

WRITTEN TESTIMONY
OF
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“BIRTHING WHILE BLACK: EXAMINING AMERICA’S BLACK
MATERNAL HEALTH CRISIS”
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Thank you Chairwomen Maloney and Kelly, Ranking Member Comer, members of the House Committee on Oversight & Reform for allowing me to provide testimony for this hearing. My name is Dr. Joia Crear-Perry. I am an OB-GYN by training and serve as the Founder and President of the National Birth Equity Collaborative, where we create solutions that optimize Black maternal and infant health through training, policy advocacy, research, and community-centered collaboration.

Contextualizing the Black Maternal Health Crisis

The History of Racism, Slavery, Colonization, Genocide, and Eugenics Projects are Directly Linked to the Maternal Health Crisis. In the United States, the legacy of devaluing Black women's experiences is directly linked to today's Black maternal health crisis. Slavery as an institution and white supremacy as a framework have had a direct impact on the maternal mortality crisis among Black Birthing people in the United States today. Dr. J. Marion Sims, famously known as the father of modern gynecology, got this title by countless occurrences of experimentation on Black women's bodies. The performance of vaginal surgeries on the bodies of Black female slaves without the administration of anesthesia on the basis that Black women could endure higher levels of pain than white women is a direct reflection of the perception of Black women in our current day healthcare system. We are viewed as vessels of reproduction in this country. Births of Black babies were deemed beneficial only when the babies were born as slaves and could contribute to the drive of capitalism in this country. However once slavery was "abolished", all efforts switched to limiting the Black births.

White supremacy and patriarchy both informed the creation of population control and eugenics-- where the idealized birth in the US was a white baby. Experimentation of birth control pills on Puerto Rican women without their consent, forced sterilization of Black, Indigenous, and women of color and women with disabilities, and many forms of legislation designed to limit the amount of births from Black women are countless. It is clear that Black women are not respected or deemed worthy of giving birth in this country. From the many stories told by Black women today of the lack of respectful maternity care they have received in their birthing experiences as well as recent occurrences of forced sterilization of women in ICE detention centers, it is clear that the very systems in place that perpetuate harm, are keeping the legacy of eugenics and population control well and alive today.

The Structure of American Society Causes Poor Maternal Health Outcomes for Black People. In order to fully understand the impact that structural and social factors have on maternal health outcomes, it is imperative to use frameworks that are holistic, intersectional, and just in nature. Structural forces include our political, economic, justice and cultural systems and social forces include race, class, gender, and immigration status. These factors impact maternal health by creating inequitable systems of oppression. Structural forces are perpetuated by racist policies and have created inequitable systems of housing, food stability, education, access to care, and safety. These factors, and more, are determinants of health and are associated with the poor maternal health outcomes that birthing people of color experience. The use of a systems level

analysis allows for a more robust understanding of the interlocking systems of oppression by examining the historical ramifications of inequitable public policy.

Police Brutality and the Inequitable Criminal Justice System Influence Maternal Health Outcomes. Police brutality is a white supremacist reality that impacts the wellbeing of Black birthing persons in the U.S. and their families. When raising their families, Black women in the U.S. are constantly worried that they, their children and their loved ones are at risk of experiencing police violence—even when they are unarmed, playing, sleeping, or doing virtually any activity that white people routinely engage in without fear. In the last five years, at least [48 Black women have been killed by police](#) and in none of those cases have the police been convicted for it. Black women and girls are overrepresented among the [more than 230,000 women](#) incarcerated in the United States, many of whom are mothers and primary caregivers to their children. In order to end the Black maternal health crisis, we need to center Black women’s lives and experiences, and that means addressing police brutality, the carceral system and state sanctioned violence.

Address Racism Within the Health Care System. Effective maternal health policies must require more expansive solutions to address racism across varying levels of power, thereby reducing maternal health disparities. Solutions that address racism within the health care system include acknowledging racism as a public health threat, addressing provider bias and discrimination through racial equity training and medical school curriculum, expanding access to Black birth workers by creating more direct training pathways, improving the quality of care at Black serving hospitals, addressing social risk factors, including access to safe housing, transportation, education, food security, criminal justice and more, and promoting respectful models of maternity care.

Climate Change and Environmental Justice are Maternal Health Issues. Another aspect of Black women’s lives that must be incorporated into solutions to the Black maternal health crisis is climate change and environmental justice. Climate change and its subsequent impacts such as extreme heat, floods and displacement are [widely recognized as an environmental emergency threatening human health](#); however, we don’t consider the impact to an already susceptible population, Black birthing persons. Extreme heat is a leading cause of weather-related deaths in the U.S., killing more than [600 people per year more than all other weather-related deaths combined](#). This heat is even more deadly for pregnant persons, who have less ability to regulate temperature and are more susceptible to serious adverse pregnancy outcomes as a result. We also know that it is communities of color in the U.S. who have the least access to air conditioning due to the impact of racist redlining practices on residential patterns. In cities like Baltimore, Dallas, Denver, Miami, Portland and New York, neighborhoods that are lower-income and have more residents of color can be [5 to 20 degrees Fahrenheit hotter in summer than wealthier, whiter parts of the same city](#). This extreme heat can [increase the risk of preterm birth, having a baby with a low birth weight, and even infant mortality](#). For Black women in particular, an additional day of exposure to extreme heat during the third trimester [doubled the odds of hospitalization compared to white women \(5 percent in Black women versus 2.6 percent in white women\)](#). Solutions to

address the Black maternal health crisis must address the clear impacts of climate change on Black birthing persons in order to be truly comprehensive and successful.

There are Not Enough Black Workers of Color leaving Black Birthing People with Little Choice or Autonomy. Furthermore, there is a dearth of Black birth workers in the field, and many Black people never have the opportunity to receive racially concordant care. Community-based birth workers such as doulas, midwives, lactation consultants and community health workers have been proven as essential to improving Black maternal and infant health outcomes. Prioritizing the distribution of resources for Black-led care practices is another necessary step needed to advance health and birth equity. This initiative will also create more pathways for birth workers of color to enter the field, all while bolstering community buy-in, and incentivizing high-quality maternity care.

COVID-19 Disproportionately Affected Black Women and Subsequently Maternal Health Outcomes. The onset of the COVID-19 pandemic has further exacerbated inequities in maternal health. Black women face higher COVID-19 mortality rates than white women and are more likely to face elevated risk of exposure to, and contraction of COVID-19 due to a number of increased social risk factors, which are the byproducts of systemic racism in the United States. Black women are more likely than white women to be essential workers, thus increasing the likelihood of exposure to and contraction of COVID-19.¹⁹ These positions tend to be low-wage jobs that do not come with benefits like health insurance or paid sick leave. Without insurance coverage, routine maternal care visits are delayed or disrupted, and barriers to providers are heightened. In response to the COVID-19 pandemic, many health care systems and providers introduced restrictions meant to curb the spread of the virus. These policies resulted in disrupted routine health care visits necessary for screening and monitoring health conditions unique to birthing and pregnant people, including maternal health care. In fear of contracting the virus, pregnant people delayed prenatal care and postpartum follow-ups. Midwives experienced increased interest from Black women pursuing home births. The pandemic exacerbated financial hardship, limited access to public transportation, and delayed routine care. Further, health system redistributions resulted in a lack of medical supplies, reduction of obstetrical care facilities, and a scarcity of skilled birth attendants. Additionally, many hospitals enacted policies that barred companions, including partners, from the labor and delivery room, limiting the support birthing people could receive during birth and infringing upon one's rights to make their own health care decisions. These policies prompted the World Health Organization to release interim guidance on clinical management practices during the COVID-19 pandemic and clinical membership and advocacy organizations to release statements condemning policies that violated women's human rights. Maternity care has been additionally limited by the pandemic as calls for hospitals to defer elective procedures, including certain sexual and reproductive procedures, may further restrict access to maternal health care and contribute to adverse health outcomes. With the continuum of healthcare for pregnant people disrupted and patients hesitant to be in the hospital, both short and long-term health outcomes are consequently impacted.

Policy Recommendations to Address the Black Maternal Health Crisis

Solution: We Must Use a Reproductive Justice Lens to Address the Black Maternal Health Crisis

Coined by the SisterSong Women of Color Reproductive Justice Collective in 1994, Reproductive Justice (RJ) is the human right to maintain personal bodily autonomy, have children, not have children, and to parent children in safe and sustainable communities. RJ is the complete physical, mental, political, environmental, social, and economic well-being of women and girls based on the full protection of their human rights. Factors such as education, income, geographic location, immigration status, and potential language barriers, and equitable access to healthcare are common barriers to achieving reproductive justice. The RJ Framework encompasses both reproductive health and reproductive rights, while also using an intersectional analysis to emphasize and address the social, political, and economic inequities that affect women's reproductive health and their ability to control their reproductive lives. It examines how the ability of any woman to determine their own reproductive destiny is directly linked to the conditions of their communities and how they are impacted by reproductive and systematic oppression. By infusing an RJ lens into policymaking and practice, the roots and intertwined nature of inequities can be addressed and health equity can be achieved as is demonstrated with federal legislation like the Black Maternal Health Momnibus Act of 2021.

Solution: Establish the Office of Sexual Reproductive Health and Wellbeing.

To address maternal health in the United States, we must go beyond siloed efforts to address it as a solo issue, but rather as one related to sexual and reproductive health and wellbeing. Sexual and reproductive health and wellbeing (SRHW) is a key component of people's overall health and quality of life, with an especial consideration given to maternal health at-large and the perinatal period specifically. Yet policies, funding streams, and infrastructure related to SRHW services and social supports are typically siloed and can be difficult to understand and navigate for federal agencies, states, healthcare systems, providers, and patients. A *permanent* infrastructure is needed to (1) develop a federal strategy for promoting SRHW through a human rights and racial equity lens, and (2) better coordinate the actions of the many departments and agencies whose actions impact SRHW. The establishment of the Office of Sexual and Reproductive Health and Wellbeing (OSRHW) can drive change and foster accountability by Develop a National SRHW Strategy, including a framework for integrating sexual and reproductive health equity into federal processes, directing and overseeing the work of a Federal Interagency Workgroup on SRHW to ensure all federal funding regulations and federally funded programs related to SRHW are free from coercion and barriers, identifying areas of improvement in federal rulemaking and guidance and provide recommendations, and leading public engagement activities, including a White House conference on SRHW and public listening sessions.

Solution: Pass Comprehensive Policy Solutions like the Black Maternal Health Momnibus Act of 2021.

To comprehensively address every dimension of the maternal health crisis, the provisions in the Momnibus advances Reproductive Justice by joining once fragmented issue areas like veteran

affairs, criminal justice and medical technology, by centering the most marginalized: Black and Indigenous birthing people. While the Momnibus is largely crafted around those who choose to have children, and parent the children in safe and sustainable communities, space is also given to those who choose not to have children through various provisions, including the Perinatal Workforce Act. With the reintroduction of this signature bill in the 117th Congress, the National Birth Equity Collaborative celebrates the return of Reproductive Justice to center stage, its rightful place at our nation's highest level of government.

As aforementioned, any solution to address the Black maternal health crisis must address climate change and its disproportionate impact on Black people, particularly Black birthing persons. The environmental justice and reproductive justice sectors need to come together to ensure that policies in both sectors are considering the impact of climate change on Black birthing persons. The *Black Maternal Health Momnibus Act of 2021* takes the first step toward this with the *Protecting Moms and Babies Against Climate Change Act*. In addition, we request an office for racial and gender justice within the Environmental Protection agency and further safeguards against occupational and home heat exposure for low-income and/or Black birthing people.

Solution: Increase Access to Health Insurance Coverage by Mandating that Medicaid Postpartum Coverage be Extended to at Least One Year

On March 11, 2021, President Biden signed the [American Rescue Plan Act of 2021](#) into law to provide relief during the COVID-19 pandemic. The bill grants state governments the [option to extend](#) Medicaid postpartum coverage beyond the typical 60 days to at least 12 months. However, allowing states the option to opt out of providing continuous coverage, does not go far enough in addressing the maternal mortality crisis and creates an additional barrier for Black and Indigenous women, who are most at risk of disparate outcomes, to access high-quality and affordable health insurance. Health insurance during the postpartum period is critical because pregnancy related complications can [occur](#) until one year post labor and delivery. For women who lose insurance after 60 days, postpartum care is not accessible and preventable health complications go undetected. While this policy has the potential to impact lives, there is no guarantee that it will as optional postpartum coverage does not equate to mandatory, and this bill lacks the provisions necessary to hold states accountable for extending their Medicaid programs.

Solution: Increase Pathways for Birth Workers of Color

Improved access to Birth Centers and community-based birth workers such as doulas, midwives, lactation consultants and community health workers are needed to improve maternal and infant health. Medicaid and private insurance can reimburse and cover doula care, but unfortunately, most states have not done so. Lack of reliable reimbursement is a barrier to accessing doula care, especially for women with low incomes. Increasing access and funding to these services by permitting Medicaid reimbursement for all types of perinatal birth workers will not only help to rebuild and repair community trust, but lead to a reduction of health disparities in marginalized communities where holistic care plays an essential role. Prioritizing the provision of resources

for Black-led care practices is another necessary step needed to advance health and birth equity. This initiative will also create more pathways for birth workers of color to enter the field, all while bolstering community buy-in, and incentivizing high-quality maternity care. Meaningful access to care looks beyond insurance coverage or geographic proximity to services to consider quality.

Solution: Address the COVID-19 Crisis

To adequately address the impact that COVID-19 has had on Black maternal health, additional funding should be allocated to Black women-led community-based organizations to support the delivery of care via telehealth. Community-based organizations (CBOs) fill gaps in the health care system by providing services that meet the social and cultural needs of under-resourced and underfunded communities. The COVID-19 pandemic underscores the importance of CBOs, but the inequitable amount of funding allocated to them reduces their capacity, and often, funding does not reach Black women-led organizations. As patients shift to telehealth services as an alternative to in-person visits, the inaccessibility of telehealth technologies and resources must be recognized. Black birthing people report barriers such as not having medical equipment needed to take necessary vitals, a lack of internet and/or phone access, and privacy and confidentiality concerns. Subsidies should be provided through private insurers and the government to assist in covering the cost for telehealth services and resources. Reducing challenges in accessing health care can help improve health care utilization and birth outcomes. Further, the Centers for Medicare and Medicaid Services (CMS) should support hybrid models of health care by providing guidance, incentives, and promoting telehealth services. By offering hybrid models of telehealth and in-person care, women have access to alternative care models and can decide which avenue of health care is most appropriate. Lastly, Congress should pass the COVID-19 Safe Birthing Act to promote birth equity during the pandemic and after.

The Oversight and Reform Committee has taken a tremendous step forward in showing that we do recognize...Yes, Black Mamas Matter. Thank you.