# Racial Outcomes in Maternal Mortality

Texas Advisory Committee

to the U.S. Commission on Civil Rights

**September 2025**

**Advisory Committees to the U.S. Commission on Civil Rights**

By law, the U.S. Commission on Civil Rights has established an advisory committee in each of the 50 states, the District of Columbia, and the five U.S. territories. The committees are composed of state citizens who serve without compensation. The committees advise the Commission on civil rights issues in their states that are within the Commission's jurisdiction. They are authorized to advise the Commission in writing of any knowledge or information they have of any alleged deprivation of voting rights and alleged discrimination based on race, color, religion, sex, age, disability, national origin, or in the administration of justice; advise the Commission on matters of their state's concern in the preparation of Commission reports to the President and the Congress; receive reports, suggestions, and recommendations from individuals, public officials, and representatives of public and private organizations to committee inquiries; forward advice and recommendations to the Commission, as requested; and observe any open hearing or conference conducted by the Commission in their states.

**Texas Advisory Committee to the U.S. Commission on Civil Rights**

**September 2021 – September 2025**

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## Introduction

In June 2024, the Texas Advisory Committee (Committee) to the U.S. Commission on Civil Rights (Commission) adopted a proposal to study the civil rights implications of racial disparities in maternal mortality in the state. While other important topics may have surfaced throughout the Committee's inquiry, matters that are outside the scope of this specific civil rights mandate are left for another discussion.

As part of this inquiry the Committee heard testimony via videoconferences held from October 2024 to February 2025.[1] The following report results from a review of testimony provided at these meetings, combined with written testimony submitted during the related timeframe. It begins with a brief background of the issues the Committee considered and then identifies primary findings as they emerged from this testimony. Finally, it makes recommendations for addressing related civil rights concerns. This report and the recommendations included within it were adopted unanimously by the Committee on August 6, 2025.

[1] See Appendix A.

## Executive Summary

In June 2024, the Texas Advisory Committee to the U.S. Commission on Civil Rights adopted a proposal to study the civil rights implications of racial disparities in maternal mortality in Texas.

Maternal mortality refers to the death of a woman during pregnancy or within one year of the end of pregnancy due to complications related to pregnancy or childbirth. The United States has one of the highest maternal mortality rates in the developed world, and Texas has one of the highest rates among the states.

There are some well-established disparities in maternal mortality based on race that prompted the Committee to study this topic. For example, Black women have a 2.5 times higher rate of maternal mortality than white women, regardless of level of education or socio-economic status.

There are several reasons for Texas's high maternal mortality rate. Texas has a large rural population. Almost half of the counties in the state are maternity care deserts, defined as any county without a hospital or birth center offering obstetric care and without any obstetric providers. In Texas, 4.6% of pregnant women lacked access to a birthing facility within 30 minutes of their homes.

In addition, mental and behavioral health issues are a leading cause of maternal mortality in Texas. Suicide and homicide represented 27% of pregnancy-related deaths in Texas. Homicides were most often perpetrated by intimate partners. The Committee also found that many new mothers delay or neglect postpartum care because of non-medical factors such as access to transportation and childcare.

Texas has taken some important steps to address these disparities. In 2024, the Texas Health and Human Services Commission extended postpartum Medicaid and CHIP coverage for 12 months. And the Texas Maternal Mortality and Morbidity Review Committee has been tasked by the Texas Health Department to study and review several problems.

The Committee found that robust data collection is essential to addressing racial disparities and evaluating the impact of policy changes on maternal health. And there are some achievable policy solutions that would decrease maternal mortality, including promising developments in technology, paid family leave, and investing in more birth workers.

Based on the Committee's findings, we provide several recommendations that Congress and the state of Texas should take, which the Committee believes would address many of the current shortcomings and greatly decrease Texas's maternal mortality rate.

Merrill Matthews
Chair of the Texas Advisory Committee to the U.S. Commission on Civil Rights

## Background

Maternal mortality refers to the death of a woman during pregnancy or within one year of the end of pregnancy due to complications related to pregnancy or childbirth. In contrast, maternal morbidity refers to serious health conditions resulting from pregnancy or delivery that do not cause death but can have lasting physical or mental health effects. The United States has one of the highest maternal mortality rates in the developed world, and the rates are getting worse. Maternal deaths have more than doubled in the last 20 years.[2]

The U.S. reports maternal mortality as deaths during pregnancy or within 42 days postpartum, consistent with the World Health Organization's definition used for international comparisons.[3] However, the U.S. also tracks pregnancy-related mortality, which includes deaths up to one year after the end of pregnancy if they are related to pregnancy or its complications. For global comparisons, only the 42-day metric is used to ensure alignment with international standards.[4]

In Texas, maternal mortality rates are increasing. From 2019 to 2020, pregnancy and childbirth related morbidity rates increased significantly from 58.2 to 72.7 cases per 10,000 deliveries in Texas.[5] The Texas Maternal Mortality Rate Report determined there was some degree of opportunity to save the woman's life in 90 percent of cases in 2019.[6]

Cardiovascular conditions are the leading cause of pregnancy-related death for both Black and White women; hemorrhage is the leading cause of pregnancy-related death for both Native American women and Asian/Pacific Islander women; and infection is the leading cause of pregnancy-related death for Hispanic women.[7]

There is a growing concern that these rates will worsen after the passage of stricter abortion laws in Texas.[8] Some scholars and healthcare officials are concerned that new restrictions will increase the number of risky and/or unviable pregnancies brought to term and increase

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[2] "What Are Maternal Morbidity and Mortality?" *National Institutes of Health.* https://www.nichd.nih.gov/health/topics/maternal-morbidity-mortality.
[3] The Center for Disease Control (CDC) Website. How NCHS Measures Maternal Deaths. Last accessed September 4, 2025. https://www.cdc.gov/nchs/maternal-mortality/faq.htm.
[4] Ibid.
[5] Klibanoff, Eleanor. "New Texas Maternal Mortality Report Shows Disparities Persist." *The Texas Tribune*, December 16, 2022. https://www.texastribune.org/2022/12/15/texas-maternal-mortality-report/; Rueff, Josh. "Texas Maternal Mortality Rate: An Alarming New Report." Hampton & King, January 9, 2024. https://www.hamptonking.com/blog/texas-maternal-mortality-rate-an-alarming-new-report/; Texas Health and Human Services. "Texas Maternal Mortality and Morbidity Review Committee and Department of State Health Services Joint Biennial Report 2022." December 2022. https://tinyurl.com/n254rtda.
[6] Texas Health and Human Services. "Texas Maternal Mortality and Morbidity Review Committee and Department of State Health Services Joint Biennial Report 2022." December 2022. https://tinyurl.com/n254rtda.
[7] U.S. Government Accountability Office (GAO), "Maternal Mortality: Trends in Pregnancy-Related Deaths and Federal Efforts to Reduce Them." April 7, 2020. https://www.gao.gov/products/gao-20-248.
[8] Gill, Julian. "Anti-Abortion Ob-GYN Added to Texas Maternal Mortality Committee." *Houston Chronicle*, May 22, 2024. http://www.houstonchronicle.com/news/houston-texas/health/article/anti-abortion-maternal-mortality-deaths-19468740.php; Chapman, Isabelle. "Nearly Two Years after Texas' Six-Week Abortion Ban, More Infants Are Dying." CNN, July 20, 2023. https://tinyurl.com/97rwx6mc.

pregnancy and delivery complications for women with unhealthy and dangerous pregnancies.[9] This is compounded by unclear guidelines given to medical professionals who may fear legal repercussions when making medical decisions.[10]

With respect to abortion, this Committee is barred from making appraisals of laws and policies of the Federal Government or any other governmental authority in the United States.[11] The Committee recognizes there may be a correlation between abortion laws and maternal mortality rates, it but will not be including an assessment of abortion regulations in Texas as a part of this project.

Texas is a state with a large rural population. All over Texas, there are maternity healthcare deserts, defined as any county without a hospital or birth center offering obstetric care and without any obstetric providers. [12] Almost half of the counties in the state are maternity care deserts. In Texas, 4.6 percent of pregnant women lacked access to a birthing facility within 30 minutes of their homes.[13] This lack of prenatal care for mothers and babies in maternity deserts causes a higher risk of poor health outcomes, including death.[14]

*Disparities Among Protected Classes*

There are some well-established disparities in maternal mortality based on race that prompted the Committee to study this topic. Black women have a 2.5 times higher rate of maternal mortality than white women, regardless of level of education or socio-economic status.[15] A Black mother with a college education is at a 60 percent greater risk for a maternal death than a White or Hispanic woman with less than a high school education.[16] Black women are more likely to experience comorbid illnesses and pregnancy complications than White women, with higher

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[9] Gill, Julian. "Anti-Abortion Ob-GYN Added to Texas Maternal Mortality Committee." Houston Chronicle, May 22, 2024. http://www.houstonchronicle.com/news/houston-texas/health/article/anti-abortion-maternal-mortality-deaths-19468740.php; Chapman, Isabelle. "Nearly Two Years after Texas' Six-Week Abortion Ban, More Infants Are Dying." *CNN*, July 20, 2023. https://tinyurl.com/97rwx6mc.

[10] Chapman, Isabelle. "Nearly Two Years after Texas' Six-Week Abortion Ban, More Infants Are Dying." *CNN*, July 20, 2023. https://tinyurl.com/97rwx6mc.

[11] 42 U.S.C § 1975a(f).

[12] "Maternity Care Desert: Texas, 2021." *March of Dimes*, December 2023. https://www.marchofdimes.org/peristats/data?reg=99&top=23&stop=641&lev=1&slev=4&obj=9&sreg=48.

[13] "The Rise of Maternity Deserts in Texas." *Legacy Community Health*, January 30, 2024. https://www.legacycommunityhealth.org/newsblog-the-rise-of-maternity-deserts-in-texas/; "Maternity Care Desert: Texas, 2021." *March of Dimes*, December 2023. https://www.marchofdimes.org/peristats/data?reg=99&top=23&stop=641&lev=1&slev=4&obj=9&sreg=48.

[14] "The Rise of Maternity Deserts in Texas." *Legacy Community Health,* January 30, 2024. https://www.legacycommunityhealth.org/newsblog-the-rise-of-maternity-deserts-in-texas/.

[15] Maternal Mortality in the United States: A Primer." Cause of Maternal Mortality in U.S. | Commonwealth Fund, December 16, 2020. https://www.commonwealthfund.org/publications/issue-brief-report/2020/dec/maternal-mortality-united-states-primer#:~:text=High

[16] Maternal Mortality in the United States: A Primer." Cause of Maternal Mortality in U.S. | Commonwealth Fund, December 16, 2020. https://www.commonwealthfund.org/publications/issue-brief-report/2020/dec/maternal-mortality-united-states-primer#:~:text=High; United States Commission on Civil Rights, Racial Disparities in Maternal Health 2021 Statutory Enforcement Report (2021). https://www.usccr.gov/files/2021/09-15-Racial-Disparities-in-Maternal-Health.pdf.

rates of specific types of hemorrhage, preeclampsia, pregnancy-induced and chronic hypertension, asthma, placental disorders, gestational diabetes, preexisting diabetes, and blood disorders.[17] Women of color, especially Black women, who "develop these conditions at earlier ages, are less likely to have their conditions adequately managed, and more likely to have complications and mortality from these conditions."[18]

Mental and behavioral health issues are a leading cause of maternal mortality in Texas.[19] Suicide and homicide represented 27 percent of pregnancy-related deaths in Texas. Homicides were most often perpetrated by intimate partners.[20] Perinatal depression is one factor that has been linked to risks for adverse maternal and birth outcomes, including preeclampsia, gestational diabetes, preterm birth, and low birth weight. It is estimated that up to 28 percent of non-Hispanic Black women experience perinatal depression.[21]

Hispanic women have significantly better outcomes of maternal health than non-Hispanic Black women.[22] A factor that may contribute to lower rates of mortality in the Hispanic community are cultural factors related to prenatal and postpartum health and behavioral practices.[23] There is some evidence that these rates would improve if Hispanic women had better access to health insurance and early prenatal care.[24]

Studies that have included women who identify as Asian or Pacific Islander as a separate race showed they have the highest rate of maternal morbidity, including higher rates of post-partum hemorrhage, acute end-organ damage, and mortality during hospitalization for delivery.[25] This

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[17] Ibid.
[18] Elizabeth A. Howell, MD, MPP, "Reducing Disparities in Severe Maternal Mortality and Morbidity," Obstet Gynecol, Vol. 61, No. 2 (June 2018): 4, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5915910/; Beckie TM. Ethnic and racial disparities in hypertension management among women. Semin Perinatol. 2017 Jun 7.
[19] Gordon, Maggie. "Mental Health Is the Leading Cause of Pregnancy-Related Deaths. so How Do We Fix It?" Houston Landing, February 10, 2024. https://houstonlanding.org/mental-health-is-the-leading-cause-of-pregnancy-related-deaths-so-how-do-we-fix-it/#:~:te.
[20] Klibanoff, Eleanor. "New Texas Maternal Mortality Report Shows Disparities Persist." The Texas Tribune, December 16, 2022. https://www.texastribune.org/2022/12/15/texas-maternal-mortality-report/; "Texas Maternal Mortality and Morbidity Review Committee and Department of State Health Services Joint Biennial Report 2022." Texas Health and Human Services, December 2022. https://www.dshs.texas.gov/sites/default/files/legislative/2022-Reports/2022-MMMRC-DSHS-Joint-Biennial-Report.pdf
[21] Chinn, Juanita J., Iman K. Martin, and Nicole Redmond. "Health Equity among Black Women in the United States." Journal of Women's Health 30, no. 2 (February 1, 2021): 212–19. https://doi.org/10.1089/jwh.2020.8868.
[22] Merschel, Michael. "After a Jump in Maternal Mortality for Hispanic Women, a Search for Answers." www.heart.org, January 24, 2023. https://www.heart.org/en/news/2022/09/30/after-a-jump-in-maternal-mortality-for-hispanic-women-a-search-for-answers#:~:text=
[23] Ibid.
[24] "Infant Mortality and Hispanic Americans." Office of Minority Health, 2020. https://minorityhealth.hhs.gov/infant-mortality-and-hispanic-americans.
[25] Grob, Patrizia C., Rachel R. Tindal, Kathleen R. Lundeberg, Jameaka L. Hamilton, Veronica M. Gonzalez-Brown, and Erin A. Keyser. "Increased Maternal Morbidity and Mortality among Asian American and Pacific Islander Women in the Military Health System." AJOG Global Reports, April 14, 2023. https://www.sciencedirect.com/science/article/pii/S2666577823000539.

difference in outcomes persists even though Asian or Pacific Islander women live in areas of higher socioeconomic status and are more likely to have private insurance.[26]

Disparately poor health outcomes by race may be a result of a complex milieu of barriers to quality health care, racism, and stress associated with the distinct social experiences of Black woman in U.S. society.[27] Well-documented studies show that women of color are more likely to receive disproportionately less care, experience reduced autonomy, and receive reduced attention and medical care when serious complications occur.[28]

Historic mistreatment and exploitation of communities of color, especially Black and Native American women, have contributed to lasting mistrust in the healthcare system. From nonconsensual medical experimentation on enslaved women in the 19th century[29] to forced sterilizations of Indigenous women well into the 1970s, these abuses have had enduring effects.[30] For generations, myths about biological differences, such as the false belief that Black people feel less pain, were taught in medical schools, influencing care.[31] Although implicit bias training is now more common, recent studies show that discriminatory beliefs still persist among medical professionals, contributing to disparities in treatment and maternal outcomes.[32]

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[26] Ibid.; Siddiqui, Maryam, Minhaj Minhaj, Alexander Mueller, Alexander Tung, Benjamin Scavone, Sabeena Rana, and Sarosh Shahul. "Increased Perinatal Morbidity and Mortality among Asian American and Pacific Islander Women in the United States." U.S. National Library of Medicine, March 2017. https://pubmed.ncbi.nlm.nih.gov/28249596.

[27] Chinn, Juanita J., Iman K. Martin, and Nicole Redmond. "Health Equity among Black Women in the United States." Journal of Women's Health 30, no. 2 (February 1, 2021): 212–19. https://doi.org/10.1089/jwh.2020.8868; Nnoli, Aisha. "Historical Primer on Obstetrics and Gynecology Health Inequities in America: A Narrative Review of Four Events." Obstetrics and Gynecology, October 1, 2023. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10510831.

[28] Njoku, Anuli, Marian Evans, Lillian Nimo-Sefah, and Jonell Bailey. "Listen to the Whispers before They Become Screams: Addressing Black Maternal Morbidity and Mortality in the United States." Healthcare (Basel, Switzerland), February 3, 2023; FitzGerald, S., and C. Hurst. "Implicit Bias in Healthcare Professionals: A Systematic Review." BMC Medical Ethics. Accessed June 30, 2024. https://pubmed.ncbi.nlm.nih.gov/28249596.

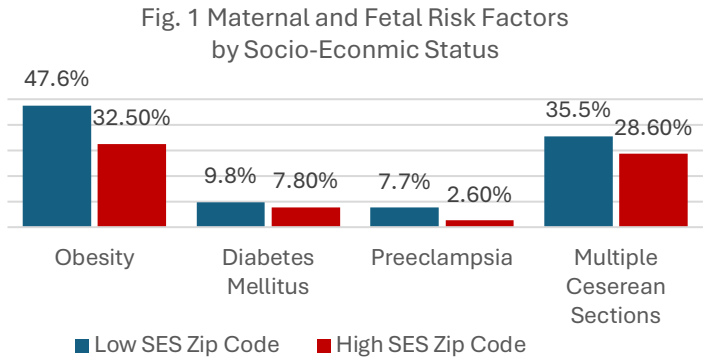
[29] Axelsen, Diana E. "Women as Victims of Medical Experimentation: J. Marion Sims' Surgery on Slave Women, 1845–1850." Women's Bodies, December 31, 1993, 93–100. https://doi.org/10.1515/9783110976328.93.

[30] National Institute on Health. "Tribes - Native Voices." U.S. National Library of Medicine. Accessed June 30, 2024. Found here. Amelia Schafer. "Indigenous women reclaim traditional birthing practices." The Missoulian. February 17, 2024. Found here.

[31] Lim, Guan Hui, Zeluleko Sibanda, Joshua Erhabor, Soham Bandyopadhyay, and The Neurology and Neurosurgery Interest Group. "Students' Perceptions on Race in Medical Education and Healthcare." Perspectives on Medical Education 10, no. 2 (January 7, 2021): 13. https://doi.org/10.1007/s40037-020-00612-1; Sabin Janice A., "How We Fail Black Patients in Pain." AAMC, January 6, 2020. https://www.aamc.org/news/how-we-fail-black-patients-pain; Mende-Siedlecki, Peter, Jennie Wen Qu-Lee, Robert Backer, and Jay Joseph Van Bavel. "Perceptual Contributions to Racial Bias in Pain Recognition." American Psychological Association- Journal of Experimental Psychology: General, 863– 889, 148, no. 5.

[32] Sabin, Janice A."How We Fail Black Patients in Pain." AAMC, January 6, 2020. https://www.aamc.org/news/how-we-fail-black-patients-pain; Durbhakula, Shravani, Tony Wang, Kara Segna, Gerard Limerick, Mustafa Broachwala, Michael Schatman, Munfarid Zaidi, Ingharan Siddarthan, and Serkan Toy. "Shifts in Students' Attitudes Towards Pain Patients, Pain, and Opioid Management Following a Dedicated Medical School Pain Curriculum." https://pmc.ncbi.nlm.nih.gov/articles/PMC10916513/; Fitzgerald C. Hurst. "Implicit Bias in Healthcare Professionals: A Systematic Review." BMC medical ethics. https://pubmed.ncbi.nlm.nih.gov/28249596/.

In 2024 a study aimed at comparing the maternal and fetal health outcomes of mothers from diverse socioeconomic backgrounds in San Antonio, Texas, found inequitable trends in women's health outcomes.[33] Pregnant women from the high socio-economic status zip codes were more likely to be admitted to the hospital from clinics or a physician's office (68.8%), while pregnant women from the low socio-economic status zip codes were admitted to the hospital from non-healthcare facilities like home or workplace (62.5%). In addition, a greater percentage of patients from the low socio-economic status communities were Black (4.3% vs 1.3%) or Hispanic (88.5% vs 35.1%).[34]




*Patel, Vaishnavi J, Victoria Delano, Aishwarya Juttu, Huraiya Adhora, Aroob Zaheer, Leticia Vargas, and Blaine Jacobs. "The Implications of Socioeconomic Status by ZIP Code on Maternal-Fetal Morbidity and Mortality in San Antonio, Texas." Cureus, February. https://pmc.ncbi.nlm.nih.gov/articles/PMC10959557/*

**Federal Law & Programs**

The Family and Medical Leave Act (FMLA) entitles eligible employees of covered employers 12 work-weeks of unpaid, job-protected leave for specified family and medical reasons, with continuation of group health insurance coverage under the same terms and conditions as if the employee had not taken leave.[35]

Medicaid and the Children's Health Insurance Program (CHIP) offer coverage for pregnant women.[36] Medicaid coverage for pregnant women began with the Deficit Reduction Act of 1984, which makes clear that it is the state's responsibility to provide medical care coverage for women

[33] Patel, Vaishnavi J, Victoria Delano, Aishwarya Juttu, Huraiya Adhora, Aroob Zaheer, Leticia Vargas, and Blaine Jacobs. "The Implications of Socioeconomic Status by ZIP Code on Maternal-Fetal Morbidity and Mortality in San Antonio, Texas." Cureus, February. https://pmc.ncbi.nlm.nih.gov/articles/PMC10959557/
[34] Patel, Vaishnavi J, Victoria Delano, Aishwarya Juttu, Huraiya Adhora, Aroob Zaheer, Leticia Vargas, and Blaine Jacobs. "The Implications of Socioeconomic Status by ZIP Code on Maternal-Fetal Morbidity and Mortality in San Antonio, Texas." Cureus, February.
[35] 29 U.S.C. Chapter 28; *see also* "Family and Medical Leave Act." DOL. Accessed June 30, 2024. https://www.dol.gov/agencies/whd/fmla.
[36] "Legislative Milestones in Medicaid and Chip Coverage of Pregnant Women." MACPAC, January 31, 2023. https://www.macpac.gov/legislative-milestones-in-medicaid-and-chip-coverage-of-pregnant-women/#:~:text=Deficit%20Reduction%20Act%20of%201984,the%20child%20.

and their children. Texas currently provides CHIP coverage only for women and families who qualify based on income.[37]

The federal Rural Maternity and Obstetrics Management Strategies (RMOMS) Program, administered by the Health Resources and Services Administration, is a pilot program that aims to improve access to maternal and obstetrics care in rural areas throughout the U.S. The program's goals are to:

- Develop a sustainable network approach to coordinate maternal and obstetrics care within rural regions.
- Increase the delivery and access of preconception, pregnancy, labor and delivery, and postpartum services.
- Develop sustainable financing models for the provision of maternal and obstetrics care.
- Improve maternal and neonatal outcomes.

The RMOMS program focuses on areas such as telehealth services, continuum of care networks, rural hospital obstetric service aggregation, and financial sustainability.[38]

The federal Healthy Start Program was established by Congress in 1991.[39] Currently one of its projects is targeting communities with infant mortality rates that are at least 1.5 times the U.S. national average, particularly among non-Hispanic Black and other disproportionately affected populations.[40] The Healthy Start program provides grants to support community-based strategies to reduce disparities in infant mortality and improve perinatal outcomes for women and children in high-risk communities throughout the nation. Major and persistent racial and ethnic disparities exist for infant mortality, maternal mortality, and other adverse outcomes such as preterm birth and low-birth weight.[41] Healthy start currently funds 115 projects in 37 states.[42] Texas has projects running in Dallas, Houston, Austin, Tyler, and San Antonio.[43]

**State Law & Programs**

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[37] Deficit Reduction Act of 1984, Pub. L. No. 98-369; "Medicaid for Pregnant Women and Chip Perinatal." Texas Health and Human Services. Accessed June 30, 2024. https://www.hhs.texas.gov/services/health/medicaid-chip/medicaid-chip-programs-services/medicaid-pregnant-women-chip-perinatal#:~:text=Medicaid%20prhave%20health%20insurance.

[38] United States Commission on Civil Rights, Racial Disparities in Maternal Health 2021 Statutory Enforcement Report (2021). https://www.usccr.gov/files/2021/09-15-Racial-Disparities-in-Maternal-Health.pdf

[39] 42 U.S.C. § 241.

[40] United States Commission on Civil Rights, Racial Disparities in Maternal Health 2021 Statutory Enforcement Report (2021). https://www.usccr.gov/files/2021/09-15-Racial-Disparities-in-Maternal-Health.pdf

[41] United States Commission on Civil Rights, Racial Disparities in Maternal Health 2021 Statutory Enforcement Report (2021). https://www.usccr.gov/files/2021/09-15-Racial-Disparities-in-Maternal-Health.pdf.

[42] Healthy Start EPIC Center, "Program Overview," https://www.healthystartepic.org/healthy-start/programoverview/.

[43] "Find Healthy Start Services." National Healthy Start Association, November 5, 2021. https://www.nationalhealthystart.org/find-services/.

Effective March 1, 2024, the Texas Health and Human Services Commission (HHSC) has extended postpartum Medicaid and CHIP coverage for 12 months.[44]

In the Maternal and Infant Health Improvement Act,[45] the legislature recognizes that the perinatal period beginning before conception and continuing through the first year of life poses unique challenges for the healthcare system and that the development of a coordinated, cooperative system of perinatal healthcare within a geographic area will reduce unnecessary mortality and morbidity for women and infants.[46]

The Texas Maternal Mortality and Morbidity Review Committee (MMMRC) has been tasked by the Texas Health Department to study and review:[47]

- Cases of pregnancy-related deaths;
- Trends, rates, or disparities in pregnancy-related deaths and severe maternal morbidity;
- Health conditions and factors that disproportionately affect the most at-risk populations; and
- Best practices and programs operating in other states that have reduced rates of deaths related to pregnancy.

In 2023, the Texas Legislature passed House Bill 852, which modified the composition of the Maternal Mortality and Morbidity Review Committee (MMMRC) by replacing a designated patient advocate position with a category for community members with experience in relevant healthcare fields.[48] The law also expanded the committee from 17 to 21 members.[49] In 2024, the committee announced it would not conduct full reviews of maternal deaths from 2022 and 2023, citing a desire to focus on more recent cases and provide more timely analysis.[50] This decision received criticism from some former committee members and public health advocates, who expressed concern about the lack of review for years following major policy changes affecting reproductive health in Texas.[51]

**Infant Mortality**

The Committee has limited the scope of this project to focus only on maternal mortality, but infant mortality and morbidity in many cases have a direct correlation to maternal health. As

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[44] "Postpartum Medicaid and CHIP Coverage Extension." Texas Health and Human Services. https://www.hhs.texas.gov/sites/default/files/documents/24D0189-postpartum-medicaid-chip-flyer.pdf
[45] Maternal and Infant Health Improvement Act, 2 Tex. HS Code § 32.041
[46] *Id.*
[47] *Id.*
[48] TX HB 852, Leg. R.S. (2023) https://capitol.texas.gov/BillLookup/Text.aspx?LegSess=88R&Bill=HB852
[49] *Id.*
[50] Eleanor Klibanoff. "Texas' maternal mortality committee faces backlash for not reviewing deaths from first two years post-Dobbs." The Texas Tribune. December 6, 2024. https://www.texastribune.org/2024/12/06/texas-maternal-mortality-committee-deaths/
[51] Ibid.

maternal mortality disparities are addressed and improvements are made, the rates of infant mortality and morbidity also improve.[52]

In 2022, Infant Mortality Rates (IMR) in Texas increased for the first time in 20 years. Texas saw more infants die than in any other state.[53] In 2022, Texas was one of four states whose infant mortality rates rose, up eight percent from 2021 to 2022.[54] The IMR is a widely used indicator for community health. The IMR for Texas has been at or below the national rate for the past 10 years, and since 2011 the state has consistently been below the Healthy People 2020 (HP2020) target of 6.0 deaths per 1,000 live births.[55]

[52] "Maternal Data Center." Maternal Data Center | California Maternal Quality Care Collaborative. Accessed June 30, 2024. https://www.cmqcc.org/maternal-data-center.
[53] Rivera, Elena. "More Babies Died in Texas than Any Other State Last Year, Report Says." KUT Radio, Austin's NPR Station, November 8, 2023. https://www.kut.org/health/2023-11-03/more-babies-died-in-texas-than-any-other-state-last-year-report-says.
[54] Rivera, Elena. "Texas Is One of Four States Whose Infant Mortality Rates Rose in 2022, Report Says." KERA News, November 8, 2023. https://www.keranews.org/health-wellness/2023-11-03/cdc-infant-mortality-texas; Stark, Sam. "Infant Mortality Rate Increases for First Time in 20 Years, up 8% in Texas." KXAN Austin, November 3, 2023. https://www.kxan.com/news/simplehealth/infant-mortality-rate-increases-for-first-time-in-20-years-up-8-in-texas/#:~:text=The%20rate%20
[55] Ibid.

## Methodology

As a matter of historical precedent, and in order to achieve transparency, Committee studies involve a collection of public, testimonial evidence and written comments from individuals directly impacted by the civil rights topic at hand; e.g., researchers and experts who have rigorously studied and reported on the topic, community organizations and advocates representing a broad range of backgrounds and perspectives related to the topic, and government officials tasked with related policy decisions and the administration of those policies.

Advisory Committee members utilize their expertise in selecting panelists who are the most useful to the purposes of the study and will result in a broad and diverse understanding of the issue. This method requires Committee members to draw from their own experiences, knowledge, opinions, and views to understand the issue and possible policy solutions. Committees are composed of volunteer professionals and advocates who are familiar with civil rights issues in their state or territory. Members represent a variety of political viewpoints, occupations, races, ages, and genders, as well as a variety of backgrounds, skills, and experiences. The intentional diversity of each Committee promotes vigorous debate and full exploration of the issues. It also serves to assist in offsetting biases that can result in the oversight of nuances in the testimony.

For the purposes of this study, ***Findings*** are based on witness testimony and data suggested, revealed, or indicated to the Committee. Findings refer to a synthesis of observations confirmed by a majority vote of members, rather than conclusions drawn by any one member. ***Recommendations*** are specific actions or proposed policy interventions intended to address or alleviate the civil rights concerns raised in the related finding(s). Where findings indicate a lack of sufficient knowledge or available data to fully understand the civil rights issues at hand, recommendations may also target specific areas in need of further, more rigorous study. Recommendations are directed to the Commission; they request that the Commission itself take a specific action, or that the Commission forward recommendations to other federal or state agencies, policymakers, or stakeholders.

## Findings

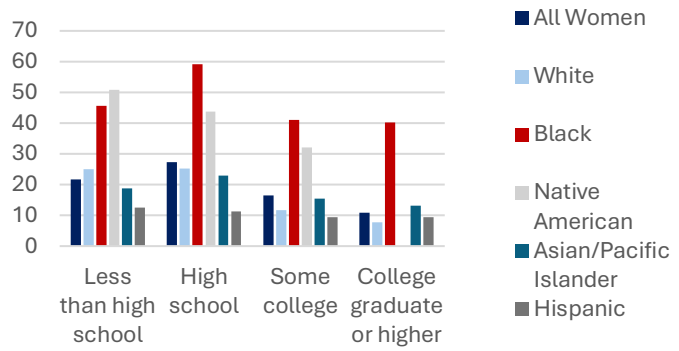
The section below communicates the observations and conclusions of the Committee based on the testimony received during its investigation. While the Committee has not independently verified each assertion and Committee members are not experts on the topic at hand, a diverse and balanced selection of panelists was chosen to testify due to their professional experience, academic credentials, subject matter expertise, and/or firsthand experience with the topics.

In keeping with their duty to inform the Commission of: (1) matters related to discrimination or a denial of equal protection of the laws; and (2) matters of mutual concern in the preparation of reports of the Commission to the President and the Congress,[56] the Texas Advisory Committee submits the following findings to the Commission.

**Finding I: Women of color face disproportionately high rates of maternal mortality, but rates are on the rise for all women.**

Black mothers in Texas face disproportionately high maternal mortality rates, nearly three times the rates of all other women in the state.[57] When it comes to severe maternal morbidity, Black women are twice as likely to experience it compared to White women.[58] Particularly concerning is that maternal mortality among Black women remains high regardless of education (See Fig. 2).[59] Among women with similar education, the largest disparities are between Black and White women with college degrees.[60] Although Hispanic women have historically had lower rates

Fig. 2 Pregnancy-Related Mortality Ratio by Race/Ethnicity and Education Completed, 2007-2016




*Maternal Mortality in the United States: A Primer." Cause of Maternal Mortality in U.S. | Commonwealth Fund, December 16, 2020.*

[56] 45 C.F.R. § 703.2 (2018).
[57] Representative Shawn Thierry, testimony, *Briefing Before the Texas Advisory Committee to the U.S. Commission on Civil Rights,* remote panel via ZoomGov, December 11, 2024. Transcript, pp. 9 (hereafter *Transcript III)*; Dr. Ingrid Skop, testimony, *Briefing Before the Texas Advisory Committee to the U.S. Commission on Civil Rights,* remote panel via ZoomGov, December 11, 2024. Transcript, pp. 7 (hereafter *Transcript III)*; Mia Johnson, Public Comment, Transcript IV, p. 31.
[58] Dr. Fatimah Lalani, testimony, *Briefing Before the Texas Advisory Committee to the U.S. Commission on Civil Rights,* remote panel via ZoomGov, October 8, 2024. Transcript, pp. 8 (hereafter *Transcript II)*; Alicia Lee, testimony, *Briefing Before the Texas Advisory Committee to the U.S. Commission on Civil Rights,* remote panel via ZoomGov, February 26, 2025. Transcript, pp. 18 (hereafter *Transcript IV).*
[59] Dr. Arline Geronimus, testimony, *Briefing Before the Texas Advisory Committee to the U.S. Commission on Civil Rights,* remote panel via ZoomGov, February 26, 2025. Transcript, pp. 11 (hereafter *Transcript IV).*
[60] Geronimus Testimony, *Transcript IV*, p. 11.

of maternal mortality, their rates have been rising since 2017, driven in part by an increase in preterm births.[61]

The gap between Black and White maternal mortality rates has narrowed in recent years, but troublingly, this is due to increased maternal mortality rates among White mothers, not improvements in maternal mortality for Black mothers.[62]

**Finding II: A woman's health before conception has a significant impact on maternal mortality. Disparities in preconception health, including those attributed to the weathering phenomenon, can account for some of the racial disparities in mortality rates.**

Many maternal deaths can be traced to indirect obstetric causes linked to preexisting conditions such as obesity, cardiac disease, hypertension, diabetes, mental illness, and other chronic illnesses.[63] In Texas, one in three pregnant women suffers from chronic conditions such as diabetes, hypertension, nicotine addiction, and/or obesity.[64] When pregnancy occurs alongside these chronic illnesses, the likelihood of complications such as maternal morbidity or mortality significantly rises.[65] Pre-existing health conditions account for nearly 80 percent of the Black-White severe maternal morbidity gap.[66] Many of the most dangerous pre-existing conditions, including obesity, hypertension, and diabetes, disproportionately affect Black women.[67]

Some of the racial disparities in preconception health are attributed to the weathering effect. Weathering is the cumulative effect of chronic stress and adversity, especially from racism and socioeconomic disadvantage, on a woman's body, accelerating biological aging and increasing health risks.[68] Women of color, particularly Black women in the United States, experience higher levels of stress, which in turn impacts their overall health.[69] Research suggests that the impact of weathering has intensified over the last 30 to 40 years.[70] This is partly because women are

[61] Dr. Alva Ferdinand, testimony, *Briefing Before the Texas Advisory Committee to the U.S. Commission on Civil Rights,* remote panel via ZoomGov, October 7, 2024. Transcript, pp. 7 (hereafter *Transcript I)*; Lee Testimony, *Transcript IV*, p. 15.
[62] Geronimus Testimony, *Transcript IV*, p. 10.
[63] Dr. Ingrid Skop, testimony, *Briefing Before the Texas Advisory Committee to the U.S. Commission on Civil Rights,* remote panel via ZoomGov, December 11, 2024. Transcript, pp. 6 (hereafter *Transcript III)*; Dr. Toi B. Harris, testimony, *Briefing Before the Texas Advisory Committee to the U.S. Commission on Civil Rights,* remote panel via ZoomGov, October 8, 2024. Transcript, pp. 13 (hereafter *Transcript II).*
[64] Lee Testimony, *Transcript IV*, p. 15.
[65] Lee Testimony, *Transcript IV*, p. 15.
[66] Lalani Testimony, *Transcript II*, p. 7.
[67] Skop Testimony, *Transcript III*, p. 7; Sonya Irby, Public Comment, Transcript IV, p. 32.
[68] Geronimus Testimony, *Transcript IV*, p. 9; Harris Testimony, *Transcript II*, p. 20; Dr. McClain Sampson, testimony, *Briefing Before the Texas Advisory Committee to the U.S. Commission on Civil Rights,* remote panel via ZoomGov, October 7, 2024. Transcript, pp. 24 (hereafter *Transcript I).*
[69] Sampson Testimony, *Transcript I*, p. 5; Geronimus Testimony, *Transcript IV*, p. 13.
[70] Geronimus Testimony, *Transcript IV*, p. 11.

choosing to delay pregnancy until later in life, giving stress and health problems more time to take a toll on the body before pregnancy.[71]

**Finding III: Postpartum healthcare is an essential part of addressing maternal mortality. Many new mothers delay or neglect postpartum care because of non-medical factors such as access to transportation and childcare.**

A significant portion of maternal deaths occur in the postpartum period, and many of these are considered preventable.[72] Texas legislators acknowledged this important period and extended Medicaid coverage for mothers in the state up to 12 months after birth starting in March 2024.[73] It is still too soon to assess the impacts of this expansion, but many panelists cited it as an encouraging development that they expect will improve mothers' access to healthcare.[74]

Unfortunately, expanding access to healthcare alone will not address many of the barriers that keep mothers from receiving postpartum services.[75] Many mothers skip their postpartum check-ups altogether and receive no follow-up care after giving birth.[76] Barriers to affordable and reliable transportation often prevent mothers from attending their postpartum appointments, which especially affects women living in rural communities.[77] A lack of access to affordable childcare can also impact a woman's postpartum care.[78]

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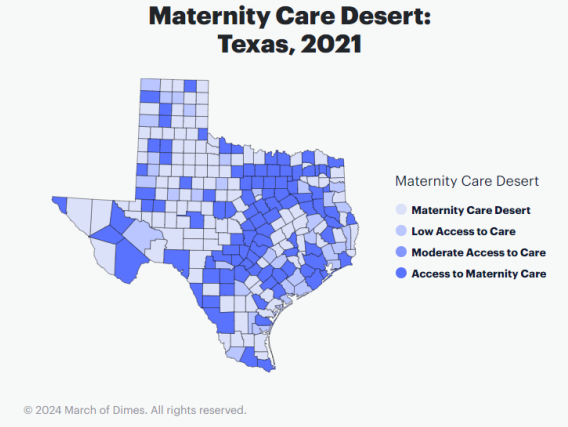
[71] Geronimus Testimony, *Transcript IV*, p. 12; Sampson Testimony, *Transcript I*, p. 24; Lee Testimony, *Transcript IV*, p. 15.
[72] Geronimus Testimony, *Transcript IV*, p. 11-12; Dr. James Hill, testimony, *Briefing Before the Texas Advisory Committee to the U.S. Commission on Civil Rights,* remote panel via ZoomGov, December 11, 2024. Transcript, pp. 4 (hereafter *Transcript III)*; Dr. Meitra Doty, testimony, *Briefing Before the Texas Advisory Committee to the U.S. Commission on Civil Rights,* remote panel via ZoomGov, February 26, 2025. Transcript, pp. 8 (hereafter *Transcript IV).*
[73] Thierry Testimony, *Transcript III*, p. 10; Lee Testimony, *Transcript IV*, p. 16.
[74] Thierry Testimony, *Transcript III*, p. 9; Dr. Diana Ramos, testimony, *Briefing Before the Texas Advisory Committee to the U.S. Commission on Civil Rights,* remote panel via ZoomGov, February 26, 2025. Transcript, pp. 4-5 (hereafter *Transcript IV)*; Dr. Candace Robledo, testimony, *Briefing Before the Texas Advisory Committee to the U.S. Commission on Civil Rights,* remote panel via ZoomGov, October 7, 2024. Transcript, pp. 33-34 (hereafter *Transcript I).*
[75] Doty Testimony, *Transcript IV*, p. 22; Lee Testimony, *Transcript IV*, p. 16.
[76] Skop Testimony, *Transcript III*, p. 26; Thierry Testimony, *Transcript III*, p. 25.
[77] Sampson Testimony, *Transcript I*, p. 5; Doty Testimony, *Transcript IV*, p. 22.
[78] Doty Testimony, *Transcript IV*, p. 22-23; Sampson Testimony, *Transcript I*, p. 5; Skop Testimony, *Transcript III*, p. 7; Ramos Testimony, *Transcript IV*, p. 29.

**Finding IV: Texas has worse maternal mortality rates than most states in the U.S. Two contributing factors to this high rate are the large proportion of Texas that is rural and the high number of women lacking access to health insurance.**

The maternal mortality rate in the United States is the highest among developed nations—and it's getting worse.[79] Nationally, the pregnancy-related mortality rate rose from 7.2 deaths per 100,000 live births in 1987 to 17.6 per 100,000 live births in 2019.[80] And Texas is one of the lowest performing states, ranking 48th overall for maternal health.[81]




One key factor affecting Texas's maternal mortality rate is its large rural population. Nearly half of Texas counties are considered maternity healthcare deserts, meaning they lack labor and delivery units or obstetric providers.[82] Texas has led the nation in rural hospital closures since 2010, and an additional 76 rural hospitals in the state are at risk of closure—including 12 at immediate risk.[83] As a result, women in rural areas often drive hours to receive care, leading to significantly less prenatal care and higher rates of preterm birth.[84] Given the limited access to hospitals and healthcare providers, investing in doulas and midwives could help address the needs of rural mothers.[85]

The Rio Grande Valley contains some of the worst counties for maternal mortality in the state. Women in this region have less access to healthcare and are more likely to exhibit risk factors known to worsen maternal mortality, including poor mental health and pre-existing conditions.[86] In the region, 30 percent of women experience high blood pressure, and two out of three women have high body mass indexes.[87] Hispanic women in the Rio Grande Valley are also more likely to experience long-term postpartum depression compared to women in other parts of Texas.[88]

Another contributing factor to Texas's poor maternal health outcomes is the lack of access to insurance and therefore consistent healthcare.[89] In Texas, 17 percent of the population is uninsured, and in some places, such as Harris County, that number can be as high as 22

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[79] Geronimus Testimony, *Transcript IV*, p. 10; Skop Testimony, *Transcript III*, p. 6; Lalani Testimony, *Transcript II*, p. 7.
[80] Geronimus Testimony, *Transcript IV*, p. 10.
[81] Harris Testimony, *Transcript II*, p. 4.
[82] Skop Testimony, *Transcript III*, p. 8; Lee Testimony, *Transcript IV*, p. 15; Ferdinand Testimony, *Transcript I*, p. 7.
[83] Ferdinand Testimony, *Transcript I*, p. 7.
[84] Lee Testimony, *Transcript IV*, p. 14; Ferdinand Testimony, *Transcript I*, p. 7.
[85] Ferdinand Testimony, *Transcript I*, p. 7-8.; Lalani Testimony, *Transcript II*, p. 8.
[86] Robledo Testimony, *Transcript I*, p. 11.
[87] Robledo Testimony, *Transcript I*, p. 11.
[88] Robledo Testimony, *Transcript I*, p. 11.
[89] Ferdinand Testimony, *Transcript I*, p. 6; Lalani Testimony, *Transcript II*, p. 22.

percent.[90] Texas also has the highest rate of uninsured women in the country, with almost one in four women of reproductive age lacking health insurance.[91] This gap in coverage may make it harder for women to access consistent prenatal and postpartum care, which is essential to preventing complications and reducing maternal mortality.[92]

**Finding V: Maternal deaths related to mental health and interpersonal violence are common, especially postpartum, and often go unaddressed.**

One of the major causes of maternal mortality is related to mental health and/or domestic violence. Twenty-one percent of pregnancy-related deaths are from mental disorders, and 28 percent are due to violence, including suicide and homicide, often occurring in the postpartum period.[93] Mental health related deaths most often occur more than 60 days after childbirth, and all of these deaths are deemed preventable.[94] Many mothers lacking social support experience feelings of despair during the challenging infancy phase and frequently prioritize the healthcare needs of their baby before seeking care for themselves.[95] Interruptions in mental healthcare, lack of screening, lack of attention to known mental disorders, and stigma can cause mothers to "fall through the cracks."[96]

Screening mothers for both depression and domestic-violence risk during either OBGYN or even pediatric appointments may help to connect mothers to potentially lifesaving care.[97] However, the expansion of Medicaid in Texas may not adequately address these mental health needs, as there are a limited number of mental healthcare providers in Texas who accept Medicaid.[98]

**Finding VI: Robust and disaggregated data collection is essential to addressing racial disparities and evaluating the impact of policy changes on maternal health.**

Data collection and analysis play a critical role in understanding maternal mortality, especially in identifying and addressing racial disparities.[99] The Texas Maternal Mortality & Morbidity Review Committee has made improvements to its data collection and its efforts to stay up to date on maternal outcomes in Texas.[100] However, more data is needed to further clarify trends and causes of maternal mortality, particularly regarding early pregnancy events. Disaggregated data

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[90] Harris Testimony, *Transcript II*, p. 3; Ferdinand Testimony, *Transcript I*, p. 6.
[91] Lalani Testimony, *Transcript II*, p. 8.
[92] Ferdinand Testimony, *Transcript I*, p. 8.
[93] Lalani Testimony, *Transcript II*, p. 7-8.
[94] Doty Testimony, *Transcript IV*, p. 7-8.
[95] Skop Testimony, *Transcript III*, p. 25.
[96] Doty Testimony, *Transcript IV*, p. 9.
[97] Doty Testimony, *Transcript IV*, p. 7-8; Skop Testimony, *Transcript III*, p. 8.
[98] Doty Testimony, *Transcript IV*, p. 9; Lalani Testimony, *Transcript II*, p. 8.
[99] Skop Testimony, *Transcript III*, p. 6.; Thierry Testimony, *Transcript III*, p. 10.
[100] Hill Testimony, *Transcript III*, p. 23; Thierry Testimony, *Transcript III*, p. 20; Skop Testimony, *Transcript III*, p. 32.

that more accurately represents Hispanic women in the state is also needed.[101] More accurate and up-to-date data collection could also shed light on how external factors, like the COVID-19 pandemic and expansion of Medicaid, are impacting mothers.[102] Building a real-time data collection platform was one of the key strategies California implemented to improve maternal mortality.[103]

**Finding VII: There are some accessible policy solutions to decrease maternal mortality, including promising developments in technology, paid family leave, and investing in more birth workers.**

There are many promising developments in how healthcare providers are harnessing technology to improve maternal mortality. Some doctors are expanding existing technology, such as telehealth and text messages, to make it easier for moms to access healthcare.[104] New tools are also being developed to better monitor the health of both newborns and their mothers.[105] For example, *Babyscripts* is a new app that has been piloted in Texas to allow healthcare providers to remotely monitor mothers' vital signs and symptoms throughout pregnancy and postpartum.[106] The continued development of predictive AI also holds promise for identifying when mothers are at risk and may require early intervention.[107]

New technology is also being developed to address racial disparities and language translation, particularly in consistency and quality of care. Some tools are being used to promote standardized care in labor and delivery units, reducing the risk of biased or inconsistent treatment.[108] Others, such as the *Irth* app, provide platforms for patients to report discriminatory experiences in medical settings, helping hold providers accountable and promoting respectful care.[109]

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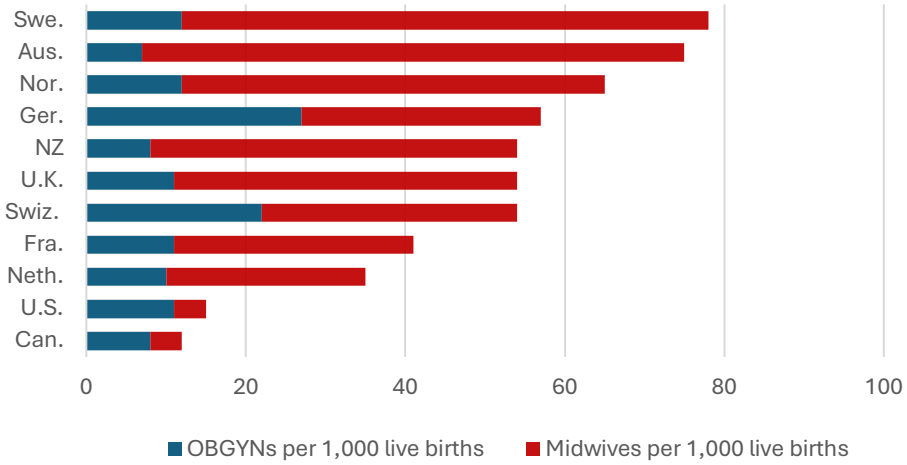
[101] Geronimus Testimony, *Transcript IV*, p. 21.; Skop Testimony, *Transcript III*, p. 6.
[102] Thierry Testimony, *Transcript III*, p. 29; Hill Testimony, *Transcript III*, p. 27.
[103] "What We Do." What We Do | California Maternal Quality Care Collaborative. https://www.cmqcc.org/about-cmqcc/what-we-do.
[104] Sampson Testimony, *Transcript I*, p. 16-17.
[105] Dr. Omonike Olaleye, testimony, *Briefing Before the Texas Advisory Committee to the U.S. Commission on Civil Rights,* remote panel via ZoomGov, October 7, 2024. Transcript, pp. 13 (hereafter *Transcript I)*; Lalani Testimony, *Transcript II*, p. 9.
[106] Harris Testimony, *Transcript II*, p. 5.
[107] Olaleye Testimony, *Transcript I*, p. 13.
[108] Harris Testimony, *Transcript II*, p. 5.
[109] Sampson Testimony, *Transcript I*, p. 20-21.

As discussed in earlier findings, the postpartum period is a critical and vulnerable time for mothers, especially in the absence of comprehensive support. Expanding paid family leave has been proven to improve maternal mortality outcomes.[110]

Fig. 3 Proportion of Midwives & OBGYNs per 1,000 Live Births, 2018 or Latest Year




*Roosa, Tikkanen et al, Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries (Commonwealth Fund, Nov. 2020).*

Increasing the number and variety of birth care workers could also help decrease maternal mortality in Texas. Other high-income countries have more than twice the number of healthcare providers per birth than the U.S. (Fig. 3[111]), and a significantly larger portion of those are midwives and doulas.[112] Utilizing a wider variety of healthcare workers, such as doulas[113] and midwives,[114] has been proven to lower healthcare costs without compromising quality of care.[115] Community-based birth workers are especially valuable in rural areas, where provider shortages are acute.[116] They also improve the cultural responsiveness of care, particularly for refugee and immigrant communities.[117] Increasing the number of birth workers from the community they serve can help rebuild trust in the healthcare system, especially among mothers of color.[118]

[110] Harris Testimony, *Transcript II*, p. 17; Ferdinand Testimony, *Transcript I*, p. 8.
[111] Roosa, Tikkanen et al, Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries (Commonwealth Fund, Nov. 2020). https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries
[112] Geronimus Testimony, *Transcript IV*, p. 11.
[113] Doulas are non-medical professionals who provide emotional, physical, and informational support before, during, and after childbirth.
[114] Midwives are trained healthcare providers who deliver babies and offer a range of reproductive care, while OB-GYNs are physicians specializing in pregnancy, childbirth, and disorders of the reproductive system.
[115] Thierry Testimony, *Transcript III*, p. 10; Robledo Testimony, *Transcript I*, p. 19-20; Ferdinand Testimony, *Transcript I*, p. 8.
[116] Lalani Testimony, *Transcript II*, p. 9; Skop Testimony, *Transcript III*, p. 8; Ferdinand Testimony, *Transcript I*, p. 8.
[117] Lalani Testimony, *Transcript II*, p. 9; Ferdinand Testimony, *Transcript I*, p. 18.
[118] Lalani Testimony, *Transcript II*, p. 16; Sonya Irby, Public Comment, Transcript IV, p.32; Sampson Testimony, *Transcript I*, p. 18-19.

## Recommendations

Among their duties, advisory committees of the Commission are authorized to advise the Agency (1) concerning matters related to discrimination or a denial of equal protection of the laws under the Constitution and the effect of the laws and policies of the Federal Government with respect to equal protection of the laws, and (2) upon matters of mutual concern in the preparation of reports of the Commission to the President and the Congress.[119] In keeping with these responsibilities, and given the testimony heard on this topic, the Committee submits the following recommendations to the Commission:

**The U.S. Commission on Civil Rights should issue the following recommendations to the U.S. Congress and Executive Branch:**

1. Invest in more timely, detailed, and disaggregated data collection related to maternal mortality and morbidity. Prioritize real-time or near-real-time reporting systems and ensure that data is broken down by race, ethnicity, geography, insurance status, and other relevant factors to better identify disparities.
2. Encourage the development of policies that improve access to family and medical leave, particularly in the postpartum period. Such policies should aim to reduce disparities in maternal health outcomes.

**The U.S. Commission on Civil Rights should issue the following recommendations to the Texas Congress and Texas Health and Human Services:**

1. Invest in more timely, detailed, and disaggregated data collection related to maternal mortality and morbidity in Texas. Prioritize real-time or near-real-time reporting systems and ensure that data is broken down by race, ethnicity, geography, insurance status, and other relevant factors to better identify disparities.
2. Support the expansion of telehealth services for maternal health across Texas, with a focus on rural and underserved communities. Ensure that services are available in multiple languages.
3. Increase investment in the recruitment, training, and deployment of midwives, community healthcare workers, and doulas, particularly from communities that are disproportionately impacted by maternal mortality.
4. Fund and implement education programs and public campaigns focused on preconception health. These programs should inform individuals of reproductive age about chronic condition management, nutrition, mental health, and other factors that influence maternal outcomes.

[119] 45 C.F.R. § 703.2 (2018).

5. Fund and expand the use of mobile clinics and traveling health units to provide prenatal, postpartum, and preventive care in maternity care deserts and communities with high rates of maternal morbidity.
6. Encourage the development of policies that improve access to family and medical leave, particularly in the postpartum period. Such policies should aim to reduce disparities in maternal health outcomes.
7. Ensure language access in maternal health services. Direct maternal health programs and providers to offer services in the preferred languages of patients, including translation of key health materials and access to qualified medical interpreters.
8. Support the responsible development and implementation of emerging technologies, including artificial intelligence, remote monitoring tools, and mobile applications. Utilize these tools to help identify risk factors, improve care coordination, and increase access to maternal health services.
9. Allow and incentivize pharmacists to provide basic maternal health services such as screenings, education, and referrals, especially in rural or underserved areas where other providers are scarce. Expand training and reimbursement pathways to support this role.
10. Engage and empower fathers and partners. Encourage maternal health programs to include and educate fathers and partners as active participants in maternal care. Support public awareness campaigns and community initiatives that promote shared responsibility for maternal and infant well-being.

**The U.S. Commission on Civil Rights should issue the following recommendations to local counties and cities:**

1. Explore the expansion of telehealth services for maternal health, with a focus on rural and underserved communities. Ensure that services are available in multiple languages.
2. Increase investment in the recruitment, training, and deployment of midwives, community healthcare workers, and doulas, particularly from communities that are disproportionately impacted by maternal mortality.
3. Fund and implement education programs and public campaign focused on preconception health. These programs should inform individuals of reproductive age about chronic condition management, nutrition, mental health, and other factors that influence maternal outcomes.
4. Expand the use of mobile clinics and traveling health units to provide prenatal, postpartum, and preventive care in maternity care deserts and communities with high rates of maternal morbidity.
5. Ensure language access in maternal health services. Direct maternal health programs and providers to offer services in the preferred languages of patients, including translation of key health materials and access to qualified medical interpreters.

6. Explore the development and implementation of emerging technologies, including artificial intelligence, remote monitoring tools, and mobile applications. Utilize these tools to help identify risk factors, improve care coordination, and increase access to maternal health services.
7. Engage and empower fathers and partners. Encourage maternal health programs to include and educate fathers and partners as active participants in maternal care. Support public awareness campaigns and community initiatives that promote shared responsibility for maternal and infant well-being

# Appendix

A. Panel Agendas, Minutes, Presentation Slides

B. Transcripts

## Appendix A - Panel Agendas, Minutes, and Presentation Slides

Meeting Minutes & Presentation Slides can be accessed at:

https://usccr.box.com/s/5u8df9svd1des3n67pgl44nypai9tr42

**Panel 1**

*Monday, October 7th, 2024, at 1:00pm CT*

**Agenda**

I. Welcome & Opening Remarks
II. Panelist Remarks
    a. McClain Sampson, PhD., The University of Houston
    b. Alva O. Ferdinand, DrPH, JD, Texas A&M Southwest Rural Health Research Center
    c. Candace Robledo, PhD. The University of Texas Rio Grande Valley
    d. Omonike Olaleye, PhD., MPH Texas Southern University
III. Q & A
IV. Public Comment
V. Adjournment

**Panel 2**

*Tuesday, October 8, 2024, at 1:00pm CT*

**Agenda**

I. Welcome & Opening Remarks
II. Panelist Remarks
    a. Dr. Toi B. Harris, Memorial Hermann Hospitals
    b. Erica Smith, NP, Planned Parenthood Houston
    c. Dr. Fatimah Lalani, HOPE Clinic
III. Q & A
IV. Public Comment
V. Adjournment

**Panel 3**

*Tuesday, December 11, 2024, at 1:00pm CT*

**Agenda**

I. Welcome & Opening Remarks
II. Panelist Remarks
    a. Dr. James Hill, Texas Maternal Mortality and Morbidity Advisory Committee
    b. Dr. Ingrid Skop, Texas Maternal Mortality and Morbidity Advisory Committee
    c. Representative Shawn Thierry, Texas State Representative
III. Q & A
IV. Public Comment
V. Adjournment

**Panel 4**

*Tuesday, February 26, 2025, at 1:00pm CT*

**Agenda**

I. Welcome & Opening Remarks
II. Panelist Remarks
    a. Dr. Diana E. Ramos, California Surgeon General
    b. Dr. Meitra Doty, The University of Texas Southwestern Medical Center
    c. Dr. Arline Geronimus, The University of Michigan
    d. Alicia Lee, March of Dimes
III. Q & A
IV. Public Comment
V. Adjournment

## Appendix B – Hearing Transcripts

October 7, 2024, Online Panel Transcript (Transcript I)

October 8, 2024, Online Panel Transcript (Transcript II)

December 11, 2024, Online Panel Transcript (Transcript III)

February 26, 2025, Online Panel Transcript (Transcript IV)

Documents found at: https://usccr.box.com/s/p9iba2rfbz584l1giu3ux5a0ghq9hgqi