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WRITTEN TESTIMONY
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SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR
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COMMITTEE ON EDUCATION AND LABOR
U.S. HOUSE OF REPRESENTATIVES
“EXPECTING MORE: ADDRESSING AMERICA’S
MATERNAL AND INFANT CRISIS”
10:00 a.m., TUESDAY, JANUARY 28, 2020

Testimony of Dr. Joia Crear-Perry

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“Expecting More: Addressing America’s Maternal and Infant
Health Crisis”

U.S. House Committee on Education and Labor

Thank you Chairwoman Wilson and Chairwoman Adams and Ranking Members Walberg and Byrne as well as members of the House Committee on Education and Labor for allowing me, Dr. Joia Crear- Perry, to provide testimony for this Expecting More: Addressing America’s Maternal and Infant Health Crisis hearing representing the National Birth Equity Collaborative and the Black Mamas Matter Alliance.

We can support improvements for all workers of reproductive age to grow their families with the appropriate wages, dignity and protections they deserve. Women are integral to every industry in the U.S. Can they trust this body to support them through their pregnancy and return to the workforce? We can begin by shoring up the existing state investments for new mothers that are evidence based; Diversifying our workforce, scaling and deepening the ACOG Alliance for Innovation on Maternal Health for Respectful Care, increasing our investment in CDC supported Perinatal Quality Collaboratives, mandating Implicit Bias and Anti Racism Trainings, and uplifting the leadership influence of National Institutes of Health Office of Research on Women’s Health on federal divisions to address racial inequities in maternal health. We can solidify these investments by heeding the recommendations of entities like us at the Black Mamas Matter Alliance.

As you may be aware, the United States is the only developed

country in the world where maternal mortality is on the rise. Further, Black women in the U.S. die at 3 to 4 times the rate of their white counterparts.¹ Despite clear evidence of this inequity, policymakers, and as a consequence, our US government had not, until now, addressed this urgent public health and human rights issue. The Centers for Disease Control defines Pregnancy Related death as the death of a woman while pregnant or within one year of the end of a pregnancy – regardless of outcome, duration or site of the pregnancy – from any cause related to or aggravated by pregnancy or its management. Based on that definition, the CDC found in their surveillance, 2,726 women died in the United States between 2011 and 2014 and of those 1,010 or 38% were Black. Based on that definition and estimates of mortality data from the CDC, a modest estimate of loss to preventable causes is 1000-1500 Black mothers in the last decade. That's a caravan of Coach buses each year. This is unacceptable.^{2 3} Furthermore, over 60 percent of those deaths were of preventable causes.⁴ A recent study of pregnancy related deaths in my home state of Louisiana found that Black women died at more than four times the rate of White women. Among the deaths of Black women in Louisiana, almost 60% of them were potentially preventable, while only 9% of the deaths of White women were deemed preventable.⁵ As a Black woman from the Deep South, who is an obstetrician and a mother, my strong desire to end this inequity

¹ Petersen EE, Davis NL, Goodman D, et al. Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016. *MMWR Morb Mortal Wkly Rep* 2019;68:762–765. DOI: <http://dx.doi.org/10.15585/mmwr.mm6835a3>

² Petersen EE, Davis NL, Goodman D, et al. Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016. *MMWR Morb Mortal Wkly Rep* 2019;68:762–765. DOI: [http://dx.doi.org/10.15585/mmwr.mm6835a3external icon](http://dx.doi.org/10.15585/mmwr.mm6835a3external%20icon).

³ Montagne, R. (2018) NPR. For Every Woman Who Dies In Childbirth In The U.S., 70 More Come Close. <https://www.npr.org/2018/05/10/607782992/for-every-woman-who-dies-in-childbirth-in-the-u-s-70-more-come-close>

⁴ Davis NL, Smoots AN, Goodman DA. Pregnancy-Related Deaths: Data from 14 U.S. Maternal Mortality Review Committees, 2008-2017. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services; 2019.

⁵ Mehta PK et al. Racial inequities in preventable pregnancy-related deaths in Louisiana, 2011-2016. *Obstet Gynecol* 2019;135:276-283. Retrieved from: https://journals.lww.com/greenjournal/Abstract/2020/02000/Racial_Inequities_in_Preventable_Pregnancy_Related.6.aspx

is amplified every time I look into the faces of my daughter and patients.

As a Black mother, I cannot buy or educate my way out of dying at 3 to 4 times the rate of a white mother in the United States. The inequity in maternal mortality rates persists regardless of our income or education status.⁶ A White woman with less than a high school education has a better chance to live in childbirth than a Black woman with a college degree. Health data for Indigenous and Native American populations is less reported, yet frequently mirrors this inequity.⁷ The legacy of a hierarchy of human value based on the color of our skin continues to cause differences in health outcomes, including maternal mortality. Racism is the risk factor – not Black skin, not Race. Race is a social and political construct.

Maternal mortality extends beyond the period of pregnancy or birth. Nine months of prenatal care cannot counter underlying social determinants of health inequities in housing, political participation, transportation, education, food, environmental conditions, and economic security; all of which have racism, classism, and gender oppression as their root causes. We have data that shows that a Black woman who initiates prenatal care in the first trimester has a worse outcome in birth than a White woman with late or no prenatal care. Currently we do not have access to Maternity care that is culturally congruent. Lack of workforce diversity and provider shortages are a direct consequence of policies created in these halls that date back to the 1921 Sheppard-Towner Act among others. This Act provided matching funds to states for prenatal and children's health centers. Although the act had positive effects—like increasing funds to health care—it discouraged the practice of midwifery, particularly Black

⁶ Petersen EE, Davis NL, Goodman D, et al. Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016. *MMWR Morb Mortal Wkly Rep* 2019;68:762–765. DOI: <http://dx.doi.org/10.15585/mmwr.mm6835a3>.

⁷ Petersen EE, Davis NL, Goodman D, et al. Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016. *MMWR Morb Mortal Wkly Rep* 2019;68:762–765. DOI: <http://dx.doi.org/10.15585/mmwr.mm6835a3>

midwifery, and portrayed midwives as too uneducated and unclean to direct births. All midwives soon saw a decrease in activity, but Black midwives were especially targeted by Sheppard-Towner. Consequently, they lost their positions as birth leaders and became “birth assistants.”

Good maternal health outcomes depend upon implementation of all sexual and reproductive rights, from comprehensive sexual education to access to all forms of birth control and safety from Intimate Partner Violence. We know that Medicaid Expansion⁸, protecting the ACA, Domestic Violence prevention and mental health parity laws are critical to ensuring that Maternal Mortality rates improve across our great nation. We have data that shows that this investment in states, such as my own great state of Louisiana through Medicaid Expansion, saves money and lives. Even if women are insured, coverage of sexual and reproductive health services is too often not comprehensive. Receiving the full range of reproductive options ensures safe healthy births for moms and babies.

There are many policy solutions available to improve the economic and workplace gender discrimination that negatively impact birth outcomes. Two weeks after delivery, the uterus is shrinking to its normal size, there is frequent bleeding and the organs are finding their original placement. Nearly 1 in 4 mothers are returning to work earlier than that to make up for lost wages at jobs that do not guarantee time to pump breastmilk, nor provide a storage cooler to ensure it is safe for ingestion.⁹ Breastfeeding is protective for both the mother and the infant’s mental and emotional health.¹⁰ Most

⁸ Searing A, Ross C D. Medicaid Expansion Fills Gaps in Maternal Health Coverage Leading to Healthier Mothers and Babies. Georgetown Center for Children and Families. 2019. Retrieved from: <https://ccf.georgetown.edu/wp-content/uploads/2019/05/Maternal-Health-3a.pdf>

⁹ Family and Medical Leave in 2012: Detailed Results Appendix. Abt Associates. 2014. <https://www.dol.gov/sites/dolgov/files/OASP/legacy/files/FMLA-Detailed-Results-Appendix.pdf>

¹⁰ Breastfeeding in underserved women: increasing initiation and continuation of breastfeeding. Committee Opinion No. 570. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2013;122:423–8.

workers do not have access to paid leave to take care of an infant, an elder, a sick family member, or their own needs- like weekly high risk prenatal appointments.¹¹ Many workers, like in my own city of New Orleans, work in industries like hospitality. They are cook the food and flip the beds in the hotels we sleep in as tourists, without access to any time off to attend a High Risk Prenatal visit. If they must make a choice between the \$7.25/hour to feed their families or sitting at a High Risk Prenatal visit, more often than not feeding their family is the priority.

Black women with family caregiving responsibilities are estimated to spend 41% of their annual income on expenses related to caregiving, in contrast, White caregivers spend approx. 14% of annual income on caregiving expenses.¹² Caregiving includes childcare costs, which are further exacerbate the income inequality experienced by families of color. We need protections and supports in paid leave and childcare to bolster any advancements made in healthcare or payment systems for maternal health care.

Private insurance and payment systems are responsible for maternal health outcomes, as well. In 2018, almost 70% of women ages 19-64 were covered by private health insurance.¹³ High cost sharing and deductibles for maternity care,¹⁴ even surprise bills from labor & delivery, cause gaps in coverage for women who cannot sustain spiking prices. The short term health plans offered on some state exchanges do not cover maternity care, which many find out after

¹¹ Geizan RVW. Paid leave in private industry over the last 20 years. Bureau of Labor Statistics. 2013. <https://www.bls.gov/opub/btn/volume-2/paid-leave-in-private-industry-over-the-past-20-years.htm>

¹² Rainville C, Skufca L, and Mehegan L. Family caregiving and out-of-pocket costs: 2016 report. AARP. Retrieved from: https://www.aarp.org/content/dam/aarp/research/surveys_statistics/lrc/2016/family-caregiving-costs.doi.10.26419%252Fres.00138.001.pdf

¹³ Women's health insurance coverage. Kaiser Family Foundation. 2020. Retrieved from: <https://www.kff.org/womens-health-policy/fact-sheet/womens-health-insurance-coverage-fact-sheet/#footnote-446031-1>

¹⁴ Moniz M et al. Out-of-pocket spending for maternity care among women with employer-based insurance 2008-15. Health Affairs. 2020. <https://doi.org/10.1377/hlthaff.2019.00296>

they read a positive pregnancy test. Families scramble to take care of necessary health care expenses, shouldering the economic burden that is exasperated by the lack of workplace protections. This is reminiscent of the inadequate insurance coverage for maternity care that dominated the market before the passage of the ACA. Let's, at a minimum, maintain this progress.

Closures of hospitals and maternity units create barriers to services and information.¹⁵ This lack of a safety net for poor and rural Americans produces gaps in access along the reproductive life span. This includes closures of rural hospitals across the United States with those in majority Black rural areas closing first and most often. All of us are impacted when we make choices to defund Critical Access facilities and disinvest in communities that we deem not economically viable. Research indicates that women living in rural communities are more likely to face maternal mortality and severe maternal morbidity, and I have seen this firsthand.¹⁶ As someone who grew up in rural America, my best friend had her baby in the car on the way to the hospital that was an hour away. That child has severe cerebral palsy. What is the value of these often forgotten communities and families? What are we saying about how we value them in our policy and funding priorities?

I am the founder of the National Birth Equity Collaborative and on the Founding Board of the Black Mamas Matter Alliance. The National Birth Equity Collaborative creates solutions that optimize Black maternal and infant health through training, policy advocacy, research, community centered collaboration. When working with large hospital systems, health departments and large legacy organizations to build a culture of Reproductive Justice, we have learned that federal policy and investment is critical. As Black

¹⁵ Peiyin H et al. Why are obstetric units in rural hospitals closing their doors? *Health Serv Res.* 2016 Aug; 51(4): 1546–1560.

¹⁶ Kozhimannil KB, et al. Rural-Urban Differences In Severe Maternal Morbidity And Mortality In The US, 2007–15. *Health Affairs* 2019. Retrieved from: <https://doi.org/10.1377/hlthaff.2019.00805>

birthing people, we have been devalued for generations and that devaluation shows up in your policy choices. The Black Mamas Matter Alliance serves as a national voice and coordinating entity for stakeholders advancing maternal health, rights, and justice, and intentionally centers Black women's leadership. BMMA has a network of organizations with the reach, relationships and capacity to support an intergenerational movement. BMMA organizes around four core strategies which aim to 1) advance policy that addresses black maternal health inequity 2) cultivate innovative research methods, 3) enhance holistic and comprehensive approaches to the care of black mamas, and 4) shift culture of the narratives of black motherhood by amplifying black women's voices.

While maternal mortality in the U.S. is on the rise, data reflects that severe maternal morbidity is 100 times more common, impacting even more women and families.¹⁷ To acknowledge women experiencing a severe maternal morbidity is to recognize that there are women suffering, at times, life-long consequences and medical complications as a result of pregnancy and childbirth. Medicare is the main driver of healthcare spending in the United States. Private Insurers look to what Medicare covers, which could be services such as Doula/Community Birth Workers, equity for Midwifery pay, multiple postpartum visits, behavioral health, when they are making economic decisions about how they will provide Employer based and Market based insurance coverage. Ultimately, what Black women in the U.S. need is accountability. We need to know that our lives are valued. This accountability may be complicated, but government still has an obligation to act. Racism, classism and gender oppression are killing all of us, from rural to urban America. This is not about intentions. Lack of action is “unintentionally”

¹⁷ Severe Maternal Morbidity in the United States. Centers for Disease Control and Prevention. 2017. Retrieved from: <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html>

killing us. It is a human rights imperative. This Hearing that calls for us to expect more, is an opportunity for the esteemed members of the Education and Labor Committee to look deeply at all of the ways the policies around our social determinants of health are causing Maternal Morbidity and Mortality .We must be willing to continue to name the problem directly. Racism is the risk factor that we must end. The Education and Labor Committee has taken a tremendous step forward in showing that we do recognize...Yes, Black Mamas Matter.