U.S. COMMISSION ON CIVIL RIGHTS

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PUBLIC BRIEFING

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RACIAL DISPARITIES IN MATERNAL HEALTH

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FRIDAY, NOVEMBER 13, 2020

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The Commission convened via videoconference at 10:00 a.m. EST, Catherine Lhamon, Chair, presiding.

PRESENT:

CATHERINE E. LHAMON, Chair

DEBO P. ADEGBILE, Commissioner

STEPHEN GILCHRIST, Commissioner

GAIL HERIOT, Commissioner

PETER N. KIRSANOW, Commissioner

DAVID KLADNEY, Commissioner

MICHAEL YAKI, Commissioner

MAURO MORALES, Staff Director

MAUREEN RUDOLPH, General Counsel

PANELISTS PRESENT:

ANGELA DOYINSOLA AINA, M.P.H.

SHANNA COX

JOIA ADELE CREAR-PERRY, M.D., F.A.C.O.G.

SHANNON DOWLER, M.D.

NICOLLE L. GONZALES, B.S.N., R.N., M.S.N., C.N.M.

GARTH GRAHAM, M.D., M.P.H.

JENNIFER JACOBY

MAURICIO LEONE, M.P.A.

JENNIFER E. MOORE, Ph.D., R.N., F.A.A.N.

CHANEL PORCHIA-ALBERT

AYANNA PRESSLEY, U.S. REPRESENTATIVE

TARANEH SHIRAZIAN, M.D., F.A.C.O.G

NAN STRAUSS

STAFF PRESENT:

NICK BAIR, Civil Rights Analyst

PAMELA DUNSTON, Chief ASCD

COMMISSIONER ASSISTANTS PRESENT:

RUKKU SINGLA

A G E N D A

P R O C E E D I N G S

10:00 a.m.

CHAIR LHAMON: This briefing of the US Commission on Civil Rights comes to order at 10:00 a.m. Eastern Time on Friday, November 13, 2020 and takes place online.

I'm Chair Catherine Lhamon. Commissioners virtually present at this briefing in addition to me are Commissioner Adegbile, Commissioner Gilchrist, Commissioner Heriot, Commissioner Kirsanow, Commissioner Kladney, and Commissioner Yaki. A quorum of the Commissioners is present. I note for the record that the Staff Director and the Court Reporter are present.

And I welcome everyone to our briefing titled Racial Disparities in Maternal Health. My Commission colleagues and I voted to take up this topic last year and had originally planned to hear from experts in March 2020 in person. Our plans shifted with the rise of the coronavirus pandemic, but we remain committed to examining the issues we take up today.

Since we voted to investigate this topic, two among our Commissioners cycled off the Commission when their terms ended, and we have welcomed two

additional Commission members. We've built into our planning for this investigation an opportunity for new Commissioners Gilchrist and Adams to offer suggestions for panelists and for information for Commissioners' review in advance of today's briefing.

With this investigation, we examine the federal role in addressing racial disparities in maternal health outcomes, including negative pregnancy-related health outcomes and pregnancy-related deaths of women in the United States.

We will analyze current data regarding pregnancy-related and pregnancy-associated deaths, including data from institutions we will hear from such as the Centers for Disease Control and Prevention, the National Institute of Minority Health and Health Disparities, and the Department of Health and Human Services State Partnership Initiative to address health disparities.

Today, we will hear testimony from experts, including government officials, academics, healthcare providers, advocates, and impacted persons. We will hear a range of perspectives today, and I note here that we had also invited several more members of the Administration to participate in today's briefing, including representatives from the

National Institutes of Health and the Department of Health and Human Services, though they declined to participate.

We are also grateful to the witnesses who provided testimony in writing. They include Juanita Chinn, who is Program Director, Demography of Health, Mortality and Population Composition, Population Dynamics Branch, Eunice Kennedy Shriver National Institute of Child Health and Human Development; Elizabeth A. Howell, who is the Director the Blavatnik Family Women's Health Research Institute; Jonathan Webb, who is the Chief Executive Officer, the Association of Maternal Child Health Programs; Melanie J. Rouse, Maternal Mortality Projects Manager at Virginia Department of Health, Office of the Chief Medical Examiner; and Ndidiamaka Amutah-Onukagha, Associate Professor of Public Health and Community Medicine at Tufts University School of Medicine.

I thank all who join us now to focus on this critical topic. Your views help us to fulfill our mission to be the nation's eyes and ears on civil rights. I'm now turning to Commissioner Adegbile, who proposed this project for the commission.

Commissioner Adegbile.

COMMISSIONER ADEGBILE: Thank you, Madam,

and thanks to all who are joining us today for this very important briefing on maternal healthcare outcomes and the causes of maternal health disparities.

I want to begin by saying that we're gathered today in the midst of a national and local health crisis to discuss the nature, causes, and possible solutions to address another health crisis that afflicts the United States and many of our people in the country.

The United States has what is considered to be the worst set of outcomes of developed countries in the area of maternal healthcare along some measures. And we understand from the CDC that Black women face maternal healthcare outcomes and the risk of maternal death at as high a rate as three times White pregnant mothers.

This is a very serious concern. It's the first time that the Commission has turned its attention to this issue, as far as I am aware. But because it's the first doesn't mean that it's not terribly important. We have turned to it because it needs to be lifted up, as the Chair said.

I'm grateful to the staff for helping us put on this briefing today. I'm grateful to my

Special Assistant, Irena Vidulovic, and the fellow Commissioners, including, as the Chair mentioned, our new Commissioners, who helped us work to make today possible. And of course to the witnesses, who we will ask today to do a couple of things.

We will ask them today to help us figure out what are the facts so we can learn more about these (telephonic interference). We will ask our witnesses to help us understand what are the causes and drivers of the disparities that we see so we can understand them better.

And most importantly, we will ask our witnesses to help us think about what more can be done. What are the remedies and solutions so that we can improve maternal healthcare outcomes and reduce disparity? And in particular, use the levers of the federal government to the extent that the federal government plays a role in these things, to improve these outcomes.

Finally, I will say that just last week there was a story about a Black pediatrician in Indianapolis in the national media, who, after delivering by C-section, lost her life as a result of complications associated with the -- with her pregnancy. These issues are timely, they are

important, they are life-and-death issues, and I'm grateful that the Commission, with the support of all of the Commissioners, is taking up these issues.

Thank you, Madam Chair, and I look forward to the testimony of our witnesses.

CHAIR LHAMON: Thank you, Commissioner Adegbile. I'll now turn to us to begin our briefing with some housekeeping items. I share deep thanks to Commission staff who researched and brought today's briefing into being, including the expert team who worked on logistics, for which this virtual environment presents a whole host of additional challenges. And I thank Staff Director Morales for his leadership.

I caution all speakers, including our Commissioners, to refrain from speaking over each other for ease of transcription. And additionally, because this briefing is virtual, I will need to cue our staff behind the scenes for the appropriate video and audio support, so please wait to speak until I have called on you.

For any member of the public who would like to submit materials for our review, our public record will remain open until December 14, 2020. Materials, including if individuals would like to

submit anonymously, can be submitted by email to maternalhealth@USCCR.gov, or by mail to the US Commission on Civil Rights, Office of Civil Rights Evaluation, Public Comments, Attention Maternal Health, 1331 Pennsylvania Avenue, NW, Suite 1150, Washington, DC 20425. We encourage the use of email to provide public comments, due to the current COVID-19 pandemic.

During the briefing, each panelist will have five minutes to speak. After the panel presentation, Commissioners will have the opportunity to ask questions within the allotted period of time, and I will recognize Commissioners who wish to speak, and then I will recognize panelists who wish to respond.

Please raise your hand so it is visible in the Zoom window or text my Special Assistant with the information in your materials if you wish to speak so I can recognize you. I will strictly enforce the time allotments given to each panelist to present his or her statement. And unless we did not receive your testimony before today, you may assume we have read your statements, so you do not need to use time to read them to us as your opening remarks.

Please focus your remarks on the topic of

our briefing. I ask my fellow Commissioners to be cognizant of the interest of each Commissioner to ask questions, so please be brief in asking your questions so we can move quickly and efficiently through today's schedule. I will step in to move things along if necessary.

Panelists, please note that to ensure we have sufficient time for our discussion this morning, I will, again, enforce the five-minute time limit. Please monitor your time so you do not risk my cutting you off mid-sentence.

Given some of the topics that come up with regard to maternal mortality, I want to inform the panelists and the public and remind my fellow Commissioners that since 1983, Congress has prohibited the Commission from, quote, studying and collecting, or quote, serving as a clearinghouse for any information with respect to abortion. Please tailor your remarks accordingly, consistent with this statutory restriction.

We will now proceed to our first panel of speakers, who will speak about policy and legislation in this area. We are honored to begin with Congresswoman Ayanna Pressley, who represents Massachusetts' Seventh District. Due to her schedule,

we will hear her opening remarks for five minutes and open up for Commissioner questions for ten minutes, and then we will continue with the remainder of the panel, whom I will introduce then.

Congresswoman Pressley, please begin.

PANEL 1 -- POLICY AND LEGISLATION

MS. PRESSLEY: Good morning, and thank you for the opportunity to address the Commission and to discuss the stark racial disparities in maternal health across our nation.

It is critical we understand that the maternal mortality crisis is part of the fight for healthcare justice. A safe pregnancy should be a right, not a privilege. Every person should be able to experience their pregnancy without worrying if they will survive delivery or make it to their child's first birthday.

Unfortunately, at alarmingly disproportioned rates, that is not the reality for pregnant people of color, especially those who are Black. Black women in particular face significantly more pregnancy-related health risks than any other ethnic group. As Black women, we are four times more likely to experience life-threatening complications or death during labor, delivery, and the postpartum

period.

And while the Commonwealth of Massachusetts has one of the lowest maternal mortality rates in the nation, in my district, the Massachusetts Seventh, we have some of the starkest health inequities and disparities. Predominantly Black neighborhoods in my district like Dorchester and Mattapan lead in low birth rate, preterm birth, and infant mortality.

In Boston, a city in my district, pre-term birth is 50% higher among Black women compared to our White counterparts. This has been the status quo for the Black families I serve, and these challenges have only been exacerbated the by COVID-19 pandemic. The truth is our current public health emergency has taken a significant toll on the mental health of pregnant people.

Many pregnant or new mothers are isolating at home for safety and due to COVID-19 protocols. Many must attend hospital visits and even go through labor without their support team, critical support systems linked to positive birth, and postpartum mental health outcomes. The CDC reported that half of COVID-positive infants were born pre-term, while Black, Brown, and indigenous communities are at least

twice as likely to contract COVID, be hospitalized, and die from the disease.

The numbers are clear: we are trapped. We are trapped in an unconscionable cycle of harm that is needlessly robbing Black and Brown communities of life, and we must act. As we work towards a COVID-19 recovery, we must reject the notion of simply returning to normal. We know that normal was unjust and unequal in the first place.

Instead, we must work to expand access to quality healthcare and ensure every pregnant person is covered for 365 days after they give birth. This is commonsense policy that will ensure our lowest income mothers are able to access comprehensive maternal care and save lives.

But make no mistake. Access to healthcare is only part of the battle if we are truly going to address racial disparities in maternal health, we need to also confront systemic racism head on. Even Black women with access to healthcare with the highest levels of education, with fame and fortune, experience severe maternal morbidity. When Black women seek care, they are pushed into the cracks of a racist healthcare system that too often ignores our pain, our voices, and discounts our lives.

This is why I introduced the Anti-Racism and Public Health Act with Congresswoman Barbara Lee and Senator Elizabeth Warren. Our bill will create a national center for anti-racism at the CDC, declare racism is a public health crisis, and further develop a base of practical knowledge to root our racism from our healthcare system.

We need policies that expand access to care and ensure that that care is comprehensive, community-based, and culturally humble. Like the Healthy MOMMIES Act legislation I worked to introduce with Senator Booker from New Jersey, which would create strategies to improve access to pre- and postpartum community-based doula care. Because the data tells us that all mothers have better health outcomes when they have doulas or midwives on their care teams.

We must enact innovative and bold policy solutions that center scientific evidence and the lived experiences of all pregnant people. Combating the maternal mortality crisis requires work at every level of government and in every institution, and the work is worth it, because Black and Brown lives are worth it.

Although it seems the nation is just now

catching up to this irrefutable fact, Black women have always been critical to the functioning of our country's democracy. We are saving and creating lives. We are raising and sustaining our families and communities. Black women continue to show up for this country, and we must fight for their lives with as much energy and urgency as they fight for the soul of this nation.

Again, I appreciate the opportunity to speak on this urgent crisis, and I look forward to answering any questions you may have. Thank you.

CHAIR LHAMON: Thank you so much, Congresswoman. I'll open for questions from my fellow Commissioners. Commissioner Adegbile.

COMMISSIONER ADEGBILE: Thank you. Thank you, Congressperson, that was very important testimony, and thanks for your leadership on these issues.

I was wondering if you could help us understand a little bit about the federal architecture here. You mentioned some bills that you have been behind and sponsored and co-sponsored, and I'm wondering if you could help us understand what limitations you may have perceived in the existing Preventing Maternal Death Act that caused you to think

more broadly about additional federal interventions in these areas.

MS. PRESSLEY: Sure. Well, I mean, the data, the numbers are just sobering, they're damning. You know, I should say my paternal grandmother I never had the blessing to know because she died in the 1950s giving birth to my father's youngest brother, sending their -- my father and his five siblings into a downward spiral of great trauma and hardship.

And the fact that my grandmother died in childbirth in the 1950s and Black women are four times more likely to still die really is just, you know, condemnation and confirmation of the embedded biases and systemic racism throughout our healthcare system.

For too long, the pain of Black women has been delegitimized. And so the US has the highest rate of maternal mortality in the developed world, despite spending more money on healthcare than any other country on Earth. And the rates of maternal mortality in the United States has more than doubled since the 1980s. So again, Black women are nearly four times as likely to die.

And within my district which I represent, while the Commonwealth of Massachusetts has one of the lowest maternal mortality rates in the nation, we

continue to see stark disparities in maternal outcomes and infant mortality across the state. The rate of infant mortality for Black mothers is nearly double that of White mothers. Predominantly Black neighborhoods like Dorchester and Mattapan lead the district in low birth, pre-term, in low birth weight, preterm birth, and infant mortality.

So, you know, all of the confluence of all of these things, and then against the backdrop of both this national reckoning on racial injustice, and also the pandemic, which has really laid bare these inequities and disparities as we see with marginalized communities living under the co-morbidities of structural racism, unequal access to healthcare, underlying conditions. And so the maternal mortality crisis has the potential to only be exacerbated by this pandemic.

And so while we're in the midst of this national reckoning on racial injustice, I think it's critical that the first thing we do is acknowledge that there is racism in public health. And that is exactly why Senator Warren, Representative Barbara Lee, and I have introduced the Anti-Racism in Public Health Act of 2020.

So what this would do, and I think is a

first step, and then I have, you know, other bills that support the work of that, but it's to create a center for anti-racism at the CDC to declare racism as the public health crisis that it is, to further develop the research base and knowledge of the science and practice of anti-racism. Because this is systemic. We must be intentional and active in the dismantling of it.

The center would be responsible for conducting research, collecting data, awarding grants, and for providing leadership and coordination on the science and the practice of anti-racism in the provision of healthcare, the public health impacts of systemic racism, and the effectiveness of intervention to address these impacts.

Now, two things I'll lift up very quickly that are interventions that have been proven to work, is investing in our community health centers. We know that they are already proven in combating disparities, they do have those wraparound services, and they also operate with that cultural humility. The other is doula care. You know, these are non-medical persons professionally trained in childbirth to support pregnant persons in childbirth, you know, in delivery.

And there's really growing evidence that the integration of professional doulas into the US maternity care system would result both in cost savings and increased cost effectiveness. Professional doula care leads to fewer caesarian births, fewer adverse maternal outcomes.

And that's exactly why I've introduced the Healthy MOMMIES Act with Senator Booker, which would expand access to doula care.

COMMISSIONER ADEGBILE: Can I ask one quick follow-up question. Under the MOMMIES Act, is one of the issues that Medicaid coverage is limited -- is it limited to pregnancy services and doesn't reach the postpartum pieces? Or what is your understanding of the gap that the MOMMIES Act is trying to get to?

MS. PRESSLEY: Right. So what we're trying to get to is that providing that full, comprehensive care throughout the entire postpartum period, rather than services that are only related to pregnancy. So it, what is does, the Health MOMMIES Act that I've introduced with Senator Booker, is that it requires the expansion of Medicaid's pregnancy pathway coverage from 60 days to 365 days postpartum.

So this is really commonsense policy that will save lives. This bill would also encourage state

Medicaid programs to improve access to pre- and postpartum doula care programs. Because, again, the data tells us that all mothers have better health outcomes when they have doulas or midwives as a part of their care teams.

And then, you know, again, against the backdrop of the pandemic, I want to also talk about the importance of access to telemedicine, which is also a tenet of our Healthy MOMMIES Act. Our bill explores ways that the telemedicine can increase access to quality socially distanced maternity care and services.

COMMISSIONER ADEGBILE: Thank you. That point about postpartum seems very important. I mentioned in my opening remarks, I alluded to Chaniece Wallace, who died two days after her pregnancy on October 22, in Indianapolis. So I think that the risks clearly exist beyond the delivery time. And we know and you have alluded to the impact of that, so I thank you for it and for your leadership.

Thank you, Madam Chair, and thank you, Congresswoman.

MS. PRESSLEY: Thank you, Commissioner, and thank you for bringing her into the room. It's so important that, you know, in the retelling of these

very sobering statistics that we not lose sight of the fact that behind each of those statistics is a person, you know, who was loved and was the member of a family and a community. And so thank you for bringing her into the room.

If you don't mind, I would also just like to speak to a vulnerable population in the midst of the pandemic that I do not believe it getting enough oxygen, focus, or attention, and that is those that are pregnant and are incarcerated.

We know that our county jails and our prisons are really petri dishes for the virus to thrive. Because of mass incarceration, we have overcrowding. And so it's virtually impossible to socially distance. And we have seen surges throughout the country, and it's why I have been pushing for the de-carceration of pregnant women, because they are more vulnerable to contracting this. And I don't believe that this should be -- being incarcerated should be a death sentence.

And so while I continue to advocate for those that are medically vulnerable to be released, I'm prioritizing in that those incarcerated women who are pregnant. I did also introduce legislation as a part of a broader omnibus package with Representative

Lauren Underwood, a Justice for Incarcerated Moms Act, which I'm happy to further unpack if there's an interest in that as well.

CHAIR LHAMON: I'm certain there's interest and I'm also worried about time, so I just to make sure that fellow Commissioners have an opportunity for questions. Commissioner Kirsanow, I couldn't tell if you were raising your hand. No? Okay. Watching people's screens. I'm going to ask my question, but I hope people will raise their hands if they have them as well.

Representative Pressley, you compellingly described the bills that you've introduced, and I note that you have a sort of one-two punch, your focus on this, increasing access to healthcare for all people who will give birth and then also a focus on anti-racism in particular as a way of addressing this issue.

And I wonder if you could unpack a bit for us how you know that we need to be focused specifically on systemic racism in healthcare delivery for Black women in particular in this area. We have received testimony on a variety of fronts about the causes of the disparities, and some of that testimony posits that racism is not the cause.

And so I am interested in your view about why it is that we need to take both approaches in the legislative response.

MS. PRESSLEY: Well, the point is that racism is systemic, it is structural. And because it is structural, it shows up in all of our institutions, it shows up -- it's pervasive even in our policies, which, you know, what I consider to be policy violence, which has often been short-sighted or discriminatory, resulting in those co-morbidities of structural racism and unequal access to healthcare.

And so again, as we find ourselves in the midst of a pandemic which has laid bare these inequities, disparities, racial injustices across all outcomes, including and especially health, you know, the way to reverse course is to get to the root. And so the way to get to the root and to bring about systemic change is to first confront and acknowledge how embedded these biases are within our systems.

Again, this is not about individuals, this is about systems. And the data, you know, bears out that, I know there have been some narratives which lean very heavily on assumption. But again, this has no ties to socioeconomic status, education level.

And so the fact that whether you are low

income or affluent, educated, non-educated, that if you are a Black woman, that you are still four times more likely to have your pain de-legitimized when you express it. And to have those biases potentially result in not only complications, but fatality.

CHAIR LHAMON: Thank you very much and I now see that we are just past your time limit. So I so appreciate your giving us your time this morning. We're grateful --

MS. PRESSLEY: Thank you.

CHAIR LHAMON: For your testimony and we'll move on with the rest of the panel.

MS. PRESSLEY: Thank you very much. Thank you all for your service. Take care.

CHAIR LHAMON: So we'll now move to the other experts on our first panel, who will speak in order as follows: Jennifer Moore, who is the Founding Executive Director, Institute for Medicaid Innovation. Then Shanna Cox, who is Associate Director for Science, Division of Reproductive Health, Centers for Disease Control and Prevention. Then Shannon Dowler, who's the Chief Medical Officer at North Carolina Medicaid. And finally Garth Graham, who is the former Deputy Assistant Secretary for Minority Health at the US Department of Health and Human Services.

We'll begin with Dr. Moore. Please proceed.

DR. MOORE: Chairperson Lhamon and distinguished Commissioners, thank you for the invitation to speak with you today on the critical topic of racial disparities in maternal health. As noted in my written statement, the US has the worst rates of maternal mortality and morbidity amongst all developed countries. We also spend the most on healthcare.

As we did deeper into the data, we see glaring disparities for people of color and those enrolled in Medicaid, the public insurance option for low-income individuals and families. With almost 50% of all pregnancies covered by Medicaid, it is important for us to consider the root causes of these inequities within the context of this population.

It has been noted that structural racism has greatly influenced the maternal health system. It has also defined the development of the Medicaid program for decades, contributing to the outcomes that we are currently faced with.

While I was working in the US Department of Health and Human Services as a Senior Advisor, I co-chaired an interagency maternal health workgroup

that culminated in a multi-day event in DC. The event provided an opportunity to learn from global experts and to identify opportunities for the US to be responsive. A report was developed with the recommendations to address maternal health disparities and poor birth outcomes and is waiting to be cleared for its release.

As a co-author, I will share the five key takeaways from the report that the Commission has the opportunity to elevate. First, it was observed that the high-income countries with low rates of maternal mortality and morbidity valued and emphasized person-centered care. In this environment, individuals weren't simply told what to do and how their birth would be, but rather were informed and supported in making their own decisions based on their own values, beliefs, and preferences.

Second, these countries acknowledge that pregnancy and birth is a normal physiologic event. It is not a disease; it is not a medical emergency or crisis that automatically requires a suite of interventions that are led by a trained surgeon. More does not mean better in maternal health. In fact, research is showing us that the US's high intensity, high intervention approach to maternity care results

in poor outcomes.

Third, and most notable during the multi-day discussion, other high-income countries maximized utilization of midwives who provide expert, high value, evidence-based care, with a obstetrician as trained surgeon serving only as specialists who are called in if needed.

Midwives are considered the standard of care for all pregnant and birthing people. Maternity care begins and ends with a midwife. As such, other high-income countries consistently have higher rates of midwifery-supported births, and it should come as no surprise that their birth outcomes are significantly better than in the US.

Fourth, these countries offer continuous access and coverage for women's healthcare needs. Other countries recognize that there's a need for continuous healthcare coverage for women if you want positive birth outcomes and healthy children now and in the future.

In contrast, for many low-income women in the US, they are kicked off their healthcare coverage through Medicaid within 60 days postpartum. However, some states have become to explore extending Medicaid program up to one year postpartum.

Fifth and finally, the high-income countries will low maternal mortality and morbidity rates emphasize the importance of offering culturally congruent care that is respectful of individuals. The multi-day event named structural racism as a social determinant of health and one of the primary root causes of the staggering rates of maternal mortality and morbidity in the US.

It is astounding the extent to which racism has been embedded into all facets of the US healthcare system, and how social, gender, and economic oppression has fed into this system. The low number of midwives of color, the opposition to Medicaid expansion, and the reliance on surgeons to care for healthy pregnant people is linked to racism and social, gender, and economic oppression.

Commission has an opportunity to take this information from the report and lead the nation. What if in the US, as we consider how to tackle the alarming disparities in maternal health, we choose solutions that we already known are innovative and cost effective?

Specific opportunities for the federal government to consider include supporting Medicaid covering during the first full year of the postpartum

period. Developing evidence-based federal clinical and programmatic guidelines to set expected standards of care. Establishing a national framework on access in coverage in Medicaid to midwifery-led models of care. Providing federal guidance to state Medicaid agencies on how to support birth equity in Medicaid.

Developing performance measures based on guidelines to drive improvement, inform consumers, and improve payment. Developing support of funding strategies aimed at reducing or eliminating financial barriers. Midwifery-led care models and freestanding birth centers, as acknowledge in the provisions of the ACA. And finally, enabling implementation of guideline and performance measures.

We do not need more evidence to demonstrate what we need to do and we can't wait for others to prioritize women and people of color. We just need to take the lead and do it.

Thank you for your time and I look forward to the questions.

CHAIR LHAMON: Thank you very much. We'll now hear from Ms. Cox. Please proceed.

MS. COX: Good morning, members of the Commission. My name is Shanna Cox and I serve as the Associate Director for Science in the Division of

Reproductive Health at the Centers for Disease Control and Prevention. Thank you for the opportunity to speak with you today.

CDC is committed to preventing pregnancy-related death and eliminating related disparities. Sadly, each year about 700 women die in the United States as a result of pregnancy-related complications. CDC's Division of Reproductive Health conducts national surveillance of pregnancy-related deaths through the Pregnancy Mortality Surveillance System, or PMSS.

PMSS data show that the pregnancy-related mortality ratio in the US is not decreasing, and given these deaths are largely preventable, these numbers are absolutely unacceptable. Considerable racial disparities exist, with Black and Native women two to three times more likely to die from pregnancy-related complications than White women.

There is a sharp increase in racial disparities with age. Black and Native women older than 30 are four to five times more likely to die from pregnancy-related complications than White women of the same age. Black women with a college degree are five times more likely to die from complications of pregnancy than White women with a similar education.

Detailed data is key to understanding the causes of maternal deaths, the drivers of disparity, and what we can do to prevent these deaths. Acknowledging this, CDC has emphasized the importance of maternal mortality review as a core public health function. Maternal mortality review is a process by which multi-disciplinary committees at the state or city level thoroughly identify and review maternal deaths.

Clinical and non-clinical information are used to provide a deeper understanding of the circumstances surrounding each maternal death in order to identify contributing factors and develop actionable recommendations. CDC provides funding for 24 awardees representing 25 states to support the review committees through the enhancing reviews and surveillance to eliminate maternal mortality for ERASE MM Program.

We are already receiving powerful information. Review committees have determined that pregnancy-related deaths are associated with a multitude of contributing factors, including access to appropriate and high quality care, missed or delayed diagnoses, a lack of knowledge around urgent warning signs. These data suggest that a majority of deaths,

about two in three, could have been prevented.

Of note, the proportion of maternal deaths that are preventable does not differ by race/ethnicity.

So what factors are driving these disparities? There is evidence of variation in the quality of care received in hospitals by race/ethnicity. Some chronic conditions are more prevalent in Black women and increase the risks of maternal death. Native women are more likely to live in rural and frontier areas where there may be challenges in accessing risk-appropriate care.

Structure racism and implicit bias also play a role in generating these differences. For example, racial segregation impacts healthcare facility access. And personal experiences of racism are associated with delayed prenatal care initiation. The weathering hypothesis posits that Black and Native women experience earlier deterioration of health due to cumulative exposure to psycho-social, economic, and environmental stressors.

This hypothesis may be supported by the data I noted earlier. Where increases of pregnancy-related death by age is much sharper for Black and Native women than White women. So in addition to

strengthening the data, CDC funds 13 state perinatal quality collaboratives and the national network of PQCs to implement and disseminate strategies related to improving quality of care for mothers and babies.

CDC has developed the levels of care assessment tool, or LOCATe, to strengthen states' ability to understand the resources in their healthcare system and to support risk-appropriate care. CDC's Pregnancy Risk Assessment and Monitoring System, or PRAMS, can provide contextual data on the experiences of women with a recent live birth, such as the content of healthcare received and barriers to postpartum care attendance.

In August 2020, CDC released a national communication campaign that brings attention to this issue. Hear Her seeks to raise awareness of potentially life-threatening maternal warning signs and encourages the people supporting pregnant and postpartum women to truly listen and take action when she expresses concerns.

So over time ensuring we have robust data to inform action will give us the tools to eliminate preventable maternal deaths in the US. Eradicating racial disparities are a critical piece of this work to ensure that reductions are achieved among those

that bear the largest burden.

Thank you for your time and your interest in this important issue, and I'm happy to answer any questions you may have.

CHAIR LHAMON: Thank you so much, Ms. Cox. We'll now hear from Dr. Dowler.

DR. DOWLER: Good morning, it's a privilege to speak with you today from North Carolina Medicaid, where we care for almost 2.4 million beneficiaries and cover over 60,000 deliveries a year.

Any death in a woman related to pregnancy is tragic. I can tell you from personal experience that looking in the eye of a new father cradling a tiny newborn and explaining he'll now suddenly be caring alone is unspeakably difficult.

But the majority of pregnancy-related deaths actually occur outside the day of delivery, or even after the first postpartum week. Two out of three maternal deaths are preventable.

We dance around the statistics, but inconsistent data collection, billing nuances, varied documentation and data, and incompatible data systems impede our ability to comprehensively study and understand maternal morbidity and mortality. Substantive federal funding for states to build

infrastructure and capacity that will teach us how to reverse these tragic trends.

Racial and ethnic disparities in maternal mortality exist even when you control for socioeconomic status in medical co-morbidities. Consistent race and ethnicity data tracking must become normative in this country if we hope to discern the path forward.

Another alarming trend we see is increasing numbers of pregnant women with chronic health conditions at the time they become pregnant. Cardiovascular conditions alone are responsible for more than one-third of pregnancy-related deaths.

For many, pregnancy is the first time a young woman has access to healthcare outside of family planning services. In states like North Carolina where Medicaid expansion's been blocked, women often only learn of pre-existing conditions once they become pregnant.

A funding and policy focus on comprehensive, pre-conception care will improve the outcomes of future pregnancies. Currently, as you heard before, we're limited in Medicaid to only cover 60 days of postpartum care. Many women develop chronic disease during pregnancy, experience an

exacerbation of prior diseases, or develop a complication at delivery. All of which require ongoing care.

High blood pressure, diabetes, anemia, dental caries, depression -- these conditions too often go untreated because women lose coverage before they can pause from the demands of a new infant to care for themselves.

One of the single most impactful things we can do in this country today is to allow, actually to insist on, one year of postpartum coverage for women who were pregnant on Medicaid. One of the real positives from COVID is the way that we've seen telehealth move forward rapidly. In North Carolina we've seen improved visit completion rates and we've seen consistent utilization across race, age, and gender.

But at the same time, we've seen telehealth use decrease as rurality increases and as access to broadband decreases. Access to ante-partum and postpartum telehealthcare could be a tremendous tool in our toolbox, but it must be provided equitably. We have to bridge the digital divide.

In my Appalachian county and many around me, there's no public transportation, no OB/GYNs, no

nurse-midwives. While family doctors lead the care teams locally, women must travel almost an hour to see a maternal fetal specialist, get advanced imaging studies, get a hospital or freestanding birth center. Six delivery units alone in western North Carolina have closed since 2012.

Strengthening local communities is a far more efficient driver of equity than sending women off to far-off horizons for care. Increasing training slots for teaching health centers could improve access to high quality care closer to home. Understanding complex social needs is really critical. In North Carolina, we implemented a pregnancy risk screen to identify high risk pregnant women to identify a linkage to care management early.

A statewide collaborative called NC Care 360 contains resources for every county of the state to help meet the social driver of health needs for women. Reimbursing care teams in the medical home for time-intensive screening and referral allows us to engage pregnant women early and often and provide for their unique needs.

Too many women in this country continue to be adversely affected by deeply rooted systemic racism. Historical fear of healthcare due to tragic

experimentation and abuse of the physician-patient relationship helped create this dynamic. Trust-building is a crucial step. Recognizing training and reimbursing a broader ensemble of team members, such as community healthworkers and doulas, will allow us to diversify our workforce rapidly and help women feel safe in their care.

Simultaneously, we must embrace first-generation minority college students and STEM majors and to help build a diverse pipeline of future doctors and advanced practitioners. To overcome health inequities entrenched in a system that created rather than eliminated barriers to equitable care means we must be prepared to share a disproportionate amount of resources to raise up historically marginalized populations.

And I'll close with this: continue listening to the field. Let us not forget the enduring mantra, not about them without them. Thank you very much for your time.

CHAIR LHAMON: Thank you, Dr. Dowler. We'll now hear from Dr. Graham.

Dr. Graham, please proceed.

DR. GRAHAM: Thank you. And I want to thank the Commission and my fellow panelists for

enlightening and discussing a very important issue that has been affecting communities, and certainly I think an increasing challenge.

I want to repeat some of the statistics that were already mentioned for emphasis. The US maternal mortality rate continues to increase, especially compared to some of our peer nations. We are at around 26.4 deaths per 100,000 live births, compared to many other OECD nations like United Kingdom that has 9.2 deaths per live births, or Germany that has 9 deaths per live births.

Earlier this year, the National Center for Health Statistics released three new reports on maternal mortality that continue to emphasize the challenges and the issues faced around maternal mortality and in particular disparities related to maternal mortality.

As said earlier, disproportionate impact of maternal mortality borne by African American, Native American, Hispanic, and other minority women were emphasized as well in those reports. Those reports updated the 2018 maternal mortality statistics and continue to emphasize the grim nature of the challenge faced ahead of us.

What's also important in terms of

understanding leading causes of mortality is realizing that up to 50-60% of those causes are preventable. Understanding the impact during pregnancy, impact of infection during pregnancy, day of delivery related to hemorrhage and other complications. Hemorrhage and other infections one to six days postpartum.

But also understanding the cardiovascular impact 43 to 365 days postpartum and the impact that those have, particularly on the lives of women.

I want to briefly touch on both clinical and non-clinical policy factors that could play a specific role. Preeclampsia prevention and the clinical interventions played there. Multiple medical professional societies recommend a low-dose aspirin for women at risk of developing preeclampsia.

Recommendation for these include starting low-dose aspirin 12 to 28 weeks and continuing through delivery. Those are associated with a 34% decrease in risk of preeclampsia, and up to a 14% decrease in preterm birth in terms of impact of low-dose aspirin.

I want to briefly touch on non-clinical factors and the impact of health disparities overall, and much in terms of what's been articulated structural racism. The Institute of Medicine in 2003 released an unequal treatment report document and the

impact of health disparities on our nation. It also identified a number of solutions that I think are relevant in maternal mortality space and relevant for tapping health disparities overall.

Those include issues related to cultural competency, and also improving the diversity of the workforce. Recognizing the importance of patient concordance, and also the impact of treating and eliminating health disparities overall.

Another factor that was brought into play with the Institute of Medicine report was the issue of data collection. It was mentioned earlier and I wanted to emphasize, collecting data on race/ethnicity and being able to track these factors throughout not just issue the rates of maternal mortality, but through a number of health disparity issues are particularly important.

Lastly, I want to emphasize the importance of the federal agencies that play a discreet and specific role. Certainly there's the Office of Minority Health within the Department of Health and Human Services. I had the privilege of leading that office in prior lives. That office plays a key role in coordinating issues related to health disparities.

Overall, I'm paying attention to issues

related to not just maternal health, but some of the issues related to social determinants of health overall. Within the National Institutes of Health as well, the Office of Women's Health and Research there also plays a key role and has been implementing a number of programs that are particularly impactful related to health disparities and related to maternal health.

Strengthening the role of these organizations is going to be a key component in terms of making sure that we have a robust federal response.

I'll close by saying I thank the Commission for taking up this very important issue. It is timely, it is relevant, most importantly I said earlier, it's about the lives of mothers, babies, and the health of our communities.

CHAIR LHAMON: Thank you, Doctor -- thank you Dr. Graham. At this point we'll accept questions from Commissioners. As a reminder, please do not speak until I recognize you, Commissioners, to ask a questions and panelists to respond to the question. Please raise your hand or notify my assistant if you have a question or would like to respond the question.

I understand Commissioner Yaki, you are ready? Go ahead.

COMMISSIONER YAKI: Thank you very much. I want to thank the panel for their testimony and for being here today under somewhat different circumstances than normally in our hearing room in Washington, DC.

This is a, you know, pretty -- this is a very important issue. It's an issue that I brought up when I was on the Board of Supervisors in San Francisco, you know, nearly 20 years ago, and it's still a problem today.

I wanted to ask the entire panel, I think some of you would have more of this than others, to what extent have there been any measurements or statistics regarding the impact or the disparity for Black and Brown populations with regard to where there -- where Medicaid expansion exists and has it been adopted by a state and where it has not.

I actually in, just in noting that I would say that doing a little research and looking at the census scope and the state of Medicaid expansion that there is a almost unfortunately one-to-one correlation between the largest concentrations of African Americans -- Black Americans in this country and the lack of Medicaid expansion adopted by the states.

But to the extent that, you know, we have

any of the information available, I would be appreciative to hear what you have to say about that.

CHAIR LHAMON: So panelists, I'm looking at you for you to raise your hand so I'll know. Go ahead, Ms. Moore.

DR. MOORE: That's a really great question, and my colleagues and myself have been leading work at the Institute for Medicaid Innovation and using the exceptional federal data sets to compare a variety of birth outcomes, stratifying by Medicaid expansion versus non-expansion states. And further drilling down by rural, urban, and race/ethnicity.

And we have certainly found increased disparities among states that have not expanded. We have a JAMA article that was published looking at the impact of expansion versus non-expansion in preterm birth.

We also have another publication that will be out soon on the same topic, specifically to maternal mortality and morbidity showing increased disparities in non-expansion states compared to expansion states, and then further drilling down to race/ethnicity, urban versus rural.

CHAIR LHAMON: Thank you. I saw Dr. Dowler nodding her head. Do you have an answer as

well?

DR. DOWLER: I was just commiserating. As someone in one of the southern non-expansion states and seeing that it significantly impacts our disparities.

CHAIR LHAMON: Thank you. Pausing to see if Ms. Cox or Dr. Graham also wants to answer, otherwise I know that Commissioner Gilchrist has a question.

Go ahead, Ms. Cox.

MS. COX: One thing that our maternal mortality review committees are able to do is take the data and understand what strategies they can implement. And so states like Illinois have been able to take maternal mortality review committee and focus their legislation in order to do expansion of Medicaid in their state. So the data really does inform these initiatives.

CHAIR LHAMON: Thank you. Commissioner Gilchrist.

COMMISSIONER GILCHRIST: Thank you, Madam Chair. Let me just thank the panel as well today for your testimony.

My first question is to Dr. Moore. You mentioned the concept of culturally congruent care.

Can you help me understand a little bit more about that and give me an example of what that actually is?

DR. MOORE: Yeah, so it's taking in account the values, beliefs, and preferences of the individual, being aware of it. Not imposing your own beliefs, values, and preferences as clinicians within the healthcare system. Hearing where they're at, what they need, what they want, and being responsive to that.

Another term that's frequently used is culturally competent. So as a clinician, we have to go through cultural competencies to maintain our license.

The term culturally congruent is really intended to imply an active process, not necessarily competency, but the active process of ensuring that you're being responsive to that individual. Whether it's their race/ethnicity, their religious beliefs, whatever they're bringing to the table, making sure that you understand that from their perspective and how to ensure that your care is respectful and responsive to those needs.

COMMISSIONER GILCHRIST: Thank you.

DR. GRAHAM: If I could add to some of the -- expanding on that well-articulated comment, and

again pointing the Commission back to the studies and into the medicine report. You know, cross-cultural education, including issue on cultural competency, addressing bias, attitudes, knowledge, and skills has been shown to demonstrate improvement and effective impact in a variety of clinical illnesses, including what we're discussing here.

And so it is -- referring back to the Institute of Medicine or the National Academy's report really does provide a good basis of the evidence base that supports much in which was discussed earlier around this topic.

CHAIR LHAMON: Thank you. I saw Dr. Dowler had a response as well.

DR. DOWLER: Yeah, I think the issue of implicit bias amongst healthcare providers is significant. And I know it was not part of my medical school training, although that was a long time ago now.

But the American Academy of Family Physicians has been very intentional with our work with the help of the public to really encourage our members to do implicit bias training. And there's some question about whether that should be mandated. Should all healthcare providers go through an implicit

bias training and to understand their own unintentional biases.

COMMISSIONER GILCHRIST: Okay. Madam Chair, I have one other question, if I may.

CHAIR LHAMON: Go ahead, thank you.

COMMISSIONER GILCHRIST: In 2018, the Preventing Maternal Death Act was actually signed into law. I know it's early, but would any of the panelists have any comments about how that act is -- you know, what we're seeing with regard to that act being signed and if it's beginning to address some of these concerns?

CHAIR LHAMON: Ms. Cox, I see you have an answer. And I'll go to you, Dr. Dowler, next.

MS. COX: Yes. So through that act, CDC was able to receive appropriations to fund 25 states through 24 awardees to support maternal mortality review committees, where they're able to identify data and strategies to prevent future maternal death. And since that time, we've seen an improvement in timeliness of maternal mortality review data, more comprehensive recommendations in regards to strategies to prevent future deaths.

And so as we continue to build the robustness of the maternal mortality review

committees, they will partner with others within their state, such as perinatal quality collaboratives, patient-centered organizations, and really identify what are those strategies to be able to reduce maternal deaths.

So there definitely has been improvement in the data that's collected and the standardization of data over time. And as more and more recommendations are developed and more standardization of data, we'll really be able to have robust national recommendations to reduce, preventable maternal deaths.

CHAIR LHAMON: Thank you. Dr. Dowler.

DR. DOWLER: Yeah, as a state that's gotten a grant recently for some technical assistance to help us to investigate and understand our own data, I can tell you that the complexities of our disparate data systems and how we collect data between the Office of Vital Statistics and through the Medicaid program and through our HIE makes it incredibly complex. And some of our systems are very, very old. And none of my systems talk to other state systems.

So in order for us to aggregate the data at a national level, we've got to somehow invest in that infrastructure to build compatible systems that

are measuring in the same way and using at least similar data tools.

MS. COX: And if I would add another technical assistance tool that CDC does provide for maternal mortality review committees is what we call MMRIA, the maternal mortality review information application. And it does speak to what Dr. Dowler is speaking of in regards to standardizing that data so that states are tracking similar data, the case narratives are built in similar ways, and the recommendations are -- are developed in similar ways.

And so as we continue to hear from states and understand their needs in regards to importing vital statistics information, linking to Medicaid data, and really continuing to learn from states in regard to best practices, we can continue to develop this information application, such that more and more states can be collecting standardized data to inform these recommendations.

CHAIR LHAMON: Dr. Graham, it looked like you had unmuted. Do you have a response?

DR. GRAHAM: Thank you. Yeah, so this issue of standardization of data I think is an important issue I think for the Commission to grasp and elevate it is how we track and understand what's

happening in these communities. And just in terms of the evolution, improvement, or lack of improvement thereof in terms of health disparities.

The federal charter for the task force on research specific to pregnant women and lactating women was renewed recently, and it really emphasized designing health records to link and monitor and track this issue around a data collection. So I just wanted to emphasize the importance of that as a core building block to really tackle issues around maternal morbidity and mortality.

COMMISSIONER GILCHRIST: Thank you, Madam Chair.

CHAIR LHAMON: Great. Waiting for other Commissioners. Commissioner Kladney.

COMMISSIONER KLADNEY: Thank you, Madam Chair, and I'd like to thank all the panelists, along with everybody else, for appearing today. I don't know how many of you may be on the West Coast, but thanks for getting up so early.

My question really is I'm in an expanded Medicaid state, and my question is we have a shortage of doctors here and we are a low paying Medicaid state. How difficult is it for women to find care, even if it may available, without it necessarily, in

those kinds of conditions? Nobody?

CHAIR LHAMON: Dr. Dowler.

DR. DOWLER: I think a lot of that depends on your state's infrastructure for community health centers. North Carolina has a rich community health center presence across our state and to all rural counties. We have family doctors practicing in every county in North Carolina. So we have been lucky I guess in making sure that care is there.

But it definitely is built on a strong Medicaid program. We have over 90% of our physicians participate in Medicaid in North Carolina, and we've built a very, I think, supportive environment for medical homes and to make Medicaid be something that they trust and they want to participate in.

And definitely in states that have had bad experiences with managed Medicaid and where rates and reimbursement tanked and went very low, they struggle with a very different problem.

CHAIR LHAMON: Dr. Moore.

DR. MOORE: Yeah, I'd just like to add to that that this is a wonderful opportunity to have a conversation about the role of midwives and how midwives can help to support that infrastructure. And what we're talking about is network adequacy within

the Medicaid population.

Considering that the majority of pregnancies are low risk, it really sets up a really nice opportunity to invest in the training of midwives and ensuring that they are able to reach this population and this population is aware of the evidence-based services that they do provide. So I think that that's a really key opportunity for us that is glaringly absent compared to our contemporary countries across the world.

CHAIR LHAMON: Dr. Graham.

DR. GRAHAM: I think Commissioner Kladney brought up a very good point about access in general that I think it's important to understand that pregnancy starts way before preconception and the health of the mother overall. And it was mentioned too before on the importance of access points like community health centers.

And I think that, again, needs to be thought of in terms of the overall strategy when we're addressing issues related to maternal morbidity and mortality is the health of the mother, even prior to even prior to preconception care, and the importance of longitudinal care overall.

CHAIR LHAMON: Thank you.

COMMISSIONER ADEGBILE: Madam Chair.

CHAIR LHAMON: Commissioner Adegbile.

COMMISSIONER ADEGBILE: Thanks to this terrific panel. We've learned a lot already, and thank you for your work and your commitment and your thoughtful answers.

Dr. Moore, I would like it if you could unpack your important testimony that explains that more does not mean better. I'd like to understand in a moment that idea and the things that could be better and maybe not more so that we can figure those out, particularly the federal government is positioned to do something about these things and to just spread that notion.

And let me just put on the table a couple of questions for the entire panel so that, because I see we're getting short on time. So maybe we can have short answers to these. Do maternal healthcare outcomes correlate with certain hospitals?

We've heard a little bit about geography along an urban and rural dimension. Are there some of these dimensions that are about the hospitals, and is it the hospitals or the geography, so that we can understand what's going on there.

And more broadly for the panel, what are

the best sources of the dimension of the scope of the problem for Native Americans and in Native American communities, and are the interventions that we're talking about generally the same one helpful in those communities or different? Help us understand the dimension for Latinx communities as well, and whether or not there's a disparity with respect to Asian Americans would be helpful to know.

And then finally, we've heard a lot about how many of these deaths are preventable. And a real focus on the types of interventions, we heard a little bit about low-dose aspirin, for example. What are the things that help us hone in on prevention? I understand that one of the things you're saying is that data matters a lot and uniformity of collection would help us know more. But it seems to me that you already know some things about these.

There's more, but not more time, so I'll stop there.

CHAIR LHAMON: I will say we have two minutes left. So we're going to do a lightening round of answers, and we also will welcome you submitting written testimony in response as well.

Who's going to go first in our lightening round? Dr. Moore, go ahead.

DR. MOORE: So in response to your last question about how we prevent deaths, first and foremost we need to listen to women. And if you look at the postpartum deaths, especially for Black women, families will share that, you know, they were not being listened to and they weren't being heard about their symptoms and weren't being taken seriously. So first and foremost, we need to listen to women.

In terms of the hospital as an issue, there's an example in a state that will be not be named in which they have one of the highest rates of caesarian sections in their hospital. We looked at evidence-based approaches to reduce that rate. They saw the midwifery model as an opportunity. They brought in midwives. Their C-section rates dropped dramatically.

Also what dropped is their NICU admissions. The NICU admissions is a critical part of their business model that helps them to remain financially sustainable. So there's this conflict between evidence-based care and the business model that we have to work through as a nation.

And then more does not mean better, because we don't have a lot of time, I'll just say check out the work of Gene Declercq, Birth by Numbers

and the Cascade Events.

CHAIR LHAMON: Thank you. Dr. Graham.

DR. GRAHAM: Really quickly, there's a Journal of the American Medical Association paper published recently on the indigenous maternal health, and I'll point to the inventions, I'll say them really quickly that they are recommending.

They're collecting better data and reporting data among indigenous people in tribal nations, ensuring decision making includes indigenous and tribal representation, especially in maternal reviews. Improving workforce diversity and paying attention to violence as a maternal health issue especially for indigenous peoples.

CHAIR LHAMON: Thank you. Dr. Dowler.

DR. DOWLER: So, having levels of care for hospitals is really important. We have that for babies, for NICUs, but we don't necessarily have it for maternity care. Also, developing regional hubs for a hub-and-spoke model where we take centers of excellence and use their expertise to help feed the communities around them.

And from a prevention standpoint, I'd say the one thing we should do is make prenatal vitamins free and available to every woman. We can prevent

birth defects that'll happen years down the road by having prenatal vitamins now, and it should be available to everyone.

CHAIR LHAMON: Thank you. Ms. Cox, will you bring us home?

MS. COX: Sure. From a clinical perspective, implementing bundles of care using perinatal quality collaboratives to improve healthcare outcomes from a clinical side. But we also have to acknowledge the social determinants of health in things such as transportation and housing and how that impacts prevention for maternal deaths as well.

Understanding Latin and Asian Americans often have lower rates of maternal deaths. What we've seen with other data over time is generational impacts that there are also differences in multi-generational health for Latin and Asian Americans.

Also understanding and working with the National Indian Health Board and other Native-serving organizations, as was mentioned, to really and truly hear from Native women and what their concerns are what their issues in regards to access of care and around maternal mortality will be really important for addressing the issues for Native women.

So overall, I think we've all kind of

summarized that there are clinical interventions, but there are also non-clinical interventions. And really, it's addressing all of these factors at the patient, provider, health system and community level that will really give us the information and the strategies to prevent maternal deaths in this country. Thank you.

CHAIR LHAMON: Thank you so much for that close, and I thank all of our panelists. This is a terrific first panel, we very much appreciate your participation. I will remind you that we would welcome follow-up written testimony if there's more information that we should know that we didn't have time to address today.

Thank you very much for now. We'll take a brief break, and we'll reconvene for our next panel at 11:15 a.m. Eastern Time.

Panelists, you can go ahead and leave the Zoom. And you can -- we invite to resume watching the briefing on our YouTube stream. We'll see you at 11:15, thank you.

(Whereupon, the above-entitled matter went off the record at 11:08 a.m. and resumed at 11:16 a.m.)

CHAIR LHAMON: Welcome back everyone.

We'll now move to our second panel, during which we will hear from service providers and private organizations.

PANEL 2: SERVICE PROVIDERS/PRIVATE ORGANIZATIONS

CHAIR LHAMON: The panel will proceed as follows. Angela Doyinsola Aina, Interim Executive Director and research lead at Black Mamas Matter Alliance.

And Joia Adele Crear-Perry, who is the Founder and President of National Birth Equity Collaborative.

Then Taraneh Shirazian, who is the president and Medical Director, Saving Mothers and assistant professor at New York University Langone Medical Center.

And then finally, Mauricio Leone, who is the Chief Operating Officer and Senior Director at Obria Group.

Given some of the topics that come up with regard to maternal mortality, I want to remind our panelists and the public again, and my fellow Commissioners, that since 1983, Congress has prohibited the Commission from, quote, studying and collecting or, quote, serving as a clearinghouse for any information with respect to abortion. Please

tailor your remarks accordingly, consistent with this statutory restriction.

And with that, we will begin with Ms. Aina. Please proceed.

MS. AINA: Good morning to the Commissioners, the Staff of the U.S. Commission on Civil Rights, and my fellow panelists.

My name is Angela Doyinsola-Aina and I am the co-founding executive director of the Black Mammas Matter Alliance.

The alliance is a national network of Black women led organization and multi-disciplinary professionals whose work is deeply rooted in reproductive justice, birth justice and the human rights framework in order to ensure that all Black mammas have the rights, respect and resources to thrive before, during, and after pregnancy.

We use the phrase "Black Mammas" to represent the full diversity of our lived experience that includes birthing persons and all people of African descent across the diaspora.

We are all aware that the U.S. is facing a maternal health crisis. Global data trends have shown that the maternal mortality rate declined in many countries around the world in the last 30 years. But

during the same time period, the United States maternal mortality rate rolled significant.

Even more disturbing, the maternal mortality rate for Black women is three to five times greater than that of White women. And ironically in the U.S., we spend about $111 billion annually on maternal and newborn care.

A recently published March of Dimes report indicated that 54 percent of U.S. counties have limited or no access to maternity care. And 35 percent of those counties are considered maternity care deserts. Meaning, within several areas across the U.S. there is limited or absent skilled maternity care providers within that county.

But presenting raw data alone does not explain the full story of why these maternal health disparities exist in the U.S. We must take a deeper dive into the root cause of these issues.

Black women and girls in the U.S. have been dehumanized and subjected to violence. Including enslavement, segregated health care and medical experimentation that entails sexual and reproductive abuses.

Lack of accountability for preventable pregnancy relates deaths in hospital settings,

mistreatment for pregnant and birthing people, limitations to quality health care and telehealth services, pervasive acts of reproductive coercion and neglect during labor in hospital settings are all contributors of maternal health inequities experienced by Black women and birthing people.

All of these issues are still an underacknowledged problem in the U.S. And yes, more research is needed to better understand the nature and prevalence of this discrimination. And under this pressure of a pandemic, these inequities have been further exasperated.

Over the past few years, there have been various legal and legislative actions spearheaded by grassroots organizations, elected officials and advocacy matrix of remedies to address pregnancy related deaths.

In 2018, the Prevent Maternal Deaths Act was signed into federal law expanding the safe motherhood initiative. Including authorizing support for state and tribal maternal mortality review committees allowing states to collect demographic and health condition specific data on pregnancy related deaths.

Though other acts exist to protect women,

mechanisms for filing complaints on the basis of discrimination are not timely to the pregnancy process. And claims based on racial discrimination require a higher threshold of proof.

And then further, federal and state laws do little to provide adequate reimbursement for midwives, doulas and other birth workers who are not physicians that fit a standard insurance system. This creates further gaps within the maternity care workforce, legislation, to discontinue to the piecemeal approach to eliminating inequities and maternal health outcomes.

To see significant positive change we believe a holistic approach is needed to increase maternity care, workers of color through equitable pay structures, provide holistic quality care to pregnant and birthing people, protections for the disenfranchised, incarcerated and detained, birthing people by upholding their human rights.

Data collection must also be a priority in new legislation for real-time maternal outcomes that offer detailed data useful for clinicians, healthcare and public health system, organizations and legislatures and in academia.

A recommendation for federal government

officials is that help in the fight to end preventable maternal deaths in the U.S. by supporting the Momnibus Act of 2020. If passed, the act has the potential to be transformative from maternal health because it goes beyond address maternal death.

It helps to advance maternal health equity through investments in holistic and community-based models of care, expanding research and improving technological initiatives to expand access to maternal services.

Thank you, again, to the entire U.S. Commission on Civil Rights for allowing us, the Black Mammas Alliance, the opportunity to provide a statement for today's briefing on racial disparities and maternal health.

CHAIR LHAMON: Thank you, Ms. Aina. We'll now hear from Dr. Crear-Perry. Please proceed.

DR. CREAR-PERRY: Good morning. My name is Dr. Joia Crear-Perry. I'm an OB/GYN by training and serve as the founder and president of the National Birth Equity Collaborative where we create solutions that optimize Black maternal and infant health through training, policy advocacy, research and community centered collaboration.

As the daughter of Black medical

professionals from the deep south, my dad is an ophthalmic surgeon, and my mother is a pharmacist. From very early on I understood the value of caring for the health in lots of America's most minoritized group the descendants of Africans enslaved in the Americas.

While I grew up with those values, my medical education tried to teach me the opposite. Not valuing the lives of Black and indigenous people is driving the maternal health crisis in the United States, where they are two to three times more likely to experience maternal death than White women.

We are the only industrialized national where maternal health is on the decline. My daughter Jade is more likely to die in childbirth, than when I had her over 27 years ago.

And in wealthy cities like New York, the disparity is even greater. Black women are 8 to 12 times more likely to die of pregnancy related causes than White women.

We know that the root cause of poor maternal health, racism and gender oppression, inside of health care systems and every other facet of societies, women of color are more likely to experience co-morbid illnesses and report being

unfairly treated within healthcare settings based upon on their race and ethnicity.

Inequities that Black women face have become more urgent as the pandemic and civil unrest show the many ways racism can kill. Whether from COVID, police brutality or hemorrhage during childbirth.

But if we know how we got here, we know what we must do, and undo, to get ourselves out. And wealthy countries, like the United States, there is a grassroots of political call for action for a radical shift in practice to reduce inequities in birth outcomes using respectful maternity care as a model for change.

Respectful maternity care is defined as, care provided to all women in a matter that maintains their dignity, privacy and confidentiality. Ensures freedom from harm and mistreatment and enables and informs choice and continuous support during labor and childbirth by the Worlds Health Care Organization.

The National Birth Equity Collaborative is optimized as Black maternal infant health through training, positive advocacy, research and community center collaboration. Including respectful maternity care.

In partnership with the Institute for Women and Ethnic Studies, Tulane, OVIA, and Johns Hopkins University and many others, we've have been asking women across the United States, particularly Black women, about their needs. What we have learned has the potential to radically transform what it's like to be pregnant in America.

Black birthing people and babies are consistently the most impacted by adverse health outcomes in the United States. Therefore, health care systems and quality improvement should be designed with them at the helm. Patients don't need to be more trusting, health care systems need to be more trustworthy.

That means treating everyone as experts in their own bodies. That means shared decision making that takes places at most marginalized, at the center. And as I always say, there is no quality, quality improvement, without equity.

Transforming the maternity care to value Black lives in service of sexual and reproductive well-being could not only improve outcomes in America but have an impact worldwide. Anti-Blackness and gender oppression are worldwide phenomena.

The opportunities and risks that Black

people experience, whether in Brazil, Botswana or Birmingham, have a common thread because of the social construction of race.

Whiteness too has a global definition. And so when the west transports its medical systems through international development and philanthropy we replicate the American exceptionalism and white supremacy that is killing so many people right here.

I am committed to dismantling White supremacy and I hope you are too. But I'm also just as committed to Black justice, liberation and joy.

And yes, liberation and joy can even be a part of birth. And they are a core tenant of sexual and reproductive well-being that values more than mere survival or the absence of disease. That's what birth equity is all about.

So, thank you, to the Commission, for allowing us to present.

CHAIR LHAMON: Thank you, Dr. Crear-Perry. We'll hear from Dr. Shirazian.

DR. SHIRAZIAN: Hello. Thank you for asking me to present today.

I am Tara Shirazian. I'm an OB/GYN and the President and Founder of Saving Mothers. We are a 501c3 medical non-profit. We develop maternal health

programs to decrease maternal mortality globally and locally.

We have worked around the world to create low cost, high impact programs that unify community and hospital-based efforts to improve maternal health and reduce death. Our programs target the front-line women's health workers.

We target the community health workers and birth attendants, to enhance their medical knowledge of maternal risks and complications. We empower them to communicate and be heard within the health care infrastructure in their own communities

We are front-line maternal health trainers. In 2019, our efforts turned from global to local. Unlike the global setting where health resources are scarce, here, where I live in New York City, with an abundance of resources, yet we have staggering rates of maternal death.

Who are most affected? Well, we've already heard from all our panelists, data from the CDC indicates that nationally, Black women are more than three times more likely than White women to die from pregnancy-related complications.

Tragically, the disparity for Black women in New York City, where I live, is even greater.

Where they are twelve times more likely than Black women to die from pregnancy-related complications.

In 2018, the severe maternal morbidity rate for Black women was at least twice as high as for White women in half of the State's regions. Over 60 percent of pregnancy related deaths in New York City occurred antepartum, prior to delivery, or within one week postpartum. So that's the period of time.

Maternal outcomes are persistently worse for Black and Latina women relative to White women, even after controlling for health status, sociodemographic factors, and neighborhood income.

Maternal mortality has not significantly changed for over 20 years, despite substantial investment in maternal health programs in New York City.

Our own comprehensive review of maternal health programs in our city, which is where we started before we starting this program, found a lack of programs using evidence-based approaches and a lack of reported outcomes. Despite the investment, the results were not evident.

Among the programs reviewed, there was only a single community-based model addressed adverse birth outcomes. But it did not address the maternal

outcomes in any way.

Hospital-based approaches to decrease maternal death have also failed to demonstrate any change in maternal death.

Ten years of global health work with Saving Mothers has produced a clear truth. Reduction in the high rates of maternal morbidity and mortality for any disproportionately affected community requires a participatory, collaborative process. Our more recent local projects have also shown this to be true in New York.

To affect real change, there must a parallel process to train front-line maternal health workers, mothers and health providers so they can challenge and overcome the disparate outcomes of pregnancy.

Systemic racism is one of the challenges affecting Black women and maternal mortality in New York State. Saving Mothers has repeatedly demonstrated that when you advance those, the health workers, the doulas, the community health workers, the birth attendance and the mothers understanding of basic medical information and hone their communication and advocacy skills, the result is a self-sustaining resilience in families and communities. We've

demonstrated this in Guatemala, Kenya and around the globe.

Our mPOWHER Curriculum focuses on providing front-line maternal health workers with needed, high quality health information and advocacy-building skills. The Mom's mPOWHER Kit provides a pregnant woman with easy to use tools to be more health literate about her pregnancy and communication coaching that will better prepare her to identify and challenge systemic racism and sexism in the healthcare system, skills she can use throughout her life.

Phase 1 of our mPOWHER program consisted of using participatory and qualitative methods to develop and evaluate the key components of our proposed community health worker training. We learned that current community health worker maternal health training is non-standardized in New York.

Community health worker training was varied, and despite their dedication to clients, respondents noted a lack of confidence in recognizing health risks and communicating health information to low health literacy clients.

Our mPOWHER curriculum and training focuses on identifying pregnancy risks, health

literacy, and self-advocacy. We really believe that empowering the front-line health workers, empowering the mothers empowers their community. And we also believe in teaching and training, again, the health care providers themselves.

We would further love to collaborate in broader ways and bring our mPOWHER program to more cities, with larger community and hospital stakeholders. Saving Mothers develops the evidence based, collaborative public health programs that tackles the staggering disparity in maternal health.

CHAIR LHAMON: Thank you, Dr. Shirazian.

DR. SHIRAZIAN: Thank you for having me.

CHAIR LHAMON: Next we'll hear from Mr. Leone. Mr. Leone, your camera is off. Well, we may need to come back to Mr. Leone when he can return.

At this point we'll accept questions from the Commissioners. Commissioner Adegbile.

COMMISSIONER ADEGBILE: Sure. Thank you, Madam Chair. And thank you to all the witnesses for your work and for your important testimony.

One question I have for you because you sort of focused today on the issue broadly, but also on what the federal government is doing and could conceivably do better to move the dial on these

issues.

And so, one of my questions to you is, what is your assessment of where the federal government is in terms of its contribution to trying to eliminate these disparities, and what specific interventions, whether they be policy or legislation based, are you thinking would make sense that the federal government should be taking up?

CHAIR LHAMON: I see Mr. Leone has returned, so we'll go ahead and take answers to this question and then after that we'll turn it back to Mr. Leone for his statement.

Go ahead, Dr. Shirazian.

DR. SHIRAZIAN: I think investing in the communities is extremely important. I think investing in community health workers and front-line workers that serve women in our most marginalized areas is key to overcoming a lot of the barriers.

If we want to build trust, if we want to have collaborative programs, if we want our patients to trust us and we want the most underserved to actually come to the hospitals when there is a need, we have to gain that trust. And through community participatory work. And also research and showing the evidence for our programs.

CHAIR LHAMON: Dr. Perry. Crear-Perry.

DR. CREAR-PERRY: Thank you. So, where we are right now, is we finally started to recognize it's an issue.

I was honored to be able to present and testify in front of Congress for the one bill that was passed to actually start sending money through the CDC to pay for counting maternal deaths. We went decades without even funding that work.

And we have not created a requirement so the federal government could do, is actually require states to count maternal deaths. Right now it's a nice to have.

But we know that we don't value what you don't count. And so, you can start tomorrow with the requirement that all maternal deaths are counted. That's a big start.

Another thing that we could, as a federal government, is actually invest in women's health. And that doesn't just mean health care services, transactional services, but that also means paid leave, it also means childcare.

I know right now my 4th Grade virtual schooling that I'm trying to do, and also testify in front of you all, is really complicated. And so, it's

important for us to really think about how we can invest, and as a federal government, women, birthing people, career folk, people who are supporting families to ensure that they can survive and thrive after having a baby.

CHAIR LHAMON: Thank you. Okay, Mr. Leone, why don't we return to you for your statement. You have five minutes. And then I'll go back to the rest of the question and answer period.

MR. LEONE: Okay. Can you hear me?

CHAIR LHAMON: Yes.

MR. LEONE: Great. Good morning. Good morning, everyone. Thank you so much for the invitation to testify and share my experience.

My name is Mauricio Leone. I am the Chief Operations Officer for The Obria Group and I am here today to present a "boots-on-the ground" perspective from the field.

We are a nonprofit organization with a national network of more than 20 life affirming health clinics in several states across the nation. Our target population experiences significant disparities accessing health care studies and health education.

We provide life affirming health care services to anyone in need, regardless of race,

ethnicity, age, gender, creed, national origin or ability to pay.

We offer prenatal care services, well woman care, STD testing and treatment, sexual risk avoidance education, parenting education, and pregnancy resources to over 10,000 patients a year. Mostly women and minorities.

Although we live in one of the most developed nations in the planet, there remains significant barriers to life-affirming health care services. We at Obria have observed the following.

There are still challenges navigating health insurance for pregnant women, which is a significant barrier to access of prenatal care.

Although pregnancy Medicaid coverage is widely available in California, and I believe in the nation for all low-income pregnant women, it is still extremely difficult to navigate or use.

There is a lack of providers who accept Medicaid for pregnant women. Health care providers don't necessarily have a contract with every single Medicaid HMO out there, or don't want to serve Medicaid patients due to the low payments. Others accept Medicaid insurance but provide lower quality care.

There is lack of access to evidence-based primary prevention strategies, such as sexual risk avoidance education. Especially for the youth population in public schools, which results in a higher rate of teen pregnancy and STDs.

This is very important because teen pregnancy is linked to low birth weight and infant mortality.

In spite of the documented benefits of sexual risk avoidance education, in 2016 the State of California enacted the Healthy Youth Act, which intended to prevent pregnancies and STDs in young people.

But cases of STDs have reached a 30 year high in California. Over 400 percent increases in some counties. Sadly, women are more impacted with STDs than men.

Unintended teen pregnancies are also very prevalent in some communities, which have higher rates of pregnancies than the national average.

Although there is a positive downward trend in late or no prenatal care, we see a significant proportion of expectant mothers who still come in late to our clinics for prenatal care services due to lack of knowledge about their options in the

community.

Our medical providers have reported that there is very little information available for pregnant women about their health care options in the community. Including information about their health insurance coverage options, for bringing pregnancies to term.

There is a prevalence of substance abuse among pregnant women coming to our clinics. This can produce preterm births and have a negative impact in women and babies who are at risk for poor outcomes.

We see the need for risk avoidance primary prevention strategies because they can lead to health outcomes that are improved when risky behaviors are avoided.

There is no consistency or follow through with preventive screening and treatment, which leads to disparities in pregnancy care. We see a trend in our patient population that, due to low educational attainment and health literacy, patients don't follow preventive health screening recommendations. They usually come to our clinics when they are already overweight, already infected with an STD, or are late in their pregnancy.

Lastly, we observe a lack of medical

compliance by our pregnant women. This is small, but consistent percentage of patients that don't comply with their care recommendations.

This includes complying with follow-up appointments and routine laboratory tests. This is due to transportation, childcare, health insurance, communication or other psychosocial issues.

In sum, there are significant disparities still affecting low-income pregnant women in this country. These disparities have a negative impact on accessing quality life affirming the early pregnancy. Which might partially explain the differences in pregnancy outcomes among different populations.

We also think that it is critical to address another social determinant of health that is equally important to achieve positive outcomes for mother and child, evidence-based risk avoidance education because it has an emphasis on personal responsibility, healthy relationships, and self-regulation skills.

As public health representatives, we advocate for strategies that help low-income women, and individuals, develop the skills necessary to make healthy choices and avoid risky behaviors. Our goal for every patient is optimal health outcomes. When we

have the active involvement of the patient in avoiding risky behaviors, we're more likely to achieve this goal.

Thank you so much the invitation.

CHAIR LHAMON: Thank you very much. We're open to continue with our questions from Commissioners. Commissioner Kirsanow. Or no, Commissioner Kladney.

COMMISSIONER KLADNEY: So, we've had your testimony, and the last panel's testimony, and they've given us a lot of food for thought. But is there a model program in the country, in the community, that you could cite that handles this problem better than anyone else?

And where would that be, and if there isn't one, is there somebody who has proposed a program to move this problem forward?

CHAIR LHAMON: Panelists, if you could raise your hand or unmute, I'll know you're ready to talk. Dr. Shirazian. And then Aina next.

DR. SHIRAZIAN: We actually did a review of all the maternal health programs that exist in the U.S. And then we focused in on New York State, because as I said, we live in New York State so we wanted to start very local.

There are a number of programs that have enjoyed some variation of success and have had elements that have been successful. But there is not like one dominating one that I would say has sort of really, really been able to do everything.

So, that's why when I mentioned the mPOWHER program and us starting sort of these, this program here in New York and starting with the participatory collaborative process of interviewing all of our community health workers and speaking with them about training and how, what training they've had to date and what training they would like, and even through this pandemic we've been doing Zoom trainings with them, focus groups and trying to understand exactly what their needs are in order to develop a more comprehensive program.

So, as I said at the beginning, at Saving Mothers we are at the beginning stages of trying to develop that type of collaborative, participatory, community engaged program that would start with the community but then would extend out into the hospitals.

And we have models of this that we've done in other communities globally. We're a global women's health organization. So we're in Kenya on the ground

doing very similar programs.

Out in the community with the birth attendants developing training for them that then allows them to be cultural brokers and advocate for women at the level of the hospital and the clinic.

So, what I'm suggesting is we use some of our global approaches to maternal health and death, apply them locally, use a collaborative community, and also hospital based model. Bring those two together, bridge our front-line workers, bring them along with us.

We have so many community health workers across this country. Most people don't even know what they do. It's kind of amazing to me.

In New York, we have so many community health workers, and whenever I mention them people are like, oh, those people exist, I'm like, yes. They go into the homes, they go into shelters. They talk to pregnant women there in the most marginalized regions of the city.

So, I think we need a collaborative training for our front-line workers that intersects with our hospitals and our clinics. We get participation from each and we build a broad collaborative program that way.

So we're prepared to work with whatever groups are interested in this, but we really firmly believe that we have a very good training model and we can start training front-line workers.

CHAIR LHAMON: Thank you. Ms. Aina.

MS. AINA: Yes. What I wanted to add to the question that was just asked is to, I'm going to take us back, to understand that the challenges of the maternal health crisis in the United States is very, very complex.

So, therefore it requires complexity and diversity in how we address these issues. And it needs to be addressed at multiple levels, across multiple sectors.

So, for example, we need more support of federal policy to be passed. Such as the Momnibus Act. That definitely needs to be passed.

That will help with a lot of the system challenges that we see at the state and local levels to get a lot of our public health programs further equipped to actually do these partnerships. These multi-disciplinary partnerships.

Whether we're talking about community, with community-based organizations, with academia, with hospital systems. All of these things need

further investment.

In addition to that, we know that we need to start creating more pipelines around providing an opportunity for maternity care providers and not just investing only in producing more and more physicians. We need to produce more midwives, more doulas, yes, more perinatal health support workers. And this can look like a multitude of things.

And then finally, what I will add to this conversation is that there is several organizations within the alliance, including the national birth equity collaborative. And several organizations across the countries that are doing this work from a holistic, maternity and reproductive health care perspective.

There is not one solution to this very complex problem. But, we definitely know that there is a significant gap in providing those necessary investments, in culturally congruent community-based approaches to addressing this, these multitude of issues.

And we know that the solution really to make these necessary changes is based at the local level. So that's why we really do emphasize really uplifting and supporting the work of community-based

organizations that had been doing first equity work, providing midwifery services for decades to their communities.

And last but not least, I also think it's important to understand that while we do talk about expansion of Medicaid, ensuring that we have programs and educational services around building health literacy, sometimes that can have an assumption that this issue is only impacting low-income people.

This issue is impacting people of all educational backgrounds and social economic status. So we have to have a very multi-prong and multitude approach to this.

And we do believe, here at the Black Mammas Matter Alliance, along with all of our partner organizations, that we have a solution to that.

CHAIR LHAMON: Thank you. I'm looking to see if the other panelists, Mr. Leone.

MR. LEONE: Yes. So I believe there are several universities showing positive pregnancy outcomes with some of the programs.

And most of the programs that I know, I don't remember exactly the names of them, but those programs that are showing positive pregnancy outcomes are the ones that are using health education, are

investing our time in educating the patients.

And I agree with the other panelists that say that we need to embrace these or confront these in a holistic way. So, it's not just physical issues that are patients are dealing with, our also psychosocial issues and spiritual issues and social issues.

So, if we have these programs that are holistic in nature and address physical issues, but also psychological, emotional and spiritual issues, I think that patients can have better pregnancy issues.

CHAIR LHAMON: Thank you. Dr. Crear-Perry.

DR. CREAR-PERRY: I just want to add and build on, especially with, so we know despite income or education, Black women are still more likely to die in childbirth than their White counterparts. So a Black woman, the CDC released a report that a Black women who is college educated and above, is five times more likely to die than a White female in a similar situation.

So this idea that if we can place, got a good job, got some health insurance and exercise and move to a nice neighborhood that everything would be okay, if we were just more compliant and showed up to

our appointments, it's not based on the actual data. The fact is, when we do all those things we're still more likely to die.

So whatever programs, to Angela's point, to Taraneh's point and Mr. Leone's point, whatever we do has to be comprehensive, but it can't be based upon bias and lack of truth.

So the truth is, even when we do all the things that's, prevalence responsibilities that we should do, we are still more likely to die. And we're not investing in the things that allow for us to have psychosocial and spiritual wellness and joy.

So, those things require us to actually invest in women's health, regardless if they're pregnant or not, community's investment, regardless or not. And not contain this fallacy that it's because we don't show up for the doctor or because we are not getting access to Medicaid.

Like, those are the reasons we die. Because even when those things happen, we're still more likely to die.

CHAIR LHAMON: Thank you. Commissioner Kirsanow.

COMMISSIONER KIRSANOW: Well, thank you, Madam Chair. And thanks to the panel, this has been a

very informative testimony.

Several panelists have testified that structural and systemic racism is one of the principle causes of maternal health care disparity. Can, and this is to anybody, can anyone give me specific examples of what you mean by systemic and structural, invidious racism or racial discrimination in systemic structures and medical systems that cause maternal health care disparities on the basis of race?

CHAIR LHAMON: Dr. Crear-Perry.

DR. CREAR-PERRY: This is my life all day. I feel like I can't help but start.

So, and the specific example is, how we structure even the policies around who gets access to care. As an OB/GYN, many of us trained in the hospitals and facilities where there were only Black and Brown bodies. We assume, still, the legacy of history of eugenics that the people who we have to train on have to be, are communities of color, right?

So if you go to any place in your cities, in your town, the hospital training institutions are Black and Brown bodies. So what would it look like to be a structural system that said, training doesn't mean Black and Brown, training doesn't mean poor people, training doesn't mean non-centered people.

If we trained, we invest in, ensure that the people who need the most resource, so those communities, if you're talking Charity Hospital, where I train, or Grady Hospital in Atlanta, those patients actually need the most. They are the most complex patients and we are sending them to places where there is training.

We're not investing in those institutions so both Charity and Grady are always struggling to get budget, that's racism, that's structural. They're begging for money to even keep their doors open, and yet we're sending the most complex patients to those centers. So, over and over again.

Then we get poor outcome. And we're trying to figure out, well, where do poor outcomes come from.

We've never invested in the people who actually need continuity, who need a birth center in their community led by a midwife, have a doula supporting them from their community whose invested with them. That's what they want, that's what we should be investing in.

That's a structural decision that we are making as policy makers to not allow for the growth of birth centers, the growth of midwives, the growth of

doulas. That's how structuralism works.

It devalues groups of people, and also institutions, and invest in things that are harmful to support the legacy and hierarchy of White supremacy.

CHAIR LHAMON: I thank you, Dr. Shirazian, oh, sorry, Dr. Shirazian, I saw you had an answer as well?

DR. SHIRAZIAN: Yes. I mean, I completely agree with Dr. Crear-Perry in terms of like how our health care infrastructure is setup, I'm also an OB/GYN, in how systems are setup.

I can just give you a few examples from a very like personal perspective. Not my lived experience, but certainly the community health workers that I work with and what they tell me. And what I actually see as well.

So, if you're a patient. So I'm just going to give you like an individual patient kind of perspective. But if you're a Black pregnant woman and you come into a clinic, let's say, in New York City, and you have to wait eight hours in the waiting room for care, that is structural and implicit racism right there.

Because that, you know, that waiting room, it just devalues that patient, right? She has to wait

nine hours to see a doctor. The clinic is busy.

When she sees the doctor, the doctor gives her five minutes to talk to her, to answer any questions. Maybe she's not a sophisticated speaker, presenter. She can't even get out her issues or complaints. Maybe she doesn't know how to articulate them even.

You know, brings in issues of health literacy and how she's heard. Whether the doctor hears her, whether he or she understands what she's saying, whether they bother to listen.

So, I mean, those are just some very simple examples. But I think from an individual patient perspective, if you go into those clinics and hospitals or you go to see your doctor and you don't feel valued, you don't feel respected, you don't feel listened to, why would you ever go back. Like, why would you go back if you have a true problem, you're going to stay home.

And that's where we see, sometimes maternal deaths happening because people don't come back in that quickly. I mentioned before, most maternal deaths, at least looking nationally at the data, they happen before delivery or in that first week postpartum.

So if you go home and you had a horrible birth experience and now you have pain in your leg that could be a blood clot, you're not going to raise your hand to go in and see the doctor, you're going to call your friend, someone in your community. Maybe that front-line health care provider.

That's why I say, a lot of the solution lies in the communities because people, women trust their community leaders, they trust their community health providers.

And until there is a day where they can also trust their clinics and their hospitals to listen to them and be respectful and not make them wait for hours, you know, that system is going to take a longer time to change. So that's why I always say, community first, educate the community, empower the community, the results lie there.

CHAIR LHAMON: Mr. Leone, it looked like you had an answer.

MR. LEONE: Yes. So, I just wanted to say that I agree with Dr. Perry that health care services is not just what is needed here.

What we need is a primary prevention strategy. Something that can educate patients when they are done. When they're, early in life so they

don't engage in risky behaviors. And then they don't show up with these comorbidities to their care.

So, again, I agree with her that health care is not, the only pin that we need to address here is also primary prevention. Because primary prevention studies are more cost effective and efficient than later remediation.

So, I believe that we need to make an effort in educating the patient early in life. And I believe that sexual reasonable education is one alternative, or one good alternative for you guys to consider.

CHAIR LHAMON: Thank you. Ms. Aina.

MS. AINA: Yes. I believe that the question was originally talking about racial and other systemic discrimination in our hospital settings and just around the entire system.

We have spoken to several women of varying ages and socioeconomic statuses via focus groups, for the past three years.

And what's pretty consistent is that when they do come into a hospital facility, the types of treatment that they receive tends to be based on the type of health insurance that they have. Whether they're on Medicaid or they don't have insurance at

all.

And many of them have reported actually being discriminated against by health care professionals. Whether it be the front desk administrators who are not taking some of their complaints very seriously, or they have gone, or they're in the laboring process and they're trying to explain to their clinical provider of any pain or challenges that they're having. Or may not understand why all of a sudden some kind of surgical intervention has been deciding upon them without their consent.

These are examples of systemic discrimination, based upon the fact that, one, basic patient consent to understanding what services are being provided to them is not happening in these facilities.

Further, during this COVID-19 pandemic, earlier on in the pandemic, a lot of hospital systems, unfortunately, were passing policies that restricted the ability for different birthing persons to bring support for, their support persons with them. Whether that's a doula or somebody else that they wanted to bring with them during that process.

And so, you know, these policies get passed at the local health care system's level at any

kind of realm, depending on what's going on. And so, these are, I'm just providing that as specific examples because they do lead to negative health outcomes.

And we see that more nationally on, fort, I mean, this is very unfortunate. We see that in the story of Amber Rose Isaac in terms of, you know, she did everything that she possibly could to navigate the health care system in New York.

She requested for midwife services and still wasn't provided that. And unfortunately died after being serviced at the hospital's system.

We saw that with Sha-Asia Washington, who was ignored. Her blood pressure, I believe, was rising and no one attended to her and she still died.

So these are actual examples of discrimination in the health care system. This is not because these young ladies came into the hospital and they had all these preexisting conditions, these were preventable deaths that health care providers are trained to actually intercede in and it didn't happen.

So these are examples of discriminatory acts in these health care systems.

CHAIR LHAMON: Thank you. Mr. Kirsanow.

COMMISSIONER KIRSANOW: Yes. Thank you

very much for that.

Dr. Shirazian, I think you indicated that female Black mortality rates are higher than that of Whites. I'm supposing that that's controlling for socioeconomic conditions?

DR. SHIRAZIAN: Yes.

COMMISSIONER KIRSANOW: How do they compare with Asians?

DR. SHIRAZIAN: Black women have the highest rates, then Hispanic, then Asians and then Whites. So, it was a cross, I listed here health state, health status, sociodemographic factors and neighborhood income. It was taking into account all three of those things.

I definitely is true that even a long socioeconomic lines, Black women die at significantly higher rates than White women.

COMMISSIONER KIRSANOW: Thank you.

CHAIR LHAMON: Dr. Crear-Perry, it looked like you had an answer as well?

DR. CREAR-PERRY: I just wanted to, because we talk a lot, we use White as like the default race. And in so many experiences, actually, Asian Americans have better outcomes than White folks.

So we got to really reframe how we talk

about race and the implications of race. Race is not biological.

I don't have a Black gene, I'm just as likely to have the same genetics as Dr. Shirazian has. We are all one human race. We completed the entire human genome project.

So when you think about the differences of how Black women are treated in the hospital and the outcomes we have in birthed, it's not because our kidneys are different shaped or our lungs are a different size and White women have different kidneys and lungs and Asian people have different, it's how we are treated and seen in the system. It's how the structures show up when we are addressed.

So, even as Angela mentioned, we have studies and data that shows, despite payer, Dr. Liz Howell did a study that show that Black women who have insurance payers who have good insurance still get treated worse than their White counterparts who have no insurance, who show up with no prenatal care.

So, until we can have an honest conversation about the devaluation of people based upon skin color, based upon gender, based upon income, we're never going to fix maternal health crisis.

CHAIR LHAMON: Thank you. Commissioner

Yaki.

COMMISSIONER YAKI: Thank you very much. And thank all of you for taking time today on this important topic.

I come at this from sort of two different angles here. One, I used to be in local government, so I understand and really appreciate and quite championing the idea of locally based, community-based organizations in delivering really critical services to communities.

The other part of me is when I was at the federal level working for the speaker and talking about how do we get the resources necessary to make that happen.

And that tension between funding us studies, who controls the studies, this kind of stuff, if we want that information. And then sort of the control. Where is it going to be distributed is really sort of the crux of how do we address this.

Are there any good models out there that the federal government can look at to say, okay, this is the kind of mechanism that we can direct dollars to that will achieve these kinds of results that we want to see on the aggregate, but at the local level, reduce the kinds of individual changes that we want to

see.

I guess, is, are there things out there that the feds can latch on to and say, this is how we want to be able to figure out a way to distribute the dollars necessary to meet this critical health need?

I see people smiling, that's interesting.

(Laughter.)

CHAIR LHAMON: Dr. Crear-Perry.

DR. CREAR-PERRY: Well, because I'm excited about the opportunity. I'm in a place of justice and joy today and I'm like, listen, what are we going to do different, how are we going to do something different.

So one of my favorite programs in the world is the Healthy Start Association. A healthy start program.

My first job in maternal child health was the medical director for the Healthy Start in New Orleans. And this idea that you can actually give money to communities and they can fix their own problem.

It was actually a Republican idea. This was amazing. We had never scaled it up, we never invested in it and we've never, and it keeps showing that healthy start communities have better birth

outcomes. We know that through the data and yet we've never actually invested in it.

So we keep doing trickle down. And we give, the federal government gives money to the state and the state tries to figure out.

And you know the city, how as a city person, states, city fights can cause that to be a lot of drama, that can be very complicated. Mayors don't get along with the governors, all that stuff happens quite a bit.

So what does it look like for the federal government to be billed out by health start model, to trust communities with the dollars to do the work. They were doing social determinism of health before the WHO made it up.

They've been doing, having housing and having legal aid and having everybody to work on infant mortality for 25 years. So, that's the kind of innovation you get when you actually invest in local communities.

COMMISSIONER YAKI: Great.

CHAIR LHAMON: I see Dr. Shirazian has an answer as well.

DR. SHIRAZIAN: Yes. And this kind of talk gets me excited me.

So, I think that, I think as Dr. Crear-Perry just said, that it really does, as I've been saying, lay in the community. But I do think that we need to understand all the communities that are out there doing this kind of work, I think we need a broad, collaborative force that brings them all together.

I think we need standardized approach and training. Like, every body gets the same roadmap, not, individuals are sort of kind of creating their own.

Because I do think that consistency is important because then we have a model that works, we have a plan that works, we have an evidence-based approach.

We need better data. I mean, we talked about death rates, we need to track death rates. It's not only in this country but it's everywhere by the way around the globe. I mean, tracking death rates in terms of mothers is horrendous everywhere.

But we need consistency in terms of the approach and we need to have training to be consistent, we need to the approach to be consistent and we need to collect data because. Because, when I did a review of the data I was shocked. I mean, there

is so many groups out there doing good work. I know their good work.

But if I go on a PubMed search and look for like their articles or their published data, I mean, I don't find anything, I find very little. I mean, that's a problem. I need to be able to look there and see the evidence for myself and read it.

And people, we need to be accountable for the dollars, right? We can't just give states money and then who knows what happened to the money, right?

It didn't go back to the communities. We don't know if there was any change in maternal outcomes of death. That's a problem.

The other problem, while I have one more second, is that people track birth data, right? They look at the babies, a lot.

They look at, this drives me crazy, okay, they look at preterm delivery rates, they look at low birth weight. How many years have we been looking at low birth weight and preterm birth weight, okay.

What about the mothers? That's why we're about the mothers. Like, we want to know, did the mothers die, did the mothers have to come back for other interventions, did they have surgery, what happened to the mothers, it's not all about the

infant.

So, I think there is this issue of maternal infant health. And the maternal gets diluted under the infant sometimes.

And we really, in order to have good programs that actually address maternal mortality, we need to focus on the maternal. We need to focus on the mothers.

CHAIR LHAMON: Thank you. Mr. Leone.

MR. LEONE: Yes. So, I think that a good idea for the Federal Government to consider is to fund organizations that are life affirming. Organizations that are providing life affirming health care services.

Why? Because we provide health care in a holistic way. Emotionally, psychologically, spiritually and physically. And we tend to expand more time with our patients then other organizations do.

So, if you can direct funding to life affirming organizations, that would be ideal. And we can show that we have a higher patient satisfaction rate too.

And also, I would like to share with you that the University of California, two months ago,

they came to us because they have a program to serve pregnant women in the local jail in Orange County California. And they came to us because they couldn't find any other organization in the community that would accept those women.

And that is very interesting because the programs are already funding several fairly funded health care clinics that are supposed to serve these women. And they are putting barriers to them.

So, we serve anyone regardless of their ability. And we don't discriminate based on race or national origin. We are life affirming organization so I believe that if you guys take a look at what life affirming organizations are doing, it will give you another perspective or alternative to what is needed in the country.

CHAIR LHAMON: Thank you. Ms. Aina.

MS. AINA: Yes. What I wanted to add is that this really does need to take a both-and approach, and not an either or approach.

And I say that because I know it was mentioned earlier about really investing in a lot of evidence-based models and honing in on a standardized training and things of that nature.

I do want to lift up that those also

actually serve as structural barriers to a lot of our, for a multitude of communities. Most especially Black and indigenous communities.

And more specifically, Black and indigenous midwives. Black indigenous midwives who practice at the public level.

We know that across several states there's different rates of regulations of how midwives can practice. Same thing for doulas as well.

And so, we really do tout that we need multiple options. Because, just having multiple options around choices is really important for a lot of birthing people across the nation. No matter their socioeconomic status in income.

And so, definitely more investments in minority serving institutions that can do this type of research to build the evidence of the positive birth and maternal health outcomes that we know that a lot of our communities of color are doing.

More investment in non-profit organizations that can do a better job of not only providing a space for workforce development but to also provide comprehensive training around whether you're talking about a holistic approach to perinatal health care or holistic approach to midwifery care,

doula care.

There is not always these, again, this one-sided, one-narrow way approach to these things. Because, multiple communities look like multiple different things. And have multiple different challenges.

And especially, and I have to lift this up, especially for a lot of us in the south region area of the United States. Our rural communities need a lot of programs and services.

And we have people in those communities, organizations, academics. People of multiple disciplinary background who are ready right now to engage in a team-based approach to addressing a lot of these issues.

And need equity-focused investments. And not just investments in the traditional players in the maternal and child health sector.

CHAIR LHAMON: Thank you. I see that we have two minutes left for this panel, so I'm looking to see if there is one last Commissioner question. It looks like Commissioner Adegbile. And then we'll do a lightning round to take us home.

COMMISSIONER ADEGBILE: Great. Thanks very much. This has been a very enlightening panel.

I'm trying to understand if one of the takeaways that we should have from the collective testimony, or the aggregation of all this great testimony, is that because of the concept of maternal health care deserts and the absence, in some communities, of access, that part of what we need is more of the, the sort of birth centers, community localized approach to be reaching folks with interventions.

I'm just trying to understand. I get that we have big hospitals and there are issues there. Regardless of what your socioeconomic status is in your education. But I'm also trying to get at this gap point.

And then the other thing I was a little bit confused about is, what is life affirming?

I'm assuming that in the plain English I would guess that all of your organizations are life affirming. You're working on issues that are trying to prevent death and disparity. And so, I'm trying to understand what is life affirming and what the object we're trying to move away from. Thanks very much.

MR. LEONE: Yes. So I can answer that question about life affirming, the concept.

I would say that life affirming, life

affirming organization is an organization that values life. And not only the life of the mother, but also the life of the baby.

So when you have that perspective, when you approach health care with that view, with that concept decision, you really take care of, you really pay attention, you really address the needs of the woman and the baby.

So, if you have that holistic approach to women, at the local level, then I believe we can have better pregnancy outcomes, as we see in our clinics. With higher patient satisfaction and a higher birth rate.

CHAIR LHAMON: Thank you. Dr. Crear-Perry.

DR. CREAR-PERRY: Yes. So, yes, you're right, Commissioner, that it is a mixture, we believe it's a mixture of local solution that the federal government can really invest in more birth centers, more midwives, more doulas, education for culturally congruent.

We left out, we didn't talk a lot about our indigenous sisters. And I think there is a lot in the tribal community that we were missing, investing in the tribal community and their maternal care.

But the goal, why I brought up that I'm the child of an ophthalmologist, is because surgery happens in hospitals, birthing a baby is not an ICU event. So all of the things we've been doing to fix maternal mortality have been as if we were all ophthalmologists and we need more technology and higher more bigger hospitals. And what people want, want patients want is care in their communities.

Life affirming, our mission is maternal and infants, so I guess I can start calling myself that too, right?

Life affirming care in their communities, ensuring that we are addressing the needs of the people, with people who actually look like them.

CHAIR LHAMON: Thank you. Dr. Shirazian.

DR. SHIRAZIAN: Yes. I mean I think to fill these deserts that exist, we definitely need community-based organizations. We need community players, doulas, community health workers, all of the community players that help us serve the needs of women everywhere in this country.

I wanted to just say one thing about standardized. I don't think that standardized has to be negative here, I really don't. I think that standardized just means that we have a common playbook

that we can take up program and we can apply it.

It doesn't mean that it has to be the hospital or the doctors that design the playbook, right? It doesn't mean that they have to be the ones creating the playbook. In fact, I think that the community investors, the doulas, the community health workers should be the ones laying the groundwork for those playbooks.

But I do think that we need to rethink how we talk about standardized and we do need to have this sort of common whatever you want to call it, but common model, common playbook, whatever it is, because we need to know what is actually working and we need to have the data. We just do. Like, we cannot not have evidence. It's just --

CHAIR LHAMON: I'm going to move to Ms. Aina for the last point.

MS. AINA: Yes, and I would agree. Definitely we are about wellness. We are about what our people want. And especially to uplift the fact that we should always trust black women in this instance and that includes over their entire life course. So it is very much life-affirming whatever choice that they seek to make about their lives.

And definitely to agree, I do agree with

you that we do need standards. And I think that also what I was trying to say earlier is that we need to make room for community-based models of care and practice to help add to those standards.

We need to make room for looking at different models of research that uplifts those (telephonic interference) from these communities that are most impacted, whether we are talking about creating more pipelines for native and indigenous people, black folks, Asian folks, whomever, who are really culturally competent and holistically-minded around different research models and understanding how to collect that evidence to build out the evidence base to show positive and maternal and infant health outcomes.

And, lastly, by doing that we also believe that that will help to debunk, right, misinformation that get pushed in our communities and anything that seeks to dehumanize our communities through services or any kind of programs that seeks to mystify or shame black women and birthing people about their choices around their maternal and reproductive health care.

So all of those things are very important. Thank you.

CHAIR LHAMON: Thank you all. This was an

extraordinary panel and we're very grateful to you for your time and your expertise.

We will take a brief break now that we have come to the end of our second panel. As we'll be very brief, we'll be back in six minutes at 12:25 p.m.

Panelists, you can go ahead and leave the Zoom and we invite you to resume watching on the YouTube stream for the rest of next panel. So thank you very much. See you all back in, now, five minutes.

(Whereupon, the above-entitled matter went off the record at 12:20 p.m. and resumed at 12:26 p.m.)

CHAIR LHAMON: Welcome back, everyone. We will now move to our third and last panel during which we will hear from individuals about their lived experience.

Panel 3: Lived Experience

CHAIR LHAMON: The panel will proceed as follows:

Chanel Porchia-Albert, who is a board member, March for Moms, and founder of Ancient Song Doula Services; then Nan Strauss, who is Managing Director, Policy, Advocacy & Grantmaking, Every Mother Counts; and Jennifer Jacoby who is Federal Policy

Counsel, U.S. policy and Advocacy Program, Center for Reproductive Rights; and Nicolle L. Gonzales, who is Executive Director and Founder, Changing Women Initiative.

Given some of the topics that come up with regard to maternal mortality, I want to remind our panelists and the public again, and my fellow Commissioners, that since 1983, Congress has prohibited the Commission from, quote, studying and collecting or, quote, serving as a clearinghouse for any information with respect to abortion. Please tailor your remarks accordingly, consistent with this statutory restriction.

And with that, we will begin with Ms. Porchia-Albert. Please proceed.

MS. PORCHIA-ALBERT: To the members of the United States Commission on Civil Rights, good afternoon, Chair Lhamon and distinguished members of the United States Commission, I would like to thank you, thank the Commission for convening this briefing and the opportunity to provide testimony on the state of maternal health disparities in the United States and the role of the federal government in addressing them.

My name is Chanel Porchia-Albert and I'm

the mother of six children and the founder of Ancient Song Doula Services located in Brooklyn, New York. Ancient Song is a community-based organization working to reduce racial disparities and inequities within reproductive health care.

We've provided approximately over 1,400-plus New York City parents with personalized, comprehensive, culturally relevant care, trained and certified thousands of doulas nationally and internationally, and demanded justice for black women and families and spearheaded the fight against racial disparities and maternal mortality and morbidity since its founding in 2008. And we're a vital community entity, a leading voice for underserved black women, pregnant people and women of color in marginalized communities in New York City.

I was ushered into this work because of my own birthing experience with a midwife and a doula. The care that was given to me was unlike anything I had experienced. I was listened to. I was centered. I was shown genuine care and warmth.

This experience led me to become a doula to support others in their birthing experiences. I started this work naive to the realities of how black, brown and indigenous women and birthing people were

discriminated against at almost every turn.

Attending prenatal visits with someone who was on Medicaid to sit with them for over four hours to only be seen for ten minutes, and then once in the room with an air of condescension. Supporting someone in labor and witnessing them be drug tested without their consent and not because they showed signs of substance usage, but because they are poor and black.

I've witnessed police officers called to escort partners out of a birthing room when trying to center their family's rights and that of their newborn child.

Delayed care or no care, it all becomes the deciding factor of whether you will seek out care because of the dehumanization that one faces when entering these healthcare institutions steeped in structural racism and bias on an institutional and interpersonal level.

Over the past few years, doulas have become key players in the fight to end racial disparities and maternal mortality and morbidity. And while legislation is critical to widening the lens of access to proper pregnancy and birth support, few outside the birthing community fully understand the long-term effects on black women, birthing people and

families in the communities when we experience maternal death or suffer a near miss due to racial constructs developed during the enslavement of African peoples that still plays out in our medical system today.

Our healthcare system is infected with a crippling disease that has seeped into every aspect of care delivery and that disease is racism. It needs to be eliminated in order to truly center a healthcare framework that is just and equitable for all.

These racialized perceptions infiltrate every single system in our country, especially health care. And the voices of our ancestors demonstrate that when we work together to centralize health care for those most disenfranchised, we center all peoples.

We owe this to the countless children who are being raised by fathers, partners and grandparents. We owe it to Shalon Irving, to Amber Rose Isaac, to Sha-Asia Washington, the names of a few individuals who have died of postpartum complications or suffered a near miss because of the ways in which they have been treated within the healthcare system.

We are at this juncture today because the United States has failed as a nation to center those most disenfranchised because of the vast inequities

that continues to plague this nation, such as redlining, inequitable housing, food apartheid and environmental injustice, poor educational systems, high incarcerable rates and police brutality.

We are here because the United States' lack of accountability in centering those who are at the greatest risk. We have an opportunity at this time to center full comprehensive collaborative care, meeting people where they are, not where we expect them to be. We have an opportunity to save lives and center hope.

Some of those key strategies are centered around fund black women-led birth worker organizations, increase access to midwives and midwifery care, community-based doula models must be paid at a living wage and a reasonable amount for the services provided, and to successfully reduce racial disparities in maternal health outcomes federal Medicaid coverage for up to one-year postpartum.

Legislation must include input from birth community stakeholders and measures must be taken to address the root causes of structural and institutional racism within the healthcare system beyond expanding access to doula care. Measures must be taken to address accountability mechanisms for

consumers self-reporting and provider reporting that can inform institutional policy and reform.

In close, we have a duty to center hope, as we are the hope of our ancestors standing in the present building a foundation for hope for future generations to rest upon. Thank you.

CHAIR LHAMON: Thank you very much, Ms. Portia-Albert.

Ms. Strauss, you may proceed.

MS. STRAUSS: Good afternoon, Chair Lhamon and distinguished Commissioners. Thank you for conducting this briefing and for the opportunity to address the state of maternal health disparities. My name is Nan Strauss. I'm the Managing Director of Policy, Advocacy & Grantmaking at Every Mother Counts.

In 2010, Amnesty International reported that high rates of U.S. maternal deaths and extreme racial disparities constituted a maternal health crisis and a violation of human rights. Ten years later, little has improved.

The U.S. ranks 55th in the world in maternal deaths. We spend over a $111 billion a year on maternal and newborn care, and severe complications and deaths are increasing even though both are mostly preventable.

But none of that is why we're here. We're here because of the fundamental injustice that when a Black or Indigenous woman brings a new life into this world, she faces a greater risk of death than a white woman. To be clear, maternal health disparities cannot be explained away as an inevitable consequence of socioeconomic other factors.

Disparities are reported between Black and white women in all regions of the country at all ages at all levels of income and education, among women with particular health conditions, among women at the same hospital. Even when you control for other factors, no matter how you analyze the data, you see the same results. So there is no way to avoid the conclusion that the devastating inequities are rooted in structural and interpersonal racism in our healthcare system.

Recent high-profile stories have shown the life and death consequences when Black women's concerns are ignored, care delayed and voices silenced. Stories like those of Dr. Shalon Irving, a CDC epidemiologist, who died after repeatedly bringing dangerous warning signs to her doctor's attention.

And Kira Johnson who was told she was not a priority and who died after her husband spent ten

excruciating hours begging and pleading for doctors to help her. Disrespect, belittling and coercion occur with unacceptable frequency and tangibly influence our outcomes and survival.

Healthcare provider factors, particularly a delayed response to clinical warning signs and ineffective care, are the greatest contributors to preventable maternal deaths. A large nationwide study found that one in three people of color reported experiencing mistreatment or disrespectful care during childbirth in U.S. hospitals -- one in three people. That makes them twice as likely to be mistreated as white women.

The most common forms of mistreatment included being shouted at or scolded by a care provider, being ignored or having their requests for help refused, violations of physical privacy, and providers withholding treatment or forcing unwanted treatment. And, currently, there's no reliable pathway for hospitals to get feedback from or provide redress to patients whose rights are violated or who experience discrimination or mistreatment, which means that no one puts a stop to these harms and they go on and on and on without being addressed.

Today, we have the opportunity to

collectively decide that Black women's lives are worth saving. To do that we have to build a maternity care system that's rooted in equity, transparency and accountability so that all women can access the high-quality, respectful maternity care that they need and that they deserve.

And we can do this by creating accountability, requiring hospitals to collect and publish data not just on deaths but on complications, on procedure rates and on the experience of care that is disaggregated by race and ethnicity to identify disparities at a targeted level, by developing measures for respectful person-centered care, establishing a system to address reports of mistreatment and discrimination, integrating underused, high-value, evidence-based solutions like the midwifery model of care and like community-based doula support and by extending Medicaid to cover people for a full year following childbirth and, above all, by listening to women.

Our country's deep, persistent maternal healthcare disparities are not inevitable. They're the results of decisions that we make as a society, decisions about whose lives matter, whose lives we value and whose lives we choose to save.

Our action's overdue. It's time that we need to do everything in our power to ensure not one more Black woman, Native American woman or woman of color suffers a preventable death while giving birth. Thank you.

CHAIR LHAMON: Thank you, Ms. Strauss.

We'll next hear from Ms. Jacoby.

MS. JACOBY: Good afternoon. My name is Jennifer Jacoby and I am a federal policy counsel at the Center for Reproductive Rights, a global legal human rights organization, and it is my honor to brief this Commission.

As you have heard many, many times today, research shows that black women experience worse maternal health outcomes than white women do, even when factors such as other health conditions or socioeconomic status are the exact same. The CDC has indicated that issues with the quality of care black women receive plays a role. So the story I am about to tell you will bring this data to life because, unfortunately, my own close call while giving birth to my own daughter is not a unique experience, not even with within my own family.

I am the daughter of a black mother and white Jewish father born and raised in New York City.

And 32 years ago, while pregnant with me, my mother nearly lost her life. Toward the end of her pregnancy, she presented with symptoms of preeclampsia, but her complaints were ignored and racist assumptions about her weight were made.

Now 20 months ago, I shared in this unfortunate family tradition. I bore my mother's symptoms which also went undetected. I was told to go home. I fought to be admitted to the hospital early. I was blamed for my condition and I had a Cesarean section that most likely could have been prevented.

For days, my mother watched helplessly by my side as history repeated itself. We did nothing wrong. In fact, my mother and I over two different time periods in two different states did the exact same thing. We advocated for ourselves. Had access to top doctors, good insurance and sufficient means, but our circumstances were no match for racial bias.

And experiences like ours have occurred over and over again for decades and the data reflects it. But, meanwhile, the United States government has yet to mount an adequate response to the maternal health crisis disproportionately impacting black, brown and indigenous people.

Eliminating disproportionate risks that

marginalized people face while forming families is an essential component of a broader struggle for racial justice and civil rights and that's why we are talking about this today.

So far, our civil rights laws have not protected these communities from inequalities in maternal health care. And, still, as a matter of human rights, we know pregnant and birthing people have the right to safe and respectful maternal health care, free from discrimination, coercion and yes, violence.

But the United States has failed to meet its obligations to protect, respect and fulfill those rights. Indeed, international treaty monitoring bodies and other U.N. experts have assessed the U.S. human rights record on maternal health and have made clear recommendations. The U.S. has not implemented these.

Just this week, a comprehensive U.N. review of the United States called on this country to address the crisis yet again and ensure universal access to maternal health care. It is clear that the federal government has an important role to play in ending racial disparities in maternal health.

The issue is overwhelmingly bipartisan.

No one wants to see mothers die and there is no question on either side of the aisle that certain moms are at greater risk. And while recent federal law has mainly focused on advancing data collection, more must be done on that process specifically to ensure timely, systematic collection of data and to ensure stronger legal guarantees to safe, respectful care.

We need the federal government's commitment to addressing this civil and human rights issue. This includes federal legislation, regulations and guidance that strengthens community conditions and safety net supports for pregnant, birthing and postpartum people.

See, the Black Maternal Health Momnibus Act is an important step toward addressing many of the existing barriers to accessible, nondiscriminatory, high quality care that improves maternal health outcomes led by members of the bipartisan Black Maternal Health Caucus, the Momnibus aims to address each dimension of the crisis from expanding the perinatal workforce to protecting our veterans.

An interagency task force on respectful care and the issuance of regulations that encourage patient-centered care and accountability in healthcare systems is one of many agency actions that would

support the advancement of such legal guarantees.

Thank you and I look forward to your questions.

CHAIR LHAMON: Thank you, Ms. Jacoby.

Now we'll hear from Ms. Gonzales.

MS. GONZALES: Good afternoon, distinguished members of the United States Commission on Civil Rights. Thank you for this opportunity to provide testimony on the state of maternal health disparities in the United States as it pertains to the Native American women.

My name is Nicolle Gonzales. I'm (native language spoken) from the Navajo Nation in New Mexico. I'm a certified nurse midwife, founder and medical director at Changing Women Initiative.

CWI is a nonprofit made up of indigenous leaders and community leaders who are centering our families and communities by transforming the cultural narrative and setting in motion policy changes. CWI's mission is to support our diverse indigenous communities to renew cultural birth and the fundamental indigenous human right to reproductive health, dignity and justice.

I've been a registered nurse for over 19 years and I've been practicing full-scope nurse

midwifery for the last nine years. I'm one of only 20 Native American nurse midwives practicing in the United States today.

I chose to become a nurse midwife following my own birthing experiences as a Native American mother birthing in a hospital and also from witnessing the mistreatment of Native American women while working as a nurse at the Santa Fe Indian Hospital in Santa Fe, New Mexico.

During my two years I spent working at the Santa Fe Indian Hospital, I, myself, experienced lateral violence by white, higher-ranking nurses overseeing my employment there. I witnessed unnecessary placement of 16-gauge IVs in Native American women by white nurses who used fear as their primary motive for excessive medical use of abnormally large IV needles that were not backed by current hospital policies. The harm done to Native American women was unconsented and not informed care with the excessive use of medical devices like the IV needle resulting in increased pain with placement.

Most of the time was working, I was working night shift in a small hospital. The nights would get cold in the winter to the point where I had to wear longjohns under my scrubs.

One of the first pregnant women I took care of on the OB floor was someone from my community. There was a lot of concern by the other nurses regarding this patient because the story was that her baby had died in childbirth at that hospital last year, and here she was again having another child there again.

Because this woman was from my community, I went in and asked her why she came back to have another baby there knowing what happened that year before. She said, I don't feel like I could go anywhere else.

On another occasion, I overheard the white nurse midwives be proud of a recent birth they attended of a woman who was from my community and was a patient. The conversation from the midwives was related to how the Native patient was so stoic in her birth and didn't need pain medication. When I spoke to this community member about her birth experience, she said to me, I wanted pain medicine and I asked for it, but the midwives just told me to go walk instead.

The combination of these experiences and feeling helpless to really advocate for my community while working primarily as a nurse is what pushed me to return to school to get my master's degree in nurse

midwifery.

While getting my degree at the University of New Mexico and attending conferences specific to Native American women's health, I continued to hear two conversations happening around the care of Native American women.

I sat next to doctors and midwives who loved working with Native American women because they appeared stoic and never asked questions. When I would return to my community to talk to women who had their babies at the Indian Hospital, they spoke of their requests not being honored.

They spoke of medical procedures being done to them they didn't really understand or even like they had enough information about it. Some questioned the care they received, but felt helpless in pursuing anything legal or didn't feel confident it would go anywhere.

Historically, we know that Native American women in the United States were sterilized against their consent in the 1970s at the Indian Hospital across the Nations. But today, in 2020, Native American women still receive high rates of unconsented care where they are not adequately educated at all on their options, and due to government restrictions and

funding are denied the choice to have all of their options available to them.

Presently, I spend much of my time educating legislators and policymakers on the working of Native communities, while there is little to no Native representation in policy-forming bodies like this Commission.

If that is not a clear example of how little control or advocacy Native women have around their own bodies, then let me be clear. Native American women are directly impacted by any and all decisions made around our funding, or under funding needed healthcare services.

With regard to maternal health care, IHS does not consistently provide reproductive health care for Native American women. For example, in 2009, Santa Fe IHS facility closed and Native women are required to divert to other facilities to have their babies.

More recently, the medical center in Phoenix, Arizona, also is closing and is requiring women to go to other facilities to have their babies without any prior given notice.

CHAIR LHAMON: Thank you, Ms. Gonzales. I'm going to have to stop us there, just so we have a

chance to answer questions. Thank you very much.

I'll open for questions from my fellow Commissioners. Raise your hand or unmute so I can know that you want to ask.

Go ahead, Commissioner Adegbile.

COMMISSIONER ADEGBILE: Thank you for all of this important testimony. It was very enlightening and it's been a day of enlightening testimony.

I wanted to drill down on some of the points we've touched upon which is the role of the federal government, the adequacy of existing efforts, and any specific thoughts you may have on interventions that the federal government could do one way or another whether it be pending bills, whether they're adequate, or something else that the agencies can be doing to better serve our women in our nation in this respect.

CHAIR LHAMON: The panelists, go ahead.

Ms. Jacoby?

MS. JACOBY: Thank you, Commissioner.

Yes, so right now there is significant interest in this issue specifically in Congress. In the last -- in the 115th Congress, we saw about 25 bills alone on maternal health. Two became law and one is perhaps the most notable, which is the

Preventing Maternal Deaths Act.

However, that only focuses on improving data collection. It was an important first step, a tremendous bipartisan effort, however, we have not really seen bills that address the root cause of the issue which we've talked about today is structural racism in care.

And so legislation that's pending right now is the Momnibus Act. It is meant to be additive of other legislation that's out there, so that speaks to Representative Ayanna Pressley's points earlier this morning where she has several other bills including postpartum Medicaid extension and doula coverage bills as well.

So the Momnibus is really, really an important part of this process because it was created alongside the community, so it was a very, very in-depth process where community members helped inform what was needed and it's a nine-bill package.

And like I said before, it covers studying veterans and coordination of VA maternity care, to perinatal workforce and diversifications, different grant programs. It touches on indigenous women's maternal health care as well as incarcerated women. So it's very, very comprehensive and meant to really

support other efforts out there.

The other thing is that we're seeing in the agencies is that there are a number of campaigns right now from various agencies in NIH. CDC has, you know, the bulk of the data collection efforts, but a lot of what we're saying is purely public health and educational campaigns as opposed to really focusing on racial disparities.

So there's a lot that can be done and I think there's tremendous opportunity in, you know, in future administrations to really focus on creating interagency taskforce or certain offices that really focus on a full federal government commitment to this issue.

It's not going to be just legislation. We need administrative buy-in here and we're not seeing it at this time.

CHAIR LHAMON: Thank you. Ms. Strauss?

MS. STRAUSS: Thank you. Thank you for those comments and that insightful question.

I want to add a couple of points to those just made which are that if you look at the history of the Preventing Maternal Deaths Act that was passed when it was originally introduced in prior form in 2011 that bill had a section intended to specifically

focus on eliminating maternal health disparities and that section was removed from the legislation, I think troubling so.

But we know that we need more work to be done because we know that in areas where there have been reductions in maternal mortality, such as California, which is the only state presently to have consistently reduced maternal deaths, and New York City, we know that not only does an overall reduction in maternal deaths not reduce disparities, because in California those disparities have remained consistent even as numbers have come down.

But what we saw in New York City was there was a significant reduction in maternal death rates for white women. At the same time rates came down a tiny bit for Black women, and what you saw was that the disparities then grew.

So now in New York City a Black woman is not three or four times more likely to die from causes of pregnancy and childbirth; Black women are 12 times more likely to experience a maternal death in New York City compared with white women in New York City.

So we can't limit our approach to one that wholesale addresses maternal mortality, we have to be targeted.

Also, the ways that we need to be targeted need to go beyond what we have seen in that legislation which looks at maternal deaths as opposed to looking more broadly at complications and targeting disparities and we really need to shift from looking at emergencies/problems after they occur.

We need to shift our perspective upstream to a prevention model so that we are utilizing the high-value evidence-based practices that are really person-centered that emphasize relationship-based care, building trust in the community and having community-based models like community-based doula support, perinatal support in the prenatal period and in the postpartum period.

Those issues are addressed by bills like the MOMMIES Act as well as the Momnibus and bills like Midwives for Moms, which integrates a midwifery model that is much more comprehensive, holistic, wellness-oriented, and has been found to have better outcomes overall, better experiences of care, but also really address those issues that are specifically underlying disparities related to trust, communication, et cetera, bills like the BABIES Act that would put birth centers in more communities.

I think there is also an opportunity for

non-legislative action such as enforcement of civil rights laws.

I think there is an underappreciated opportunity for looking into how can the requirement of the federal government either in the Department of Justice, in the Civil Rights Division, or in the HHS, Office of Civil Rights, looking at how there can be greater impactful, robust, enforcement of civil rights protections.

COMMISSIONER ADEGBILE: Thank you. Thank you for those good answers. I wanted to drill down for a second on this New York City problem which seems extraordinary and really severe and requiring important attention.

I wanted ask Ms. Porchia-Albert, who also does this work in New York, if we have any understanding of why it is that New York City has this level of disparity and what the interventions may be to change it, and then more broadly to the panel, we are interested in all of the disparities, so we are very interested in what's happening to black women nationally, but we want to hear about the Native American population, the Latinx population, so that we understand the full dimension.

It would helpful if you could just send us

sources that have the worst, the places that are the worst so we can shine a light on all of this and do better.

MS. PORCHIA-ALBERT: Greetings. Thank you for the opportunity to speak today, again. So, yes, I mean being in New York City I think some of the biggest challenges that folks have witnessed is, you know, they want to be seen, they want to be heard, and they want to know that someone genuinely cares, and that is what is not happening. They are not being listened to.

I recently supported a client who had a labor who, you know, postpartum -- Had to have a caesarean, it was medically necessary, came home the very next, or not the very next day, but two days postpartum, was, you know, I went to go do a postpartum visit with her and noticed signs of preeclampsia.

She was not given information around being able to diagnosis this. I told her about, you know, some of the signs and symptoms of preeclampsia. Later that day she ended up going to the hospital calling me saying, you know, she had increased edema.

The fight that we had to have just for her to get care in the postpartum period was something

that was atrocious. She was placed outside in a gurney in a hallway, and this is someone who had served in the military, who also is a police officer, and a black woman who, you know, found herself with individuals who were in the ER who were handcuffed to chairs.

I had to call the hospital administration just for her to get the care that was necessary for her to get. At the end it was told to us that the reason why that, you know, she was sent from ER back up into labor and delivery, back down to ER, gone back to L&D, and she was told by the hospital we apologize but we don't have a policy around individuals who come back during the postpartum period.

So once you give birth you are found in this situation where you are left out in the cold. You are left with no type of resources and no information.

She was not provided education around preeclampsia and what are the signs and symptoms to expect. So I think a lot of it has to do with education and having providing proper education to patients during the prenatal period but also understanding the warning signs for postpartum care.

It also has to center around medical and

provider education around interpersonal biases and racism, because also this individual experiences biases.

She had a Russian provider who when expressing and trying to give a timeline of what had happened to her was met with condescending tones, was then left to her own devices in a room by herself that had no windows and was not seen again until hours later when the shift would change and the doctor came back in and said, oh, I'm leaving now.

Then when the new doctor came in it was told to her that no orders had been given to her. Now between that time that she was admitted at 9:00 to 7:00 in the morning she could have experienced eclampsia where she could have had a severe case of hypertension and then she could have had postpartum seizures.

But this is something that people experience all the time and if it wasn't for her sitting there and advocating for herself and saying repeatedly like, no, I need to be seen, having me there helped her to advocate for herself and saying this during this time then she would have been sent home.

She would have been sent home and she

could have also become, you know, one of the statistics that we are talking about today.

And so a lot of it is centered in respectful care at birth around education, around listening to patients, around, you know, a collaborative care framework where you have, you know, OBs, midwives, nurses, and doulas working together, but also accountability measures and transparency, which is something that is truly lacking within our healthcare infrastructure, which is that accountability.

We have offices and task forces for almost everything, but when it comes to maternal health services we don't take the same level of consideration for the women and pregnant people in our country and to me that is sad.

When we are supposed to be one of the most industrialized nations and have the most advanced technologies to be able to center individuals we find ourselves in predicaments where individuals can't get the proper care that is necessary based on fear-based coercion, based on the overuse of medical devices, right, and not allowing for someone to be seen and to be heard.

We really need to center our human rights

framework within our birthing and our care system that sees the bodily autonomy within the individual because what is happening is that black, brown, and indigenous people are walking into these hospital-based institutions and are being treated like they are in the carceral system where their rights are no longer their own, where their rights are taken away from them, where they are told what something is going to happen to them as opposed to speaking to someone and asking how can we best assist you through this process, what does that look like, which tells me that we have lost the humanity and seeing in one another.

We have lost our moral compass and what it means to really center people where they are and really give them the care that is necessary. So I think that what we need is, you know, what we definitely need is institutions and offices that are separate that really are looking at maternal deaths and near misses.

We need to have a commission or an office that looks at gender equity and centers accountability measures and transparency that holds institutions accountable because we spend so much money in our healthcare infrastructure to have to have poor outcomes is a really poor reflection of spending, I

mean like really and truly.

And so we really need to think about how are we really keeping our house in order. Are we keeping our finances in order? Are we really like taking care of the individuals who hold our house together? And that is the women and the folks who guide us through our nation, and we're not doing that right now.

COMMISSIONER ADEGBILE: Thank you.

CHAIR LHAMON: Commissioner Kirsanow? Commissioner Kirsanow, you're on -- Oh, good.

COMMISSIONER KIRSANOW: Thank you, Madam Chair. Thanks very much for your testimony. It has been informative.

I'm trying to further isolate and identify those factors that could yield optimal outcomes for pregnant women and those about to give birth.

Can you or does anyone have any idea of the why -- What are the factors that result in Asian-American women having better outcomes than white women? Anybody?

CHAIR LHAMON: I see no hands raised. I am also not sure if that data is accurate. I think on a prior panel we heard a different data, but I am waiting for hands raised if there any.

COMMISSIONER KIRSANOW: One of the prior panelists said that Asian-Americans do have better outcomes than white women.

CHAIR LHAMON: We can check our transcript.

COMMISSIONER KIRSANOW: Thank you.

MS. PORCHIA-ALBERT: I mean if we want to speak from a -- We could speak to colorism and we can speak to the ways in which people sometimes, you know, how Asian-Americans are often times treated as our white counterparts if we want to talk about that, right, because what we are talking about here on the panel is racial discrimination and bias and the ways in which shows up and particular around melanated people and those melanated discriminations are something that are far and vast and wide so we can't pinpoint it to one.

One could say, oh, it was just chronic health conditions, but chronic health conditions are a by-part of what has happened systemically centered around structural and institutional racism, right.

We could say, oh, well, you know, it's because they are low income or they have a particular literacy level, but we have also seen that regardless of literacy level, regardless of income, it's that we

still are seeing the same poor outcomes.

So one must say that then the diagnosis has to be then that it goes far deeper than that, right. It goes into the ways in which people's humanity is centered at bedside.

It goes into the ways in which people are treated. When a birthing person -- Me, as a black woman, who sits before you right now as a mother, when I go into a space the things that I think about are is someone listening to me as a black woman.

When I take my child to an emergency room I am not thinking about, oh, are they necessarily about the care aspects of it as much as are they going to see them as a human being, right.

I have two black sons and four daughters and the ways in which they grow up in this world is reflective of how they are seen in this world, right, and how they are seen and perceived in this world is the basis for how they are treated in this world.

When you don't see young black men treated as such as men or as the individuals and the human beings that they are then they are dismissed and thrown aside.

But the same goes for our black women and our young girls, they are also dismissed. They are

not listened to. A lot of that injustice happens at bedside. It happens when we are expressing pain and that pain is not listened to.

It happens when we can identify what is going on in our bodies and people are dismissing that, it is identified when people use fear-based coercion to get people to comply with medical procedures, or when other systems, such as child protective services, are used as a tool to get someone to agree to something, because automatically if someone tells you, oh, I'm going to take your child away from you then you are automatically going to comply with them.

So when we start to talk about this issue, again, it's not one thing, it's a multitude of things that culminate into someone's birthing experience. A provider will look at something as a good outcome based on, oh, we have a healthy mother, we have a healthy child.

But when it comes to the patient, the patient and the one who is experiencing is how was I treated, did someone listen to me, right, did they take the time to explain things to me and to my family.

Did they take the time to really center us and to say you know what I may not understand, please

tell me, what has been your experience since you came, since you were birthed into this world, that has shaped your identity and how you are able to function in this world, because all of those different things are factors into how someone can and will access healthcare services and what they will look like.

But it's also based on the perceptions that have been told about black, brown, and indigenous people throughout the United States.

CHAIR LHAMON: Thank you. Any other questions? Ms. --

(Simultaneous speaking.)

COMMISSIONER ADEGBILE: I have one. Sorry, Madam Chair, did you want to get in?

CHAIR LHAMON: Go ahead. I can go after you.

COMMISSIONER ADEGBILE: Okay. Just very quickly, one of the things we have heard about are making sure that people's voices are heard and in a sense taking apart the way people are trained and the social construct which lowers and debases some people's stories and pain and ability to provide inputs that are necessary for medical care.

Is there training going on on any broad scale for medical professionals to understand these

things that are now manifest and that we are having a better understanding about?

It's very important to understand how to use needles, how to give a drug, in what dose, all of those things are important, but you are sharing with us and the other panelists are sharing with us things that are leading to people dying because they are unable to relate to other people and diminishing inputs that are vital in healthcare, and so I am wondering both in medical schools and in other venues are we doing training in this regard?

I would add there was a recent Administration Executive Order that makes it harder to have diversity and inclusion type trainings and raises questions about it that's having an effect in the federal government.

How does that impetus affect what you are telling us needs to be more understanding not less?

MS. PORCHIA-ALBERT: Yes, so I know -- Oh, go ahead, Nicolle.

MS. GONZALES: So I work primarily in New Mexico which is 90 percent rural. We have a high rate of traditional indigenous birth attendants in our state because Department of Health actually supported the Native indigenous traditional midwives and birth

attendants historically.

And so I believe when we start to privatize and professionalize a service, midwifery or birthing attendants, to colonize standards in regards to license and regulation, we actually curved a lot of these areas that are without healthcare providers and basically what our communities really need is skills and knowledge and so how are we making skills and knowledge accessible to everyone regardless of education or background.

I can tell you in other countries traditional indigenous birth attendants are used widely and are accepted and are actually addressing this maternal health crisis in their own communities and it's from a community center while including cultural knowledge and preservation of their traditional indigenous ways.

And so for me when I see, and I get this question regarding, you know, privatization, professionalization of midwifery and skills and service, really it's our own thinking and way of navigating and limiting how skills and services are delineated to our communities.

We can actually address these issues by training those in communities who live in rural

settings like Gallup Indian Center, Window Rock, you know, all of these areas that my community members are from where there is not only one healthcare provider for 50 miles, but you are limiting what people can have access to.

We have trained doulas, we have trained birthing assistants, we have trained lactation people. So how are we training community people without the labels and the education and all the credentials to actually provide skills and services to their community.

They are actually very hungry for this information. It's just do we have funding focused on those areas and are we thinking about innovative ways to use the funding and not just focusing on people who are medically trained. It costs a lot of money to train a nurse midwife.

My student loans are $100,000 right now. Imagine if we could use that $100,000 to train several indigenous midwives, birth assistants, lactation specialists, doulas, many communities who are already the experts in how their communities function and take away this whole credentials on who is appropriate to provide the services in their community.

We are actually creating those barriers

and those holes in services in our communities by thinking this way.

CHAIR LHAMON: Ms. Porchia-Albert, it looked like you had an answer, too?

MS. PORCHIA-ALBERT: Yes. I wanted to say that there are many organizations like Black Mamas Matter Alliance, individuals within the organization who are kindred partners who have been providing that education to medical providers who have been working, like Dr. Joia Crear-Perry who gave testimony earlier, have been providing training to medical providers.

I, myself, have taught grand rounds at many hospital-based institutions. I also mentor medical students around what does it mean to provide anti-racist medical model frameworks.

It has been, you know, a challenge to be able to continue to still provide that care, you know, that education, but I think that, you know, folks are finding creative ways to be able to still educate and to give the information that is necessary because providers are also very hungry for it, right.

They want to do a better job. I think that when they take their oath, you know, they are saying, you know, to do no harm, and they mean that, but we also have to remember that they, too, are

experiencing the same racism and bias.

When you have providers of color who are presenting themselves who get into this work because they want to serve their communities in equitable ways but then come against these institutional barriers that don't allow them to provide care in the ways and means that it really centers them in the communities that they want to serve.

And so it's not just from a patient perspective as well, it's also from the provider's perspective of being able to really meet people where they are and give them the care that is necessary in a way that centers them.

Having being able to have, you know, institutions having adequate funding, you know, giving providers the freedom in the room to be able to think creatively and have solution-based and evidence-based answers to, you know, institutional problems that are affecting various communities, and those will look different based on the community, right, and so understanding that it is not just one single approach to care.

As, you know, Nicolle mentioned, you know, within the indigenous community it's creating and sustaining and decolonizing the frameworks that have

already, that have been placed on them, right, in the structures and institutions.

But it's also within black and brown communities, you know, teaching and providing the education that is necessary so that people can take care of themselves.

People don't want handouts. People want to know that they have full bodily autonomy and the basic human rights to live in a way that they, you know, that's freedom of expression, right, but that's not what is happening.

And so, you know, folks like Deirdre Cooper Owens who wrote the book "Medical Bondage" is a prime example, who is a professor who goes around and teaches medical students about the history of medicine in the United States and its very complicated relationship as it pertains to black, brown, and indigenous people as well as immigrant individuals who have immigrated here, right.

And so it's really important for us and for these healthcare institutions, these educational systems, to have a framework that talks about the history of other people, not just white males and white women, but also of black, brown, and indigenous people who live within this country who have not had

the same experiences, whose experiences have been steeped in for sterilizations, fear-based coercion, Tuskegee experiments, which all play a role, too, on that inter-generational trauma of being relayed down to the present time and folks feeling like how can I trust this space that has never really truly centered me and centered my identity and who I am as a human being and as an individual.

And so, again, it's a trust-based factor of the institutions and hospitals really working to build trust within communities, listening to them, but then also having those accountability measures to really center the voices of the patient and the provider who is doing that work within those communities.

CHAIR LHAMON: Thank you. Ms. Strauss?

MS. STRAUSS: Thank you. In addition I do want to flag that the American College of Obstetricians and Gynecologists acknowledges themselves that racial bias is contributing to the disparities in maternal health outcomes.

This is not just an issue for advocates, it's an issue that the main professional association themselves notes is a problem and that implicit bias training is needed.

It's needed at all levels. It's needed in initial training, medical training, nursing training, but also in professional development. There needs to be continuing education around implicit bias, around trauma-informed care, consent, patient-centered approaches.

There are a number of bills that have been introduced that do address these issues, including the Maternal Health Quality Improvement Act, the Maternal Care Act, and the MOMMA's Act.

It is a big part of the Black Maternal Health Momnibus that you have heard about today many times.

I think also one of the other ways of approaching this issue of getting at implicit bias and getting at really truly person-centered models, models that center the needs, the perspective, and the respect and dignity for the pregnant and childbearing person is to advance models that have that at their core.

That means making community-based doula support and perinatal support workers available, making sure that they are covered through Medicaid, covered by insurance, so that those models that already are doing this work well are available and

accessible to people, making sure that people have access to midwives, making sure that there is enough of a pipeline of midwives who are being trained, making sure that it is a diverse workforce and a strong workforce so that we are coming at this issue from all different directions from increasing the training, improving the training and perspective of physicians and nurses, all sorts of providers, everyone in the healthcare system, and then lifting up those models that we know are already doing well in these areas.

CHAIR LHAMON: Ms. Jacoby, I think you had your hand raised.

MS. JACOBY: Thank you. And my colleagues have addressed many of the points that I wanted to raise, but I will add just a few things.

Again, yes, the federal government has an obligation here and, exactly right, there are a number of federal bills that would support implicit bias training.

At the same time I think we need to take a step back and realize the two tensions here. Not everyone wants to birth in a hospital, right, and we have the right to, you know, labor and deliver where you want to, so there is a tension between dismantling

white supremacy and racism in our hospital and healthcare systems but also supporting, you know, home births and community-based healthcare workers, folks like Nicolle, folks like Chanel, not just even in hospital settings but in other, you know, birth centers and home births.

It is really important that we focus both on, you know, dismantling the racial bias in traditional systems but also supporting and funding those workers who we know have really, really successful models and outcomes.

MS. PORCHIA-ALBERT: Yes. And just to, you know, also I have six children and I have birthed my children at home with home birth midwife and doulas, but I also, you know, went to the hospital.

I have identical twin daughters who, you know, I had in the hospital via caesarean because of preeclampsia. You know, understanding, too, that when that framework is necessary then it is necessary, you know, but if someone can have the option to have a home birth and they want that they should be able to afford that.

They should be able to have the care providers that look like them, that can center their culture identities, be able to support them through

that process, and the providers should be respected and should have the necessary means to be able to practice in a way that is, you know, self-sustaining, not for just themselves but also for the communities in which they serve.

MS. JACOBY: And I will add quickly just in the COVID-19 pandemic we have seen an influx of folks wanting to birth at home, right, because there is fear about the disease of the virus in hospitals, and so we are at a point where the COVID-19 pandemic is exacerbating the maternal health crisis.

Our system was not built for, you know, to sustain this anyway and then you have people trying to birth at home and there are issues like what Nicolle deals with regularly in terms of midwifery regulations and prohibitions on where she can provide care.

So it's a very interesting intersection of issues that we are seeing right now during the pandemic.

CHAIR LHAMON: Commissioner Yaki, I saw you came off mute, is that because you have a question?

COMMISSIONER YAKI: Not yet.

CHAIR LHAMON: Okay.

COMMISSIONER YAKI: But soon.

(Simultaneous speaking.)

CHAIR LHAMON: Well, soon is now because we are at the end of --

COMMISSIONER YAKI: I have been enjoying the testimony.

CHAIR LHAMON: We are at the end of this panel so if there is one last question we can go forward, otherwise we will thank your panelists.

Seeing none I will thank our panelists. This has been just an extraordinary day of testimony and an extraordinary final panel, very, very grateful to all of our participants, including our public participants and also those who sent in comments.

Today has been just tremendously informative and on behalf of the entire Commission I thank all who presented for sharing your time, expertise, and experience with us.

As I said earlier our public record will remain open until December 14, 2020. Materials, including if individuals would like to submit anonymously, can be submitted by email to maternalhealth@usccr.gov or by mail to the U.S. Commission on Civil Rights, Office of Civil Rights Evaluation, Public Comments, Attention: Maternal Health, at 1331 Pennsylvania Avenue, NW, Suite 1150,

Washington D.C. 20425. We encourage the use of email to provide public comments due to the current COVID-19 pandemic.

Before we adjourn our meeting today I do want to recognize that today's briefing will be the last business meeting for our General Counsel, Maureen Rudolph.

Maureen, thank you for your service to the Commission and thank you for your ongoing service in the federal government in your next position.

If there is nothing further I hereby adjourn our meeting at 1:22 p.m. Eastern Time. Thank you.

(Whereupon, the above-entitled matter went off the record at 1:22 p.m.)