ASSOCIATION OF MATERNAL & CHILD HEALTH PROGRAMS

November 8, 2020

Dear Commissioners, thank you for the opportunity to participate in this hearing on the very important topic of maternal health disparities. My name is Jonathan Webb and I am the CEO of the Association of Maternal & Child Health Programs (AMCHP). AMCHP is a national resource, partner, and advocate for state public health leaders and others working to improve the health of women, children, youth, and families, including those with special health care needs.

AMCHP's members come from the highest levels of state government and include directors of maternal and child health programs, directors of programs for children with special health care needs, and other public health leaders who work with and support state maternal and child health programs. Our members directly serve all women and children nationwide, and strive to improve the health of all women, infants, children, and adolescents, including those with special health care needs, by administering critical public health education and screening services, and coordinating preventive, primary and specialty care. Our membership also includes academic, advocacy and community-based family health professionals, as well as families themselves.

AMCHP builds successful programs by disseminating best practices; advocating on our member's behalf in Washington; providing technical assistance; convening leaders to share experiences and ideas; and advising states about involving partners to reach our common goal of healthy children, healthy families, and healthy communities.

AMCHP has been engaged in efforts to improve maternal health for decades and over the past 15 years, specifically, we have been collaborating with national partners and our state members to conduct maternal mortality and morbidity surveillance, including maternal mortality review, and translate those findings into population-based action. At the core of our maternal health work is equity; a belief that everyone deserves the right to a fair and just opportunity to be healthy. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care. Frankly, though, we haven't achieved this in the U.S. and it is reflected in our health outcomes.

As one of the richest countries in the world, we have the highest maternal mortality rates among developed countries and among communities of color, Black, American Indian, and Alaska Native women are two to three times more likely to die from pregnancy-related causes than white women. The U.S. infant mortality rate (IMR) is 5.7 deaths per 1,000 live births and

the numbers by race and ethnicity show that the IMR for Non-Hispanic Black infants is 2x that of their white counterparts. It is of the utmost importance that we eliminate these disparities, because each one of these maternal deaths is a lost mother, wife, daughter, friend, community member and every lost infant is the loss of a future leader, world changer, problem solver, cure finder, etc. Each of these losses are experienced by families and communities.

In order to address this inequity, there are a couple of points I'd like to highlight.

1. Equity in Data - We must acknowledge that data sources our country has been using weren't created by the people most acutely impacted by negative outcomes—people of color. Given this, we are left wondering if we are capturing critical information, like lived experiences, making appropriate statistical comparisons, etc., that provide us with valuable insight into actionable and targeted solutions. We must ensure we're asking the right questions by engaging the people most impacted in what we collect and when and how we distribute it. We have to thoughtfully partner with tribal communities, ensure their solutions are being supported and think about how government can facilitate justice for them, while not further perpetuating inequities. When it comes to research and data, we must ensure we are answering these questions and then use what we learn to formulate solutions.

2. The Impact of Structural Racism – for decades, we have looked at race as a factor in determining or predicting potential health outcomes. More recently, research demonstrates that racism and not race is the actual risk factor. The public health community's response to addressing inequities has evolved over time. Several decades ago, we began with looking at the social determinants of health (SDOH) – the conditions in the places where people live, learn, work, and play that have an effect on a wide range of health, quality-of life-risks and outcomes. In the maternal and child health (MCH) field of public health, we have layered onto the SDOH, the life course theory (LCT). Life course theory is an integration of advances in multiple disciplines over the past century in understanding the interconnections, interdependence, and dynamic interactions across time and space of persons and their environments. Simply put, LCT is a way of understanding human development and adaptation across the life span, meaning a pregnancy outcome is the culmination of a woman's total life experience up to that point in her development, not simply her experiences during the pregnancy itself. Pulling all of this together, more recent research has recognized that the environments in which people live and develop (SDOH) and the lifetime experiences that impact their health and MCH outcomes (LCT) are influenced by racism. Structural racism exists in every major system (healthcare, education, housing, workplace, child welfare and criminal justice), and causes intergenerational stress for the people it impacts and likewise determines the investments/policies that support or hinder community well-being.

If we are looking to really advance racial equity, we need to shift our conversation from eliminating racial and ethnic disparities in maternal and infant health specifically – which continues a focus and blame on people – to eliminating the systemic, structural, and institutional inequities that produce the racial disparities. We also need to acknowledge that these systems, structures and institutions were not created to produce equitable outcomes for Black, Indigenous, Latinx, Pacific Islanders, and other People of Color. They are the products of systems created over time that create an advantaged group and a disadvantaged group, in part because communities of color have not had a seat at the table in the creation of these systems.

The federal government has a tremendous responsibility to play in addressing disparities in maternal health outcomes – after all, institutionalized racism enabled by our federal government for far too long has been a contributing factor to the disparities we witness today. Given the interconnectedness of health outcomes to the SDOH mentioned earlier and the federal government's involvement in housing, education, job creation, transportation and health care, the federal government can play a major role in ensuring equity in policies, practices, hiring, funding, community investment, criminal justice, health system transformation and insurance coverage/provision. I am glad to say, however, that steps have been taken in recent years to begin addressing the social determinants of health to improve health outcomes, as well as, attempts at tackling issues like paid family leave and environmental justice.

Additionally, there appears to be an unprecedented level of interest and commitment among policymakers to take necessary steps to further achieve equity. For example, AMCHP is a proud supporter of the *Black Maternal Health Momnibus*, which addresses a multitude of factors related to improving maternal health and reducing disparities. This bill is expansive so I will not touch on every aspect of it, but I would like to highlight some of the approaches relevant to improving data and research, given the topic of this particular panel.

The *Data to Save Moms Act*, Title V of the *Black Maternal Health Momnibus*, promotes including racially, ethnically diverse, geographically and professionally diverse members in maternal mortality review committees; conducting outreach and community engagement efforts to seek greater input; establishing a "Task Force on Maternal Health Data and Quality Measures" to evaluate maternal health data collection measures; commissioning a comprehensive study on the maternal health crisis among American Indian and Native Alaskan women; and more. The purposes of these provisions are to improve how we collect data and conduct research in order to ensure that the information is more representative of communities impacted as well as to ensure that the right people are at the table asking questions and crafting solutions.

The *Kira Johnson Act,* Title II of the *Black Maternal Health Momnibus,* would invest in community-based organizations especially committed to preventing adverse maternal health outcomes for Black women and supports robust evaluation so that the evidence base can be built in support of models that show improvement in Black maternal health outcomes.

In addition to our support of these types of legislation, we issued a statement on anti-racism on June 23, 2020, {attached} in response to the murder of George Floyd, Breonna Taylor and Ahmad Arbery and the many before them. In this statement, we identified racism as a public health crisis. This is significant, because we believe it's important to honestly call out the problem, so the solution that we arrive at can be targeted and proportional. Likewise, identifying racism as a public health issue will hopefully influence the investment in this work, as well as the health focused/centered approach required to make strides in this space.

In our statement, we also offered recommendations for how partners in addressing racial inequity can assist. These suggestions, include efforts to:

- **Establish honest conversations** on racism in your spheres of influence and challenge racial and implicit bias wherever it exists
- **Educate yourselves,** your staff and organization members on implicit bias and the history of racism in our communities and country
- **Examine current and new policies** to determine its impact on equity and actively advocate against any policy or program that perpetuates inequity and racial disadvantage
- **Promote life course theory** to understand accumulated disadvantage and advantage and encourage efforts that support resilience and restore power to communities of color
- **Engage and partner, with humility and truth**, with impacted communities and local organizations to understand their strengths and the impact of past acts of racism
- **Ensure funding/contractual awards**, related financial processes, and decision-making are aligned with business practices that optimize inclusion, accessibility, operational transparency, accessibility, and technical/advisory supports for fair and equitable access to resources

Specific recommendations for federal agencies include:

- Declare **racism a public health crisis**
- Be **mindful of the language** we use and stop using terms that further perpetuates narratives that place and describes communities of color as deficit populations, (i.e. using the terms 'vulnerable', 'at-risk' or 'low-income' to describe a particular racial or ethnic group. Use of this language implies there is something inherently flawed in that community and places blame on the individual and not the system that has failed to

invest in creating an optimal environment for positive health outcomes. Instead use language like 'marginalized' or 'underserved'.

- **Go upstream** to identify solutions; programs are good, but the upstream efforts to explore processes that produce inequity bring about the change in the system that is required.
- Encourage/support the **creation of a White House Task Force** on Racism.
- **Provide continued funding to state and tribal nation maternal mortality review committees** (MMRC) to study cases of maternal deaths, but encourage MMRCs to partner with community-based organizations as members and thought partners in all processes of the MMRC and supports health equity impact assessments for MMRC recommendations.
- **Extend Medicaid coverage for moms** to a full year after birth. Explore how we provide health insurance to individuals that are underpaid and disenfranchised and address the way our current insurance payment system incentivizes low-value care and underpays skilled health professionals.
- **Address the biases that permeate health care in this nation**, starting in medical school and extending into the nation's hospitals and clinics by requiring education/training on the history of racism in this country and its presence in the system.
- **Promote culturally competent solutions** that centers the leadership of black, indigenous, Latinx and other birth workers and includes greater access to doula and midwifery care. Reach women in maternity care deserts by expanding broadband access that support telehealth services.
- **Expand group prenatal care,** which reduces premature birth among Black women by about 40% and among all women by one-third, and ensure it is delivered in a culturally reflective way by culturally congruent providers.
- **Focus on accountability** metrics within the healthcare system; ensure accountability measures go far enough to repair that trust.
- **Ensure meaningful engagement** with all people of color (immigrant communities, indigenous communities, varied gender identities, etc.) by building this in to current processes.
- **Ensure equity** in partnership opportunities. Community-based organizations have solutions to address many public health issues, including maternal and infant morbidity and mortality, preterm birth, etc., but they are often unable to secure meaningful funding to build on this work because they lack the financial capacity to validate an evidence-based practice or indirect rates on subrecipient agreements that prevent them from scaling up.
- Develop, track, and regularly present indicators that:
    - Measure social health and wellbeing, including inequities in population health status, similar to the national presentation of economic indicators; and
    - Identify the institutional sources of decision making cumulatively generating health inequities (e.g., uneven investment in local infrastructure by neighborhood; inequitable distribution of city fiscal resources by neighborhood;

discriminatory lending practices, foreclosures by neighborhood; discriminatory law enforcement polices for minor offenses; and political influence).
- Recruit a racially/ethnically diverse workforce.
- Engage in anti-racism training for and dialogue with the public health workforce.
- Support local policies that address root causes, such as paid sick leave, land-use, and living wage.
- Develop a public narrative that articulates the relationship between health inequities and the underlying social inequalities, and reclaims the legacy of social justice in public health.

In closing, our country's founding documents offer certain assurances. The Declaration of Independence identifies self-evident truths, which acknowledges that all men are created equal and are endowed with certain unalienable rights which include, life, liberty and the pursuit of happiness. The Constitution highlights the foundational responsibility of "a more perfect Union" to "Promote the general Welfare" of its people. Essential to a person's ability to life, liberty, the pursuit of happiness and the promotion of general welfare is health. Therefore, the health of pregnant women (and their children) is, in large part, the responsibility of our government. This responsibility must extend to all. The federal government has the responsibility of ensuring that the equality described by our founding fathers extends to access to quality health care for all, healthy conditions for all, and translates into equitable health outcomes.

Although we have not yet arrived at the desired destination of equitable maternal and infant health outcomes, I am hopeful for what's to come. Despite the challenges we face, there has been progress and we must take the time to celebrate those, yet still acknowledge there is more work to be done. I am encouraged by the attention equity in maternal health outcomes is receiving. I implore this committee and our nation to maintain the urgency on addressing this issue and be acutely focused on implementing actionable solutions. The time has come for change. There are lives literally depending on us and the status quo is simply not an option.