counterparts in private hospitals. Meanwhile, people of color continue to birth in those chaotic and understaffed hospitals, reporting troubling instances of neglect and discrimination. In the first few months of the pandemic, at least two Black women who were negative for COVID-19 died giving birth in New York City hospitals. Amber Rose Isaac had her prenatal care interrupted by COVID-19 and expressed concerns about low quality care at the hospital where she later died. The family of Sha-asia Washington believes that her death was also caused by inadequate care. The deaths of both of these 26 year-old, first time moms led to protests outside the facilities where participants holding "Black Lives Matter" signs decried a medical system that has repeatedly failed pregnant Black women.

Increased stress

Third, pregnant, birthing, and postpartum people may experience additional health complications caused by increased stress. Fear of the virus and its unknown consequences for maternal and infant health, social isolation, confusion about changing maternity care conditions, disruption to normal routines and expectations, racism, the economic fallout of the pandemic, and uncertainty about the future are all potential sources of stress caused or escalated by the pandemic. While some sources of stress can be mitigated or managed on an individual level, many of the stressors currently affecting pregnant, birthing, and postpartum people are beyond an individual's control. This is particularly true for stress caused or exacerbated by racism.

While racism is not new or unique to the pandemic, COVID-19 has escalated xenophobia and discrimination against immigrants and people of Asian descent, highlighted structural inequalities affecting Black, Brown, and Indigenous communities, and facilitated a national reckoning with racism. Black women who find their health, safety, and ability to raise children chronically undermined by state-sanctioned violence are experiencing grief as well as joy as they bring new life into a world that routinely devalues Black lives. Research demonstrates that exposure to racism not only harms mental health, but also has a "weathering" effect on Black women, damaging their health throughout their lifetime and contributing to adverse maternal health outcomes. As Black women are forced to deal with multiple public health crises simultaneously, from the maternal mortality crisis to the COVID-19 pandemic to the murder and brutalization of Black people by law enforcement, toxic stress is an ever-present risk to physical and mental health.

Finally, the rapid social, economic, and health systems changes currently underway in the U.S. have the potential to transform maternal health care for the long term. While emergency driven disruptions to the status quo can foster reflection and lead to systemic improvements, they also risk normalizing reactive policies and practices that cause disproportionate harm to Black, Brown, and Indigenous people. Without a strong commitment to the human rights of pregnant and birthing people, some of the restrictions currently imposed on patients in maternity care settings could become even more deeply entrenched and disproportionately applied.

3. PREGNANT, BIRTHING, AND POSTPARTUM PEOPLE ARE EXPERIENCING AMPLIFIED BARRIERS TO QUALITY MATERNAL HEALTH CARE DURING THE COVID-19 PANDEMIC

In many cases, the challenges pregnant, birthing, and postpartum people are experiencing right now are compounded by laws, policies, and policy gaps that limit their health care access and options. These longstanding weaknesses in U.S. health care and health governance—including access barriers, fragmented care, unevenly distributed health care resources, institutional and provider biases, constraints on patient decision-making, and disempowering maternity care practices—have been amplified by the COVID-19 pandemic.

Barriers to primary, preconception, and prenatal care

For some people, adverse maternal health outcomes begin with lack of access to care pre-pregnancy. A growing number of individuals enter pregnancy with pre-existing health conditions. Many of them encounter economic, social, and geographic barriers (including lack of health insurance, transportation, etc.) to primary care, preconception care, and family planning services which prevent them from entering pregnancy in their best health, at the time that is right for them. COVID-19 has made access to basic and preventative health care services even more difficult by disrupting health care visits, income, and travel. In the first 4 months of the pandemic, over five million people became uninsured due to job losses.

Fear of contracting the coronavirus has caused some pregnant people to avoid or delay seeking health care, and many are feeling anxious amid rapidly changing maternity care practices and unanticipated access barriers. The number of pregnant individuals who initiate prenatal care later than recommended is increasing due to the pandemic as it becomes more and more difficult to find available providers and appointments. A Blue Cross Blue Shield survey found that one in four women skipped prenatal appointments since the start of the pandemic or when social distancing requirements were put in place. Missed care can lead to missed diagnoses and missed opportunities to change the course of a pregnancy complication by meeting the pregnant person's time sensitive needs.

Restricted provider options and limited places to birth

An overwhelming reliance on hospitals to manage pregnancy and birth also complicates access to care as these facilities fill to capacity with sick coronavirus patients. Unlike many other countries, most pregnant people in the U.S. give birth in hospitals, in the presence of obstetrician-gynecologists, even when they are at low risk for complications. Childbirth is typically treated as a medical problem rather than a normal, physiological process and midwifery and community-based birth settings have been legally and culturally marginalized.

Birthing in a hospital setting surrounded by surgeons makes interventions into the birth process more likely. The U.S. has higher rates of labor induction, episiotomy and cesarean delivery than are medically necessary, and Black women have the highest cesarean birth rates among those with low-risk births. As the coronavirus strains hospitals, birth interventions are being used to control the timing of hospital stays. Interventions come with risks and benefits, depending on a patient's unique circumstances, and pregnant and birthing people should be able to make autonomous, informed choices about these interventions. However, large variations in intervention rates across providers and facilities pre-COVID-19 indicate that providers wield significant influence in these decisions.

Community based birth providers and insurers are reporting increased demand for home birth as a result of COVID-19. But whether or not a pregnant person can choose midwifery care or birth at home or in a freestanding birth center depends heavily on where they live, how much money they have, and whether their state and insurance provider have refused to license and cover these options. These limitations constrain pregnant people's ability to meaningfully decide where they will access maternity care, give birth, and who they will birth with, and they can make it more difficult for pregnant people to receive the right level of care at the right time.

While many low-risk pregnant people have no other option than to give birth in a hospital surrounded by sick people where they are more likely to experience interventions, other people who need specialized, high level hospital care cannot easily access it. The U.S. health care system does not ensure that hospitals, providers, and essential health care services are available in all geographic areas or distributed to meet public health needs. Across the country, but particularly in states that did not expand Medicaid, hospitals have been closing, disproportionately harming rural communities and communities of color. When struggling hospitals reduce services, the maternity care unit is among the first to be cut. Forty percent of U.S. counties have no obstetrician, and many do not have enough midwives or access to specialists. Some hospitals have stopped delivering babies while they cope with COVID-19. Others may close under the

financial pressures that the pandemic has caused and never reopen. Greater distances between pregnant people and lifesaving medical care increases the risk of adverse outcomes. Even in areas where hospitals are nearby, paramedics and ambulance services have been overwhelmed by COVID-19 cases, slowing response times and, in some jurisdictions, leading paramedics to withhold CPR.

Low quality care and discriminatory, disempowering maternity care practices

The U.S. government's failure to adequately prepare for public health emergencies and effectively respond to the coronavirus outbreak have accelerated the pandemic's harms and jeopardized the safety and rights of both health care workers and pregnant people. Many health care institutions have faced surging COVID-19 infections without sufficient staffing, personal protective equipment, and diagnostic tests.

In the face of these challenges, some institutions are implementing policies that conflict with human rights principles and guidance from the World Health Organization, such as prohibiting patients in labor from choosing a support person to accompany them and separating newborns from mothers with a confirmed or suspected COVID-19 infection. These policies can be devastating to pregnant and birthing people, and in some cases, they are being imposed without adequate warning or consent from patients.

A Blue Cross Blue Shield survey of COVID-19's impact found that 53% of women surveyed were not able to have a loved one in the delivery room with them. In some places, pregnant people have been allowed a support person during labor, but not during postpartum recovery. The presence of a loved one or doula is an important aspect of safe birth and healing. A companion of choice can provide physical and emotional support, assist the laboring person with advocating for themselves and communicating with health care workers, and can alert hospital staff to symptoms of complications. For some Black and Indigenous people, doulas who share their background may also facilitate important spiritual and cultural connections during a birth. In contrast, policies requiring people to birth alone sow fear and apprehension, prompting some patients to switch hospitals or providers late in pregnancy.

The moments after birth are also critical. Newborns and parents both benefit from close contact and the opportunity to bond immediately after birth. Separation of newborns can disrupt breastfeeding initiation and harm mental health. In an example of hospitals independently setting policies that are unnecessary, discriminatory, secretive, and overly broad, a hospital in New Mexico created a list of zip codes that encompassed Native American reservations in the region and separated newborns from patients that lived in those areas and appeared to be Native. Moreover, separating newborns from parents immediately after birth may not prevent their exposure to COVID-19 since most newborns and their parents are ultimately discharged from the hospital together two to three days after birth. Due to the pandemic, some hospitals are discharging postpartum patients even earlier.

Policies that restrict pregnant people's rights—or rely on stressed providers to use their discretion when determining what rights birthing people will retain during a pandemic—risk amplifying the impact of implicit biases. Provider biases influence diagnoses and treatment decisions and adversely affect Black and low-income women especially. Experiencing discrimination and mistreatment during pregnancy and childbirth can be traumatizing, but in an obstetric emergency, it can also be life-threatening. For instance, a Black woman whose pain is ignored or not prioritized by her maternity care providers might die because a pregnancy complication went unrecognized and untreated.

Neglect of postpartum individuals after pregnancy ends

Finally, postpartum people are facing even greater challenges with fewer supports. According to pre-pandemic data, more than half of all maternal deaths occur in the year following birth. With the arrival of COVID-19, stressors have increased while access to health care and support systems have decreased. For many, challenges arise immediately. Individuals who give birth in hospitals during the pandemic may be forced to recover alone or be pressured to leave early. After months of frequent prenatal visits during pregnancy, health care for postpartum people is typically limited to just one visit, six weeks after birth. Due to the pandemic, some people are missing this check-up and going without care during a critical time in their recovery. Because of physical distancing measures, postpartum people may also be isolated from their social networks, including family and elderly parents, while they heal and care for a newborn. COVID-19's economic impacts are also adding to the strain, making it difficult for some postpartum people to maintain housing stability and obtain the things they need to care for themselves and their families. Since the onset of the pandemic, maternal mental health conditions have increased significantly.

4.HUMAN RIGHTS STANDARDS SHOULD GUIDE DECISIONS ABOUT MATERNAL HEALTH CARE DELIVERY

Rather than retreating from human rights based standards of care during the COVID-19 pandemic, government and health care decision makers should look to the human rights framework as a guide to ensuring pregnant people's rights to respectful maternity care and preventing the normalization of policies and practices that increase harm to women and marginalized communities. Respectful maternity care seeks to prevent mistreatment by providing person-centered health care that affirms human rights and dignity. There are many sources of guidance on respectful maternity care, including recommendations from the World Health Organization.

International human rights experts recognize that a human rights-based approach to maternal health care, rooted in a just, effective health system, catalyzes women's empowerment. Adherence to human rights principles also helps facilitate broader cooperation and participation in efforts to mitigate the impact of the pandemic, especially where mistrust between communities and government and medical authorities may complicate public health measures.

In health systems that do not prioritize human rights, structural discrimination manifests in hospitals as mistreatment of pregnant and birthing people, a recognized form of violence against women fueled by gender stereotypes and power imbalances. In the U.S., a significant proportion of individuals who give birth report experiencing some type of disrespectful care or mistreatment. The risk of experiencing human rights violations in maternity care settings is even greater for women of color, who also confront racial discrimination when accessing care. Mistreatment can include physical, sexual, and verbal abuse, coerced or unconsented medical procedures, privacy violations, neglect, abandonment, and delayed care, withholding treatment or pain medication, and detention or restraint of the birthing person or newborn, among others. When violations occur, circumstances involving resource constraints, high stress, and risks to health care workers' own human rights can be contributing factors.

Throughout the duration of the pandemic, health care decision makers should commit to ensuring that pregnant individuals can seek care and give birth in conditions that enable them to:

- Decide whether, where, and with whom they will give birth
- Access medicine, supplies, and health care services that enable them to prevent, end, or continue a pregnancy
- Access affordable, quality pregnancy-related care from a willing provider they choose and trust, and receive timely, quality care during an obstetric emergency
- Make sexual and reproductive health decisions free from coercion
- Give or receive informed consent to treatment after receiving information about their health conditions and options in a form that they understand, including information about the risks and benefits of medical interventions in the context of the pandemic
- Choose at least one person to accompany them and provide continuous support during labor and birth
- Experience labor and birth free from verbal and physical abuse, violence, or humiliation
- Have their privacy protected and be treated with dignity and respect
- Move and make noise during labor and birth
- Have help managing pain, and be listened to and treated appropriately when reporting pain or health concerns
- Be supported to breastfeed, bond with, and care for their newborn baby, and make decisions about their baby's health care
- Rest and recover from birth
- Access resources that help sustain and preserve their families
- Participate in evidence-based measures to protect themselves and others from COVID-19 infection and benefit from government preparedness and policy responses to the COVID-19 pandemic that prevent avoidable deaths and other harm

5. GOVERNMENT AND HEALTH CARE DECISION MAKERS SHOULD TAKE IMMEDIATE ACTION TO MITIGATE THE IMPACT OF THE COVID-19 PANDEMIC ON MATERNAL HEALTH

Many of the policy changes required to protect pregnant and birthing people during the COVID-19 pandemic were needed before the pandemic began and will still be needed after it ends. Before the pandemic, pregnant and birthing people in the U.S. faced a health care system that did not adequately protect their health and rights. The coronavirus outbreak has only exacerbated that reality.

Urgent reforms are both necessary and possible. Through executive orders, state and federal legislation, and policy making within health agencies and institutions, decision makers at every level can take immediate steps to protect maternal health

and prevent one public health crisis from accelerating another. The recommendations compiled here highlight specific actions that government and health care decision makers should prioritize now to safeguard maternal health and rights in the near term, while paving the way for longer-term transformations in the way that maternal health care is understood and delivered. This list does not contain all the changes needed to ensure and sustain human rights in U.S. maternal health—rather, it identifies key entry points for making positive impacts at this particular moment. Whether the U.S. emerges from the COVID-19 pandemic with a health care system that has enhanced or diminished capacity to ensure human rights and protect maternal health will depend on the decisions that law and policy makers make at this critical stage.

Ensure respectful, quality maternal health care

- Ensure that all pregnant people can labor, give birth, and recover accompanied by at least one support person.

Hospital decision makers should ensure hospital policies permit at least one support person during labor, delivery, and postpartum recovery. Law makers and health care agencies at the state and federal level should reinforce that right in law and guidance.

According to the World Health Organization, "[a]ll women have the right to a safe and positive childbirth experience, whether or not they have a confirmed COVID-19 infection." This includes, "a companion of choice." Continuous labor support provided by birthing partners and doulas improves outcomes and is especially important for people of color, people with disabilities, non-English speakers, young people, and anyone else who is at risk of experiencing discrimination. In addition to physical and emotional support, a support person can alert hospital staff to complications and assist the birthing person with communicating their needs. At a time when health care workers are short staffed and over-burdened by COVID-19, it is especially important for people in labor, delivery, and postpartum recovery to have someone they know and trust at their side.

- Facilitate greater access to doula care.

Hospital decision makers should support in-person and remote access to doula care to the greatest extent possible. In collaboration with doulas and the communities they serve, state and federal law makers should continue to explore mechanisms to expand economic access to doula care, including through public and private insurance coverage, and ensure that doulas earn living wages.

Doulas are important members of the maternity care team. They typically establish relationships with pregnant individuals many weeks or months before births occur and provide physical, emotional, and informational support that improves health outcomes and birth experiences. Doula support is particularly important for birthing people of color who are exposed to provider biases and discrimination during health care encounters. In exceptional circumstances, if a hospital determines that it is not safe for more than one support person to be present during labor, delivery, and postpartum recovery, birthing people who do not choose the company of their doula should be accommodated so they can access doula support remotely. However, in no circumstances should doulas be required to attend births in person during the pandemic if they are not comfortable doing so.

- Support new parents to safely bond with and care for their babies.

Health care decision makers in hospitals, professional organizations, and state and federal agencies should promulgate clear guidance clarifying that decisions to separate newborns from parents in hospitals must be based on the best available evidence, made in cooperation and communication with parents, and in consideration of all the risks and benefits, including the benefits of close contact and breastfeeding, and the physical and mental health risks of separation for both parent(s) and child.

According to the World Health Organization, "close contact and early, exclusive breastfeeding helps a baby to thrive. A woman with COVID-19 should be supported to breastfeed safely, hold her newborn skin-to-skin, and share a room with her baby." (The CDC has revised its guidance on newborn separation and now advises that "[w]hen temporary separation is being considered, its risks and benefits should be discussed by the mother and the health care team. Decisions about temporary separation should be made in accordance with the mother's wishes").

- Ensure that individuals in all communities have the information they need to understand and navigate their pregnancy and birth options during the pandemic.

State and federal government health agencies should provide clear public health guidance that reflects the needs and rights of pregnant, birthing, and postpartum people. Providers and health care authorities should provide patients with current, transparent information about hospital policies and how the possibility of COVID-19 transmission alters risks and benefits associated with health care decisions. Hospital decision makers should ensure that institutional policies and practices do not violate patients' rights to reject treatments or birth interventions during a meaningful informed consent process.

Information about the impact of COVID-19 on pregnant people and newborns is rapidly evolving, as are laws, public health recommendations, and hospital protocols. As

The international human rights framework provides critical guidance regarding the rights of pregnant people and healthcare workers, and the corresponding obligations of governments and other stakeholders to uphold those rights. The right to safe and respectful maternal health care is grounded in the human rights to life, health, equality and non-discrimination, and freedom from ill-treatment.

To fulfill its human rights obligations during the COVID-19 pandemic, the United States must ensure that all pregnant people can access the full range of health services in connection with pregnancy, birth, and the postpartum period. Maternal health care must be available, accessible, acceptable, of good quality, and free from discrimination, coercion, and violence. While seeking maternal health services, women's rights to autonomy, privacy, confidentiality, informed consent, and decision-making must also be respected. Moreover, because intersectional discrimination impedes access to safe and respectful maternal healthcare, United Nations human rights experts have urged countries to address the social determinants of health and focus on the maternal health needs of women from marginalized groups.

circumstances change, health care institutions, providers, and local officials should proactively communicate accurate and relevant information to patients and community members. Information must reach all patients and communities, enabling pregnant people everywhere to prepare for changing scenarios, make informed medical decisions, and protect their health.

- Ensure that hospitals do not apply COVID-19 related policies to pregnant and birthing patients in arbitrary or discriminatory ways.

Government and health care decision makers should issue guidance on COVID-19 and maternal health that incorporates and requires alignment with respectful maternity care practices. Government and health care decision makers should also ensure that any hospital policies restricting options for pregnant and birthing people, including policies regarding visitors and newborns, are truly necessary, evidence-based, and applied equitably and without discrimination on the basis of patient characteristics, such as race/ethnicity, income, sexual orientation, marital status, age, etc.

United Nations human rights experts urge countries to center human rights in their response to the COVID-19 pandemic. Emergency responses "must be proportionate, necessary, and non-discriminatory" and restrictions should be "narrowly tailored" and the "least intrusive means to protect public health."

- Protect the safety and human rights of health care providers and essential workers.

Government leaders and health care employers should ensure that health care workers have the personal protective equipment (PPE) they need to protect themselves and their patients. State and federal law makers should also ensure safer labor conditions for all essential workers, including fair renumeration for the risks they are exposed to, paid family and sick leave, and workplace accommodations that reduce the risk of COVID-19 transmission among workers and the families and communities they belong to.

Health care workers must have the supplies and support they need to perform their jobs as safely as possible. Many health care workers have already died from COVID-19, including pregnant providers. Adequate resources, including sufficient testing materials and PPE, improve safety and enable more tailored, less restrictive response measures. Federal and state policy makers can further enhance workplace safety by strengthening and clarifying the rights of pregnant workers to accommodations during the pandemic.

Expand access to pregnancy-related health care

- Expand and diversify the maternal health care workforce.

State government officials should permit skilled midwives to assist pregnant and birthing people immediately, without penalty or fear of punishment. State and federal policy makers should fully incorporate the midwifery-led model of care into the Medicaid program and private insurers should cover midwifery services. Government leaders should also ensure that midwives practicing outside of institutional settings have access to adequate PPE, medicines, supplies, and information related to the pandemic response.

The pandemic will continue to strain the capacity of the health care system and its workers for months to come. Pregnant people need more available providers and a wider range of provider types to ensure access to safe, respectful births that meet their individual and family needs. States that support autonomous midwifery have better birth outcomes and hospitals that incorporate midwives have lower rates

of birth interventions. Depending on the state, removal of regulations that impede access to midwifery care might include executive orders permitting credentialed midwives licensed in any U.S. jurisdiction to practice; amending licensure laws or the rules and regulations that interpret them to ensure that Certified Nurse Midwives (CNMs), Certified Midwives (CMs), and Certified Professional Midwives (CPMs) can all obtain statewide midwifery licenses; and amending medically unnecessary physician-supervision requirements to facilitate greater availability of midwifery care.

- Expand the settings in which pregnant people are supported to give birth.

State and local government officials, providers, hospital decision maker, and insurers should cooperate to ensure birthing people have meaningful, safe options when it comes to where they will give birth. Government officials should remove restrictions on an individual's right to birth at home with the assistance of a midwife. State and federal policy makers should identify and remove legal and policy barriers to opening birth centers and other short and long-term alternative birthing sites for people with low risk pregnancies. State, federal, and health insurance decision makers should further ensure that public and private insurance covers midwifery services provided in an individual's home or at a freestanding birth center, and that these services are reimbursed adequately and equitably. Additionally, midwifery care and births outside hospitals should be integrated into the broader health systems, ensuring that emergency responders and hospitals are prepared to facilitate safe transfers when a birthing person needs a different level of care.

Both patient demand and public health concerns warrant the removal of obstacles to safe, supported, out-of-hospital births. Laws and policies that make it difficult for midwives to operate birth centers and/or assist birthing people in their homes effectively coerce pregnant people into birthing in hospitals. Pregnant people should have meaningful choices when it comes to where they will birth and who they will birth with. Some people, anticipating a low-risk pregnancy and birth, wish to pursue a physiologic birth in a home or home-like setting where they feel most comfortable. As pregnant people seek to avoid hospitals overwhelmed by COVID-19, interest in alternative birth settings has increased dramatically. However, even under non-pandemic conditions, pregnant people are entitled to make decisions about their body and health and should not have those decisions determined for them by restrictive laws and insurance policies that make midwifery care unaffordable. Additionally, for some Black and Indigenous midwives and birthing people, non-institutional birth settings are an important part of reclaiming birth practices and bodily autonomy undermined by racism and colonization.

- Sustain health facilities and providers serving tribes, communities of color, low-income people, and rural populations.

Federal law makers should pass COVID-19 relief legislation that prioritizes safe staffing levels and the preservation of safety-net hospitals and other health care providers and facilities that serve low-income patients with and without Medicaid coverage, especially those serving Black and Indigenous communities.

For many years, budget driven hospital closures have been contributing to "maternity care deserts," leaving communities across the United States without access to obstetrical care. Financially precarious hospitals have fallen short of safe staffing levels and repeatedly eliminated labor and delivery units in an effort to cut costs. The closure of these obstetric units disproportionately affects rural populations, and low-income communities of color. Increasing the distance to hospital-based obstetric care disrupts continuity of care and increases the risks of maternal mortality. Law makers early efforts to assist hospitals during the COVID-19 pandemic did not prevent cuts to frontline staff and have largely benefitted wealthy hospital systems and their CEOs, disproportionately aiding those with high rates of private insurance revenue from wealthy patients. Meanwhile, Indian Health Services remains chronically underfunded and COVID-19 funding for Native American tribes has been delayed while infection rates in tribal communities soar.

- Ensure affordable, flexible access to comprehensive maternal health care services.

State and federal law makers and health care decision makers should fund longer, more frequent prenatal and postpartum visits, remove in-network/out-of-network insurance restrictions on providers during the pandemic, and ensure that obstetric and gynecologic care, midwifery care, childbirth education, mental health care, and doula services are covered by public and private insurance and can be provided via telehealth when necessary.

While social distancing and stay at home measures are in effect, pregnant, birthing, and postpartum people must be able to access providers wherever they are sheltering in place. Policy makers can increase the types of providers who are able to provide telehealth services and waive licensing requirements to allow out-of-state providers to provide telehealth. Telehealth rules should permit and require insurance coverage of visits and check-ins for both established and new patients conducted through a variety of technologies including video conferencing, telephone or audio-only consultations, and communications through online patient portals. It is imperative that a variety of mediums are covered to ensure patients who cannot access internet or video-capable devices can still receive care.

- Remove barriers to public health insurance.

States that haven't already done so can expand access to early, adequate pre-natal care by implementing presumptive eligibility for pregnant individuals and increasing income eligibility thresholds for pregnancy-related Medicaid coverage. Since access to care before and after pregnancy can help prevent and address pregnancy complications that lead to maternal deaths, and because all people need access to health care during a pandemic, states that have not done so should expand Medicaid under the ACA and remove restrictions on telehealth care and reimbursement. Additionally, the federal government and states that run their own ACA health insurance exchanges should offer special open enrollment periods due to COVID-19.

The Affordable Care Act (ACA) has had a significant impact on outcomes relevant to maternal health, including reduced racial and ethnic disparities in health insurance coverage. States that expanded Medicaid under the ACA reduced racial disparities in low birth weight and preterm birth outcomes and have lower rates of maternal mortality. Medicaid expansion is also associated with improved health among Black people, including those with chronic health conditions.

Increase access to postpartum resources and support

- Ensure access to adequate health care in the postpartum period.

Hospital decision makers should ensure that hospital policies do not force the premature discharge of medically vulnerable patients. Health care decision makers should expand access to and coverage for multiple postpartum visits, including telehealth and phone visits and the expansion of (optional) home visiting programs. State and federal policy makers should extend pregnancy-related Medicaid coverage to cover the entire postpartum year.

More than half of maternal deaths occur in the year after pregnancy. Postpartum care was already limited before the coronavirus outbreak, and now some hospitals are discharging patients early to preserve resources and reduce transmission risks. Postpartum patients must be stable at discharge and should be supported with additional follow-up resources to ensure their safe recovery.

- Ensure that postpartum people have the economic and social support they need.

State and federal policy makers can mitigate postpartum risks by guaranteeing paid sick and family leave for all workers. Government and health care decision makers can also ensure public and private health insurance coverage for services such as lactation support, postpartum doula care, and mental health care. State and federal policy makers should ensure that high quality, affordable childcare is available for infants and children when states re-open, expand access to food through WIC and SNAP benefits, and assist pregnant and postpartum people in obtaining other essential household items (including formula, diapers, wipes, toilet paper, menstrual products, and cleaning supplies) during shelter-in-place measures and associated disruptions to employment, social support networks, and supply chains. Policy makers can help connect postpartum individuals to social and material supports by investing in community-based organizations that are led by people of color and are accountable to and embedded in the communities at highest risk for adverse maternal health outcomes.

In addition to the typical challenges that accompany postpartum recovery, postpartum individuals are now facing infectious disease, increased isolation due to physical distancing efforts, and varying degrees of economic instability. These conditions increase health and safety risks for postpartum people and their families. Paid leave enables people time to heal from childbirth, care for their newborn, breastfeed, and attend health care visits. It is also associated with better maternal mental health. These benefits become even more urgent during a pandemic. Most countries have some form of national paid maternity leave. Because the U.S. does not, one quarter of postpartum people return to work just two weeks after birth and women of color have very little access to paid leave and protections against pregnancy discrimination. Moreover, childcare was already unaffordable for many before the pandemic and has now become unavailable in some places. Women are disproportionately carrying the burden of these impossible situations. Without paid leave or childcare, many people who give birth during the pandemic cannot work and cannot afford to not work. Meanwhile, government programs meant to fill gaps in access to basic necessities do not include key resources (like diapers and cleaning supplies) that are essential to postpartum people during a pandemic.

- Ensure that pregnant, birthing, and postpartum people have safe living conditions and the ability to protect themselves from infection and other health harms.

Local, state, and federal government decision makers should consider releasing individuals, including pregnant and postpartum people, from jails, prisons, and immigration detention facilities where access to quality health care is already limited and safe social distancing protocols cannot be implemented. Government leaders should also ensure safe housing for pregnant and postpartum people who cannot "stay at home" during the pandemic because they are experiencing homelessness and/or domestic violence.

Studies show that pregnant people are at higher risk of severe illness due to COVID-19 than non-pregnant people. After months of uncertainty, it now appears that airborne transmission and transmission of the coronavirus from a pregnant person to their fetus may be possible as well. In the absence of a vaccine, the most effective strategies that people have available to protect themselves from COVID-19 involve limited contact with others and avoidance of crowded indoor spaces. People in jails, prisons, immigration detention, and crowded shelters do not have that option. Detention settings have fueled the spread of COVID-19, putting detained and incarcerated pregnant, birthing, and postpartum people at risk. Homelessness and housing instability are risk factors for maternal mortality that disproportionately affect Black women and are associated with a variety of adverse birth outcomes. The impact of homelessness and housing instability on maternal health outcomes may become even greater during a pandemic where crowded shelters increase the risk of contagion. Moreover, stress and domestic violence—a significant cause of pregnancy associated deaths and homelessness—have escalated during the pandemic, amplifying the need for safe housing. Government instructions to "stay home" should be accompanied by resources to ensure that pregnant and postpartum people have a safe place to isolate during the pandemic.

- Ensure that parents are supported to care for their children during the COVID-19 pandemic.

State and federal government decision makers should respond to the growing material and health needs of families with support, and ensure that families are not punished by child welfare agencies for enduring health challenges or difficult social and economic conditions. Rather than investing in punitive systems, state and federal policy makers should direct resources towards families and community-based organizations that center and serve them.

The child welfare system disproportionately targets families of color for surveillance and separation. Between 2000 and 2011, the child welfare system removed one in seven American Indian children and one in nine Black children from their parents' care. Most allegations against parents are claims of "neglect," which simply describe the conditions of poverty. As communities of color suffer the worst health and economic impacts of the pandemic, pregnant, birthing, and postpartum people of color are at risk of losing the children they bring into the world to a system that perpetuates structural racism and does not alleviate the root causes of child poverty.

- Maintain maternal health funding and accountability mechanisms that promote health equity.

Federal, state, and local government health entities should maintain and improve data on maternal health outcomes by race and ethnicity and should collect similar data on COVID-19 to ensure that diagnoses and treatment resources reach and include Black and Indigenous communities and other communities of color. State and federal lawmakers should mandate that hospitals and providers report maternal deaths to their state health department and publish updated hospital-level data on perinatal outcomes on their website. Decision makers at all levels of government should maintain funding for maternal health programs and include women, pregnant people, and birth workers in decision-making bodies working on pandemic response.

Government policy makers must ensure that equity and accountability measures are built into public health responses to both COVID-19 and the maternal mortality crises. To facilitate equity and accountability, government decision makers should prioritize transparency, thorough data collection (that includes American Indian and Alaska Native people), consistent communication with the public, and participation of communities directly affected by the crises in decision making processes.

The U.S. Maternal Health & Rights Initiative promotes the human rights of pregnant, birthing, and postpartum people in the United States. Harnessing the power of law, policy, and strategic advocacy, the Initiative seeks to improve access to safe and respectful maternal health care for all who need it, and to ensure that all people have an opportunity to attain the highest standard of maternal health possible for themselves. The Initiative seeks government accountability for discrimination and inequalities in U.S. maternal health, and it provides advocates, lawmakers, and leaders with human rights-based advocacy tools that they can use to catalyze policy change.

Maternal Health & Rights Initiative