

Good afternoon. Thank you for joining us for today's webinar. The pathway to reproductive justice: Research, practice and policies. I am Dr. Regina Davis Moss, associate Executive Director of the American Public Health Association. This second webinar, in our advancing racial equity series is especially meaningful to me. Not only because I'm passionate about ensuring women and girls have the power and resources to make decisions about their bodies and reproductive lives but because I'm excited to have you hear from the bold, brave and courageous women, commitment to what gives us hope, that equitable and compassionate care that centers the person, and respects race, gender, ethnicity and economic background, and cultural values, is achievable. Racism and systemic oppression are the drivers of preventable maternal morbidity and mortality and in high rates in United States, recent events have yet again underscored the necessity of change, the atmosphere is — we have to continue to raise our voices from loud protests all the way to quiet conversations. We can reach places, where our voices can change our land. We are called to this work. I would now like to introduce you to APHA Sexual and Reproductive Health Section Chair Dr. Monica McLemore, today's moderator.

>> Thank you, Regina many thanks to all of you for joining us today, before we get started with our presentation s I want to go over a few housekeeping items. First, closed captioning is available for our webinar and instructions for accessing closed captioning, are in the chat. This webinar is being recorded, and all registrants will receive follow-up email with link to the recording, and slides, which will be posted, at [APHA.org/ APHA.org/racial-equity](https://www.apha.org/racial-equity), today's webinar has been approved for 1.5 continuing education credits for CHES, CNE , CME and CPH, and none of the speakers have relevant financial relationships to disclose. If you want continuing education units you should be registered with your first and last name, and participate for the entire webinar. All registered participants will receive an email within a few days, from [CPD@ confex.com](mailto:CPD@confex.com), with information on how to claim credit and relevant deadlines. We'll take questions at the end of all of the presentations. You can ask a question, by entering into the Q&A function. The chat function is currently disabled for all participants, and will be used for announcements only. At the end of the webinar, you will be redirected to a survey, please take moment to fill out the 2 minute questionnaire, to help us improve our future webinars. And as always, please follow the conversation on twitter, using [#RacismOrHealth](https://twitter.com/RacismOrHealth) and [#APHAwebinar](https://twitter.com/APHAwebinar). Before we begin I would like to share some Remarks to set the stage for the discussion today. I can't tell you how excited I am, that I not only get to been a panel of all Black women, and not only that, but I get to do so with people who I admire, respect, and, completely fan girl over (laughter). COVID-19, has laid bare for all of us to see so many of the flaws that need a do over, reimagining and a reconceptualization. I say this, to all of you in the midst of a pandemic that ironically hit us as the world health organization's designation of 2020 being the year of the nurse and the midwife. These are odd times, indeed. So, before we begin let's set the stage of how we got here, where we are, and, where we are going. First, any suggestion of returning to a past normal that did not work for everyone is disingenuous and short sighted. I will call anyone out for manifesting this perspective. We are in a water shed moment we can make radically different decisions than we have made in the past and I ask all of us to shed our fear and to, collectively join together, to imagine a different, post pandemic less racist future, where we invest in Black indigenous and people of color. Next, let's demand that many of the changes that we have seen, since March, be made permanent if the last 16 weeks have taught us nothing is that this is all built it doesn't have to be this way. Invest in our brilliance, innovation and our courage. Dismantling whiteness and

divestment from racism cannot be our only goals. As I often say, if everyone is divesting, who is building? And who is receiving in investment. Before I introduce our speakers my last point to consider is this --let's not just pass the mic, let's not be performative in our gestures, around maternal health and inequities and addressing public health, let's build power and re allocate resources. I trust you'll be deeply engaged in this hard yet important work. I'm convinced our panel today, has many of the answers, and that this could all be different, if we only choose to listen, and, act. With that, without further ado, I have the honor and pleasure of being able to introduce.... I'm going try that again. I have the honor to introduce, Dr. Ndidiamaka. Who is an associate professor, in the department of public health and community medicine, at Tufts university school of medicine. She has a longstanding commitment to public health that spans over 15 years of experience, her current research interests include, maternal mortality and morbidity, health disparities, reproductive health and infant mortality and HIV/AIDS in women of color, she is a member of the American Public Health Association is currently the co-chair of the Perinatal group in the child and health section.

Good afternoon everyone. And thank you, to the leadership, of APHA, Dr. Regina Davis Moss, our moderator and my panelists, Dr. Howell and Perry and representative Lauren Underwood it is my deep pleasure to join you this afternoon for the second series in advancing racial justice. So, where does the United States rank globally? We know our ranking is falling we know the ranking is continuing to go in the wrong direction regarding the rates around maternal mortality, according to the center of reproductive rights , under the circumstances has ...increased where we were 15 years ago, maternal mortality rate is rising in the United States as it continues to decline in other countries. So we know that, in the United States, our ranking is poor and that we are not doing anything, to address the inequities that we see in maternal mortality and morbidity as experienced by women of color and in particular. US MMR does a comparison with industrialized countries with 300,000 of births, using 2017 data from WHO the United States still, ranks last among wealthy countries even if you only limit the analysis, to white mothers. So if you look at the pink line here we see US white women only and wise, all women, in the red lines this is the ratio per 100,000 births, the United States is very poor we'll talk about it, my fellow panelists will discuss a lot of the reasons that, underlie these inequities and then we'll talk about solutions to how we can address this origin to address it. In the United States, according to CDC 700 hundred women die every year due to complications related to pregnancy and child birth I would venture to say this numbers higher, we're still in the process of the latest data came out from CDC in January this year I think that the numbers are actually probably, higher than that. Additional 50,000 women suffer from severe complications, what we call a near miss or maternal morbidity. We have data from recent paper in OBGYN, that looked at mortality of race ethnicity the Black line at the top is, the MMR for Black race we see, excuse me more of a navy line we see the gray bar the light blue and the darker blue line, for all races, white another's, again, we see the MMR for Black women is disproportionately higher than other races. So, according to CDC's pregnancy mortality surveillance system during 2011- 2016 the regular pregnancy related ratios were 42.4, deaths, per 100,000 live births for Black women. Um, and then, followed by, American Indian and Alaskan Native, 30.4, 13.0 for white women and 11.3 for Hispanic women. Now there's a huge gap, we know that for Black women in United States, who are new mothers, um, they die at a rate similar from women of lower income countries where the white women rates across more of affluent nations we see here that, comparison for women

of all races Black women, non-Hispanic Black women, maternal deaths is around 40, for Hispanic, is 12.4, when you compare to other developing countries lower income countries such as Brazil, and those are comparable to what we seeing Black women, as compared to white women, who are comparable to countries such as New Zealand, United Kingdom and France and Japan. So after decades of decline there was a window we were doing a pretty decent job, at least trying to, close some of the gaps the rates began to raise again by the 1990s and by 2013, threats had more than doubled. Now what is most significant, to me, in this space is that more than half, um of these deaths are due to preventable causes around 63%, are actually due to preventable causes so we know that the rate of the maternal mortality is climbing and continues to do so, markedly higher among Black women. So this is just another representation, this is from NCHS, national center for health statistics, really highlights the wide racial and ethnic gaps Black women at 37.1, this is the mortality rate, followed by non-Hispanic white women and Hispanic women. So, this, particular graph looks at the causes of the pregnancy related deaths in the United States, from 2011 to 2016 we know that the majority of this is caused by hypertension cardiovascular conditions there's a percentage that is unknown I think that, represents a unique opportunity for intervention so this kind of highlights the latest data that we have, looking at the causes and pregnancy related death and where the points of opportunity are, by cause of death. So, drilling down a little bit more, around maternal reproductive health disparities we know Black women are 3-4 more times likely to die of pregnancy related complications or delivery complications and that is, 243 percent higher than their white counterparts. Black women are also more likely to die from heart disease and cervical cancer so, the case that I'm making here is that, if we are really going to advance a racial justice and equity, we have to examine the full range of the disparities and inequities that Black women experience around reproductive health it's not only around mortality although that's a critical health crisis that is also seen in other parts of the reproductive systems such as, heart disease, cervical cancer, um and -- pregnancy related complications. So this quote comes from moms rising.org *"as a Black woman, I knew the numbers were especially dire formed I knew factors usually are produce pregnancy Tobe what we call productive factors, reduced pregnancy and labor risks being under 35, having high education, having high income, starting early consistent prenatal care, would not be enough to counteract the dangers of my race"* I would encourage you to look at the resources, the resource book .It's a really good reference that I use often and we know that the higher risk factors, faced by Black women 's maternal health spans income and education level. So the things that are normally protective, age, education, income, don't close the gap, don't buffer, the inequities that Black women experience. So, a New York analysis, from 2016, looked at five years of data, concluded this is -- no surprise to those of us that do the work on a daily basis ,concluded that Black college educated mothers gave birth in local hospitals were more likely to suffer from severe complications than white women that graduate from high school. I know my colleague Dr. Howell will speak to that. I want the set the stage the narrative around education as protective factor does not buffer the case of maternal mortality morbidity in Black women. Is it low socioeconomic status? No. That's not the case either we know low SES can create obvious and discrete barriers to adequate care, lack of paid maternal leave -- and lack of child care flexibility to attend appointments. What is also significant is that Medicaid finances, almost 50 percent of all of the U.S. births, and, this heightens the strain of provider and appointment availability for women using Medicaid. >> The reality of is women of higher SES are not immune, from the disproportionate rates of pregnancy and child birth related complications. I would urge all of you who

may not have seen this from ProPublica the lost mother's study, series points out that Black women living in the wealthiest neighborhoods have more complications than white Hispanic and Asian mothers living in poorer neighborhoods. So looking at the historical context, I want to frame it for you, from the - historical perspective and we know that in 1807 and even before, the importation of humans, became illegal forcing Black women to actually procreate, for economic benefit of slave-owners. Now we know the -- in around the 1850s and, he has been named the father of gynecology, James Marion Sims, and others began experimentation on Black women's bodies a lot of the procedures, the instruments that we use today, were perfected, on the bodies of 3 particular slaves, Betsy, Lucy and Ankara. I wanted to frame it the historical context what we know to be true in the medical field, in the reproductive health and reproductive care field, started with the abuse of Black women and their bodies. And in 1930s we see the beginning of the movement of including the next negro project included on the sterilization including that narrative in the 1800s under Reagan and other leaders at the time, we really heard of framing and messaging around the Welfare queen and being a crack baby the negative messaging that means for Black mothers and their children. So, the reality of racism throughout the life span really, with the focus on maternal health disparities that Black women in particular sit at the intersection of race and gender and we know there's tremendous chronic stress that exacerbates the pregnancy related disparities. A large body of research on the toll that being a Black women in America can take on someone's body, now again I want to remind everyone this type of stress cannot be avoided, by getting more education, having a higher income, and things of that nature. Um, because, the reality of it is, that there's a concept of weathering, weathering has been proven true not just around pregnancy, but in many other -- um, physiological responses to stress. So, weathering is a term that was developed by Dr. Dr. Geronimo's a professor at the University of Michigan school of public health and her work has shown that this type of chronic stress causes many health vulnerabilities and increases susceptibility to infection. So we know that weathering causes early onset or earlier onset of chronic conditions like diabetes and hypertension, in her 2010 study the telomeres of Black women in 40s and 50s appeared 7.5 years older than those of white women. This is significant for many reasons right. Weathering talks about the cumulative effect of stress, physiologically what it does to a woman's body, impact of race and discrimination over her reproductive life span and because maternal age is such an important risk factor, for many severe pregnancy complications these aggregated risks that occur earlier for Black women are problematic in particular. Another thing that really, exacerbates or underlies the disparities we see in maternal mortality are attitudes and the treatment by health care professionals from OBs to medical assistants to nurses to PAs. As providers we know research has shown implicit bias can cause doctors to spend less time with Black patients, we know this also impacts the way that Black patients receive less effective care, Black patients are less likely to have their pain symptoms heard and acknowledged by providers. So I just want to give quick case study around the Serena Williams pregnancy, post-partum complications you may be aware, not everyone, she had -- some pre-existing conditions, around a blood clot so after she delivered, she went to her nurse and said hey you know I'm not feeling really well I think this is something that we should think need a CT scan the nurse told her you're just tired you just had a baby finishing delivering, um you know, go back and lay down she had to really put pressure on her health care providers to get the necessary test and, once she did she found that she did actually have a blood clot forming. Without proper diagnosis and treatment, it could have killed her. Just imagine the permanent stain that would have made on the United States. This is a world

class athlete, and her medical symptoms were dismissed, because of implicit bias right. We also know about the case of Beyoncé and many, other women have complained and either been dismissed or, um, under acknowledged by their health care providers. I want to give a special tribute to the young woman who died this week who was 26 years old; delivered in Brooklyn and -- I know that's a relatively new case but, the point I'm making is that, women are still dying at the hands of providers. So, this is a quote by Dr. Neal Shalun, in Boston he says the common thread is that when Black women, expressed concern about their symptoms, clinicians were more delayed and seemed to believe them less. There's a very fine line, between clinical intuition and unconscious bias. So, another point I want to highlight is just the very limited diversity, medical professionals, and this particular graphic looks at the percent of Black doctors in Boston hospitals we know overall, that there's very limited diversity in the medical field, 6 percent of MDs are Black, 11 percent of OBs are Black, 3 percent of medical school faculty are Black I represent that 3 percent. But what is most significant to me, in addition to the limited diversity that we see as providers, is the funding deficit. There's a lot of recent research that talks about just the lack of funding from NIH, to principle investigators like myself, less than 2 percent of us are getting funded. To do this type of work that's really problematic because one you have a pipeline issue. There is no diversity in the leadership and two, the funding, is not going to investigators of color who come from communities who are also doing deep work around these issues. So -- I just wanted to highlight and paint this full comprehensive picture around why we're seeing some of these things. Um, we know that the funding gap between African-American and Black and white scientists at each stage continues to get wider and wider and wider. So from the applications that were submitted to the applications that are funded we're seeing disparities. Um, and this is a recent study that came out, so we know that, 10 percent of Black investigators funded versus 17 percent for white investigators which leaves a 2 time disparity across the application and review process. So, this, really highlights, again the fact that less than 2 percent of funding RO1 goes to Black investigators grants compared, 94 percent of white and Asian investigators. And in 2018, Black investigators received 113 R01s, compared to 8,000 received by white and Asian investigators. So, there's a lack of diversity in funding and lack of diversity in the medical field and profession, we're seeing this lack of diversity and lack of inclusion really, play out in outcomes for Black women. So what do we do to address some of these things particularly around funding? Develop and implement mentoring programs that provide all new and early stage investigators with quality guidance and how to navigate the NIH system, provide targeted funding opportunities to enhance post doctoral career transitions to keep people in the public health workforce and a more democratic medicine work force and then NIH and relevant centers establish policies that direct discretionary funding to towards applications under appreciated by review, but align well with the overall mission and priorities of the funding agency. So, looking at the focus of intersectionality as I mentioned earlier Black women sit at the intersection of race and gender. It's important to really improve cross cultural patient provider communication right. More than implicit bias training provide communication training that emphasizes understanding, acknowledging and addressing the needs and complexities of diverse patient populations, again, increasing number of minority physicians and researchers, providing reform in the post-partum period, more than half of preventable maternal deaths occur in post-Partum and implement maternal safety bundles such as hypertension Hemorrhage kits. We need to focus in the clinical environment on how to improve maternal outcomes also cultural humility is necessary for equity delivery of health it's on going, not just one training, but an ongoing self-

respective process of increasing self-awareness and really understanding the biases that providers are bringing to the clinical opportunities this increases understanding of others, lived experience that is necessary for improved provision of care. So, to really provide health care to Black women that is ideal we need to provide health care that is culturally incompetent, and congruent as much as possible, safe, high-quality, and respectful. And the policies should include practices that include, nonclinical and social needs of Black women we need to look at the full package of what a Black woman brings to the clinical encounter which will help change the negative historical narrative of the healthcare system, and hopefully, begin to develop trust in the health care system. This report that came out in 2017, shows that 22 percent of Black women reported discrimination is actually much higher that's the latest data we have, 1 in 5, which is too much. So here are my references, I just wanted to end, with my contact information. Um, and thank you again for the opportunity. I'm going to turn it back over to Monica. Thank you so much.

>> Thank >> NDIDIAMAKA AMUTAH-ONUKAGHA: For setting context and sharing the most recent data, um, on reproductive health disparities for birthing mothers, and individuals in the African-American community. Our next presenter is Dr. Elizabeth Howell. She is a professor in the departments of population health sciences, and policy and Obstetrics, gynecology and reproductive, she is assistant chief chair and, Director at the health institute at the medicine at Mount Sinai. She is a NIH funded researcher her major research interests are the intersection between quality of care and the disparities in maternal and infant mortality and morbidity and, postpartum depression and impact on underserved communities this fall she will be taking over as chair of the OBGYN department at the University of Pennsylvania, Dr. Howell thank you and please begin.

>> Thank you very much, it is an honor to be a part of this really esteemed panel on such an important topic. >> So I'm going to be talking to you about quality, equity and maternal health. Protests sparked by the police killing of George Floyd, have swept the globe, his cry of I can't breathe, was heart breaking. And his story of not being listened too is all too familiar for so many women of color in the United States. And it explains part of our current maternal health care crisis. I think, these pictures are probably familiar to many of you, but just to remind you, I always like to acknowledge, Dr. Irvin, a CDC epidemiologist who died following child birth 3 weeks later she died from complications of high blood pressure and she was seen four or five times by health care clinicians in these 3 weeks. Erika Garner the daughter of Erich Garner killed by the New York City police she was a big advocate against police brutality, she died after child birth from heart attack. More recently the story was covered in ProPublica, Rosa Diaz, had an ectopic pregnancy because she did not have insurance she -- delayed care and she died from a ruptured Ectopic pregnancy. You saw earlier in the earlier discussion about these profound racial and ethnic disparities. This is data from the CDC documenting that the fact that Black women in this country are more than 3 times, indigenous women are about twice as likely to die, from a pregnancy related cause, as compared with white women. This is data from the CDC, slide this shows you the wide variation in the pregnancy related mortality ratio across, the United States and Washington, D.C. and I just show you this slide, to document that, it doesn't matter where, which region which cluster you're in, Black and white disparities and indigenous disparities, remain sizable across the entire country. I also like to include this definition by Dr. Braverman, remind us we're talking about a social justice issue which

is the theme of this -- this, webinar. Health equity and health disparities are intertwined. It means social justice in health. No one is denied the possibility to be healthy for belonging to a group that has historically been economically/socially disadvantaged. Health disparities are the metric we use to measure progress towards achieving health equity. And as you saw in the earlier presentation, this goes beyond class. This is data from the CDC, looking at pregnancy related mortality ratios from 2006-2017 and it stratified by educational attainment on the X axis it highlights for you that that, college, African-American Black women in green, um, who have a college education, more than 5 times more likely to die than white women, with a college education and you can see they're much more likely to die than white women of less than a high school education which is in blue. This slide also highlights indigenous women, American Indian, Alaskan native women have elevated rates across the different educational groups. You heard earlier about the fact that for every death, pregnancy related death over 100 women experience a severe complication something we call severe maternal morbidity, life-threatening events such as having stroke, having a seizure, or losing your uterus because of bleeding so much with your delivery. The rates of these, experiences are increasing actually. And this is data from this is national data, showing you, the -- the severe maternal morbidity rates among indigenous and white women, by rural-urban distance. You can see there's a divide you can see that, indigenous women have higher rates than white women, indigenous women are in Pink and rural have higher rates than urban. White rural has higher rates. This is really important to note, because, 33.5 SMM of the indigenous women versus 19 percent of white women live in rural areas this rural, urban divide is quite, has a few implications. This is, um, some more data, just documenting, racial ethnic differences in each of the different components of the severe maternal morbidity I put this slide up here to remind you and make sure that you note that, Black women, and American Indian and Alaskan Native women have elevated rates across many of these different conditions. The COVID crisis has shed additional lenses on this, this is recent data from the CDC, now I just want to point out that, pink are the 8,000 cases that they had of pregnant women, who, were SARS seropositive they had the virus, for COVID-19 you can see that, 46 percent were Latinx, 22 were Black and 23% were white. There are issues during question and answer we can talk about this sample more I just wanted to highlight something that they put out in this, in this, um, weekly report. This is, compared, to what, rates across the United States in 2019 where 24 percent of all the births were to Latinx women, 15 percent to Black women and 51 percent to white women, we see COVID-19 is disproportionately impacting Black and, um, Latina women, in a recent study that's not up here yet done in Philadelphia, by folks at UPenn they counted about 50 percent these two hospitalized capture about 50 percent of all births in Philadelphia they were looking at antibodies exposure to the virus and they found that Black and Hispanic women were five times more likely to have antibodies to COVID, compared to white women, thus reflecting, exposure to the virus. So, how did we get here? We heard a lot of important information in the earlier presentation that sort of underlying racism and discrimination how that plays out. On the health services researcher this schematic really talks to you about the different level of patient factors, Community factors, clinician factors and system factors you see many of this social determinants that we are talking about that are drivers of health in this schematic, education, poverty, beliefs, health behaviors, psychosocial stress, weathering that you just heard about social support, community factors, clinician factors such bias, experience, communication, and then system factors. These all combined to create a women's health status when she gets pregnant, and she may or may not have certain co-morbidities that put her at higher risk. She interacts with the

healthcare system, preconception, and antepartum and post-partum. I'll take a couple of minutes to talk about the ethnic disparities with the weeks at the end of the study, that I'm going to quickly highlight some of the -- um, earlier phases, mixed method study to investigate hospital quality and disparities. We examined risk adjusted severe maternal morbidity rates across hospital, accounting for patient mix, we looked at the racial and ethnic distribution deliveries we conducted qualitative interviews with hospital leaders and front line staff to understand what creates variation and how folks are dealing with disparities and then we conducted focus groups with, mothers who actually had experienced severe maternal morbidity events during the delivery and hospitalization. And here are the overall rates of severe maternal morbidity in New York City. You can see here the Black women are 3 times and Latina women are twice as likely to have a severe morbidity. Here are the Hospitals rank from highest to lowest, this is risk adjusted and New York City, you can see, there's about 6-7 fold variation here. Divided into tertiles, we looked at the distribution of deliveries across the hospitals and you can see that all much the Black deliveries occurred during this period, 23% occurred in those low morbidity hospitals, while 65 percent of white women delivered in those hospitals and 33 percent Latino mothers as opposed to in the high morbidity cluster of hospitals were 37 percent of all Black women delivered in those hospitals, 18 percent of white women and 29 percent of Latina women. We estimate that these differences in delivering in the hospital may account up to 48 percent of the Black-white disparity, and 37 percent of the Latinx-white disparity in severe maternal morbidity in New York City hospitals. We next went onto try to do hospital qualitative interviews in hospitals, with, um, leadership leader and front line caregiver to try to better understand what going on we is asked questions around structural characteristics, organizational factors clinical processes and patient outcomes. We layered that with questions on disparities and bias, diversity, communication and families. Some of the common themes we learned about was just the wide variation in the way that quality was measured and how quality improvement methods were utilized. The metrics used were different. The amount of staff and type of staff that were assigned, to quality and safety were different. And, whether and how data were distributed beyond leadership was different. There was very little attention and no one was actually, doing what we called the disparities dashboards where they stratify their quality metrics by race and ethnicity so they can see how they're performing for the specific populations they serve and individual adverse events, for likely to lead to quality improvement, than monitoring trends. We also did focus groups with mothers who experienced severe maternal morbidity. We did these focused groups with seem settled identified as Black women and Latina and then we also focus group with white women. And they all shared the severe trauma from one of these events during a delivery hospitalization. The 3 major themes were not only about the trauma, but also about poor communication "they just rushed me to the OR" that was i.e. "felt I was lying there, I'm cold, I'm shaking. I know I'm not feeling good, but no one is telling me anything" And again, and again, many of these women talked about not feeling heard. Similar to what we heard and -- the way I started this presentation, with the -- the thinking around many women felt they weren't heard or their symptoms paid attention to. So I thought I would end by just sharing some of the activities that have been going onto try to reduce disparities. And, in actual levers to-do something. I think many of you have heard about the alliance the funding through Hesiod this program to put bundles in hospitals and health care systems across the country, as a way to standardize care for pregnant women and trying to, tackle both maternal mortality and morbidity. Um, we also have a bundle on the reduction of Pre partum, which really highlights a few things and it

recommends, the collection of self-identified race and ethnicity and language data. Implementation of disparities dashboards, and then using quality improvement to address the identified gaps in care .It encourage s community participation, in and suggests to am hospitals and health care systems they should bring community members in for quality and safety committees and it talks about, thinking more critically about, you're --doing more enhanced mortality and severe morbidity reviews within hospitals, and enhanced communication share decision-making. Implementing bias trainings thinking not only about implicit bias but explicit bias and promoting a culture of equity. Similar to the way that we promote a culture of safety, um, where there's no blame there's a mechanism for reporting. That's also recommended in this bundle. More recently I was part of a group with the CDC working with the MMRIA bias working group this is a response to maternal mortality reviews across the country reporting the role of bias and racism and maternal death there was no distinct category for collecting it. And for those of you who are not familiar with the MMRIA this is a program that has through the CDC, so that they can, collect standardized information on all of the deaths through maternal mortality review boards across the country they can then put that data together and then report back to us, we really have a much better understanding of maternal deaths. And this committee's group work aim was to design a consistent approach for documentation in racism and discrimination as contributing factors to pregnancy related deaths, to provide recommendations on how to prevent pregnancy related deaths when bias was contributing factor. We have, um, finished our work in terms of coming up with a formal definition and having searched the literature and we have a number of experts on our committee for discrimination. For interpersonal racism and structural racism and then we have done, some webinars for maternal mortality review boards to help them understand our definitions and how they might be able to capture this in their reviews. And just to end to remind you as a person in the health care field, I think we have -- we can't emphasize enough about the life course we have to think if we're going to tackle mortality disparities an severe maternal disparities weave to think about this across the life course, tackling preconception, Antenatal care thinking about new models of delivery and hospital care and thinking about standardization, disparities -- boards then post-partum care, patient navigators case management we have a lot of tools and our tool house is building we keep need to work and keep doing these things, very, very important we have to eliminate and do these implicit bias and explicit bias trainings do more to counter this, culture of racism that we know, plays such a role in these deaths, we need to engage community, and we really need to work on enhancing our communication between our staff and ourselves, clinicians and as well as with our patients. Thank you .

>> Thank you so much for sharing data cross data groups as the actions you've been developed with to strive for reproductive justice .I now have the measure of introducing our next presenter who is Dr. Joyia Crear-Perry. She is a thought leader around racism as a root cause for health inequities speaker and a trainer --and advocate , a policy expert, and a fighter for justice. She happens to be a friend of mine. Joia is founder and president of the national birth equity collaborative, she has testified before the house energy and commerce commodity democratic support of the only maternal health bill signed into the law since the new administration came into office. Dr. Perry received funding from the Robert Wood Johnson Foundation to work with the American college of obstetrics to develop a standard of maternal care, served on the joint Commission Perinatal technical advisory panel, she currently serves on the

advisory committee along with me, of the Black Mommas Matter Alliance. Dr. Perry, please school us (laughter)

>> Not about schooling you my dear good afternoon everyone I hope -- that you all have learned a lot as I have, so far. And that we can continue on this path to reproductive justice through research practice and policy. Next slide. >> So, as was mentioned our organization the national birth equity collaborative is five and a half years old we really start with this mission and believing that all Black mothers and babies Thrive when you center reproductive justice that you recognize including things infertility, contraception, abortion, cancer treatment, that the entire ability to thrive is all parts of our lives we recently looked at our core values and I want to lift up today is sisterhood, because if it weren't for the people on this call, like Dr. Regina and Dr. McLemore, Ndidi and Dr. Howell I want to uplift the sisterhood as a core value of our organization, how we move in this work and thank you very much all very much. Next slide. >> So, as was mentioned we'll talk about respectful care, we'll, articulate some Levers and wins we'll talk about the Black Mommas Matter alliance platform wean think about for reproductive justice and racial equity, next slide. Next slide. So, what is the respectful maternal care? As you may or may not know, um, through the Whom, a -- we have, universal rights for respectful maternal care, it was started with the white ribbon alliance, we have maternal care councils including people like researchers like using the call and, through the APHA through the webinar, practitioners, nurse mid wives, OBGYNs, advocates and policy makers we look for guiding principle how we can have, respectful maternal care. In general, these principles are held in low-income countries, um, you know the privilege of being a western country is do thing like assume, once you have wealth you're magic tally respectful we wanted to see what that looked like in the U.S. context how could we use global standard, because antiBlackness , patriarchy, white supremacy are all global phenomenon, we have to think about our work going forward when it comes to accountable and global context as we move forward , and -- around health. Next slide. We also work with our colleagues of the New York City health department, four years ago began this process of looking at what, respectful maternal care would look like in hospital setting and operationalizing that, they started with committee members where they had birth justice defenders they had community engagement group, he willed by a high-level employee in the health department and great partner of ours in his work working with the community members to develop, a standard for respectful maternal care, this is really for me at least the first time only time I know of in the United States, where the community members, created a standard and the health department, adopted what the community said instead what we normally do, as all of us inside of public health we come up with standards we then higher organizations like mine to ask, the community does this sound about right? So this was a first time, at least in the work that we do, that we've seen, people actually follow and trust and listen, to community and, follow the lead of what, community members say. And it said things like in this, standard for respectful maternal care what is decision-making look like. You deserve to decide what happens with your body to make decisions, for your body. So, this is about your choices and this is, um, for -- ground breaking as OBGYN's we may speak language around saying patients have the personal body autonomy it's tenant of reproductive justice one of the main tenants of reproductive justice we don't treat patients as they have personal bodily autonomy we don't say to them, you have health care choices if the outcome, is untoward we provided with you all of the information this is your -- you have the -- opportunity to make choices that you believe are best for your

family about where you want to deliver, how you want to deliver what interventions you would like to have, in birthing your baby.>> And education, looking at all the different information we should have, you know now the conferences within the American college of OBGYN reframing the conversation on Marion Sims the founders of the gynecology of my field and understanding that, um, up lifting the fact that they have --were harmful and they practiced on Black women enslaved, with out's I can't and how does that education, really then lead down into currently today I've seen some conversations when people are, questioning, that they never were taught in school, that Black women, have different pain tolerance. When we say we learned that in school it's not today it was necessarily one slide or that, lecturer said to you always remember that Black women don't feel pain. But you do know, that people are not given, um, adequate pain medicine we have data now out of ...Dr. Jasmine and others showing this miseducation unlearning and belief we're biological different has caused, people to do things like delay pain management for Black patients, um, which we have quantitative data to support and prove so how do we really undo this belief of evaluation of birthing people, based upon skin color and then the quality of care, adds. Dr. Howell mentioned we know that, there's a difference in quality of care, there's a difference in how people are treated in different hospitals, we know that hospitals that are in Black communities are undervalued just like the people in those communities they get less resource have less income they don't have, if you need to have a --interventional radiologist in-house to make sure that when someone is hemorrhaging to death after having a baby you have someone available. That person costs a lot of money that individual provider type, costs a lot of money most of the hospitals who are in under resourced undervalued communities don't have access to the people who can save the lives of the patients who have higher complication rates. Because they're low income, have lack of access to resources how do we imagine quality of care not just blame or shame individual nurses or doctors or providers or even hospitals really reimagine, how all of us-- have been undervalued how the treatment of patients who are, not centered has been allowed to be segregated and allowed to be underinvested in for decades in this country and how do we make a choice, to really invest in the people who actually have the most need and have quality of care that matches their needs? Next slide. Dignity and nondiscrimination is really important it is what, when we ask, Black birthing people what do they want out of a birth? How do they want to be seen, they want to feel they want to have trust, they want to feel, they want to have dignity they want their, um, choices and values regardless of race gender religion sexual or again nation, age, HIV is it ad us, immigration, income level or form of insurance and so, what we have not created in our system, is a way to for the patients to have redress, right how do we ensure if they are discriminated against and if there is --they're treated without dignity, what happens? How do we create a system where people are, um, can have an expectation their needs and their wants and dignities is honored no matter, their income or ability. Next slide. This is our work that is, um, that was referenced .That was referenced, at --earlier. About the the funding through the Robert wood Johnson foundation part what is fundamental about this work is we, the small non-profit are the grantee. And, the American college of OBGYN and Johns Hopkins school of public health with Dr. Lisa Simpson are our subcontractors that is transformative so if anyone is here working in the public health and, really investing in the small non-profit to lead and guide how the work goes -- we have now listened to Black birthing people across the United States, and now created framework for respectful maternal care we are publishing, that really is embedded in quality improvement we recognize there's no quality, without equity .We recognize that we must listen to and trust and respond to Black women. Understand that

culture you're in. Humility requires us not to take a 90 minute course even though I teach those and train them, and do them a lot. That one course is not going to undue 400 years of a belief of a hierarchy of value based upon a skin color we know it's a long term journey we're all taking together of self-reflection and change and it's important we embed those things not in our individual behaviors how we treat individual patients but then within our structures how we decide for example that, Black and Brown patients don't need continuity of care and they're almost always seen in a clinic where she sees a different person each time and yet we are, surprised when they have worst outcomes we create system where they don't have continuity of care which is a prime need for birthing people. Next slide. Next slide. Yeah. So this is -- oops ,sorry, this is a quote from Karen Scott, who really her research is foundational for how we 're building out our work and she has the sacred birth work in California, and this cultural transformation deepens the capacity for providers and systems to listen to, understand and respond to community voices and sharing stories of disrespectful and dismiss I have care and service gaps. These are the places where we interviewed patients. Next slide. The themes were things like accountability, right. People want to know, who do I even ask, who do I go to, if something happens to me in a birthing system? She can witty, right. So many times people talk about disparity as if they're fixed numbers that people perceive to be built around biology or access, they don't want to fix, where equity gives you a sense of justice in the need to change policies. And, that the belief that biology, was colonized that there was never -- we don't have stop believe in biological race, biology doesn't, that was, um, something that was brought into the sciences that's not something that was created by the sciences. And, empathy. people want to know that you see them as fully human, and fully capability, racism, people -- the patients birthing people recognize, that you -- that they're devalued they know they sit in the rooms know there's a waiting roomful of Black and Brown people and other waiting rooms that are -- nostrum, health care is one of the most segregated in America just like, churches and we have to think about and question why that is. And trust. We talk a lot about trust building and health care and public health we talk about it in the sense we want patients to trust use need to figure outweighs to build trust the patients want us to trust them. They want us to trust they are, um, making the best choices they are, not compliant this idea, that they are, refusing to come to appointments because they don't care or not interested in their own birth and baby's birth, makes no logical sense that is, built in racism, and built in a disregard and dismissal of Black and Brown and indigenous bodies trusting people are really working hard to do the best they can and they come with knowledge around their own bodies and around their own experiences. Um, and -- really you can see this highlighted during this COVID-19 moment. We know and I'm sure you've all heard about substances where hospitals are, turning away partners or turning away birth support, and this lack of communication and this not having, transparency and not having connectedness to social capital networks in community, is, deeply highlighted, with this COVID moment we have not created a system in public health or health care that works with community, follows community, built communication strategy with the community so you see the gaps see how this causes, increased numbers of harm, for Black and Brown indigenous patients across the United States. Next slide. So the Black Mamas Matter Alliance is you know, Monica and are on the board this is, what -- micro-chair of the on the board of the care working group, said what's missing from the care of Black women their centered voice, validation of experience and freedom to choose and be informed. Black women need respectful care that is free of implicit and explicit bias this is the providers responsibility to address those biases. To address the issues of maternal mortality we

need the care that originates from and is defined by Black women-led organizations, practitioners and community members. Next slide. This is recently we had Black maternal health week back in April we were even despite COVID to have virtual Black maternal health week which was successful. Um, really, we understood that our movement requires both research, policy change and, culture shift. And, this, this culture shift around, having large organizations like the American college of OBGYN, and APHA, and others embracing Black maternal health week we recognize that part of the reason we can talk about race and racism, and the context of health or Black maternal health is because it investment and research, that has been done to be able to segregate the data, to show that despite income or education, we're still more likely to die in child birth and so that, this -- we're able to then, defunct the myths and narratives have always blamed and shamed Black people. I would say just like Ndidu you would see these same data in hypertension and diabetes and cardiovascular illnesses but, right now, because we are able to highlight it, so much, in this -- in the maternal health moment we can say, okay, so we know the racism is real, we know that people, despite income or education are dying, so what are we going to do as a community to improve, how we treat people of color across the health care spectrum how the strike you're have been created to be harmful and toxic to them. This is just a list of all the partners , everyone from Mommato village in DC like folks of sister reaching Memphis, people arresters, Duals mid wives organizations working on breastfeeding and abortion space it's really important for us to know the spectrum the reproductive well income and sexual freedom is bailment into and harmed by the current structured siloed and demand that we do things like family planning, pregnancy and tension without investing in being for us to have justice and Joy and freedom. Next slide. This is the Black paper we wrote, not a white paper, setting for holistic care of and for Black women. You can find on the website. It talks about things that are, really some of it, is in the bundle that Dr. Howell created for the American college of OBGYN, where we look at things like, trauma informed storytelling, looking ensuring that we have, community informed advocacy how do we build on what we know and inside of health care and quality improvement make sure itis led by a, hold list tick maternity care model that is -- created in the community by community members no the something that we do inside of A Academia, not saying that you should like it because we put it together, these are a couple of partners I mentioned, Mamatoto village, and others, de colonizing birth conference every year. All right .Next slide. Okay. This is, our, research meeting at the motherhouse in Atlanta with our we lead, the important work many reproductive justice advocates in the work the principles, for conducting research with for and by Black mam as you nun you invest in women's Black women and researchers it is very disheartening at times when I get messages from folks who want to now because much the current political movement we 're in, excited about doing racial justice work they don't want to invest in the Black women doing the work prior to their excitement. I hope this is an opportunity to pivot and think about, as we spend money we invest in what we value it's now time for us to invest in the organizations who have been doing work with very little money for creating change in their communities without, the celebration or the -- the praise that others get, because of white supremacy and because of devaluation, next slide. Provider add voluntary Casey we can do, is really work on rig a lens , people ask me what can we do now, racial equity lenses in the matrix once you take that, blue pill you see it it's hard to never unsee it it's everywhere you can now see, the parts of your policy that you need to change, you can see - - the importance that you need to steps you need to take, so you'll recalls when you talk to people like me , and others that do the work we don't expect you to fix racism with a 90 day cycle we recognize you

have to do this for the long term and so -- we want you to have lens that lasts forever you're fighting you want your grandfather to fight for racial justice is that the last slide .>> Here are some tools, policies if you were going to have reproductive justice would not be focused on --contraception and abortion, paid family sick leave, economic protections during COVID-19. Expanding post-partum Medicaid coverage, funding maternal mortality review board, solitary confinement any kind of birthing confinement, birthing education and supporting, and eliminating police Bare utility and excessive use of incarceration, those are all parts of the advocacy. Next slide. This is my last slide, if you've ever heard me give the talk I gave the same talk the Congresswomen is coming I will end on that note.

>> Thank you so much Joia really appreciate you. This is now honor and --just humble and I'm so excited I just can't believe I fan over Congresswomen Lauren Underwood she serves Illinois 14th Congressional district was sworn into the 116th United States Congress, on January 3, 2019. She is the first woman, the first person of color and the first millennial to represent her community in Congress she is also the youngest African-American women to serve in the United States, House of Representatives. And, she serves on the house committee on education and labor, the house committee on veterans affairs is the vice chair of the house committee on homeland security. She also serves on the house democratic steering and policy committee and representative Underwood is a member of the future forum of the group of young democratic members of Congress, committed to, listening to and standing up for the next generation of Americans, she is member of the congressional Black caucus and the LGBT equality caucus. Representative Underwood you're also nurse I hope you're here with us. Please begin

>> Thanks so much for moderating this critically important conversation for your leadership on maternal health issues I also like to thank the American Public Health Association for hosting today's event and for your partner, your tremendous with the Black maternal health Caucus being an important voice in public health issues during the pandemic and to the fellow panelists your true champion for racial equity and maternal health outcomes honor to join you in this conversation. This is such an important issue to address. So, since the very first confirmed COVID-19 case in the U.S. more than a million babies have been born. In June, the Centers for Disease Control and prevention reported for the first time, that Black and Hispanic pregnant women are suffering from disproportional rates of severe illness from COVID-19 the virus has highlighted and likely worsened existing disparities and maternal health outcomes. We know nationally Black women are 3-9 more times likely to die from pregnancy related complications than white women. In my state of Illinois , Black women are 6 times more likely to die, these statistics are glaring but each represent, a story and one of those stories, belongs to my friend , Dr. Irving, a Ph.D., level sociologist and Gerontologist. A classmate of mine at Hopkins, she went to serve in the public Commission health Corps working in the epidemiology intelligence service, on health disparities and, um, ended up, expecting and was so excited to be a new mommy, she did everything right. Delivered her baby, in January 2017, 3 weeks later she died. Of complications related to her pregnancy. I was devastated and, her, story, is what inspired me to launch the Black Maternal Health Caucus with Congresswoman Adams. Since then our group has grown to 100 bipartisan members, enhancing policies to improve Black maternal health comes, we fought for expanding health care coverage from 60 days to a year, championed from Congresswoman Kelly. In join the act was required requiring every state to expend post-partum Medicaid coverage for a full year, in Illinois a full third of pregnancy related deaths

take place more than 6 weeks of post-partum this policies ensure the moms receive the care and they need and deserve for the full period of postpartum the single best thing to save moms lives and tackle disparities in maternal mortality, we can't stop there. In March this year I introduced the Momnibus act of 2020. The Momnibus, includes 9 bills that build on existing maternal health legislation to comprehensively address the Black maternal health crisis it addresses topics like, maternal mental health and behavioral health, improving our data collection, processes and, investing and community based organizations, growing and diversifying the perinatal work force addressing social determinants of health like nutrition, housing and transportation, and, investing in telehealth and digital tools in supporting our pregnant and post-partum women veterans. Our goal is to handed, Momnibus in this Congress we'll need your voices elevating this issue and advocating for these critically important policies, thanks so much and looking forward to conversation.

>> >> Thank you so much. Thank you it has been such an incredible, incredible discussion.>> I would like to thank all of the presenters for outlining the context and the existing health disparities among mothers and birthing individuals as well as some of the solutions , you're engaged to -- that we are engaged in, to advance reproductive justice. Before we open up for questions and answers, I would like to take some time to share an APHA resource addressing health equity, entitled racism, science and tools for the public health professional. This important publication builds on the racial equity, and racial health equity work that advocates and others have been doing for decades. It is available, on the APHA website. I have this book I use it often. Also, note this series has been in the works for some time and it is evolving to allow us to be responsive to current events and the needs of our field. And here are a few topics for upcoming webinars; we welcome your feedback on this webinar and in the two minute post webinar survey. Now, let's get to your questions. We will do our best to answer as many as possible we will not get to them all. We will be drafting responses to some of your questions we'll be including them in discussion guide that will accompany each webinar recording in the series. I don't think Representative Underwood is able to stay with us, but all of our other panelists are here with us now.

>> So this is a question for -- Dr. Howell or --excuse me Dr. Howell are the outcomes similar when you compare health outcomes from Black women, and in the United States, and Black women who are immigrants from other countries if so what are the key differences ?

>> So there's some older data from the -- um, that was published that was from the CDC that looked at, country of birth and um, pregnancy related mortality that older data showed that although, if you looked at American about a born Black women their rate was 4 times higher than white American white women who were born in America. Um, and -- that, ratio of 4:1, 3/4:1 was true for Black women born outside of the United States, compared to white women born outside the United States. And then the margin between the two, groups was very small. So -- in that older data, we saw that very similar for Black women born in the country, as well as women who were born outside. I don't know if you have anything to add Ndidi?

>> Yeah thank you so much for the question, um, in addition to what Dr. Howell said I think the important take home for me, when I get questions regarding foreign born and native-born Black women the longer you stay in the United States the worse your outcomes are going to be. So a lot of the,

impact of the benefit that immigrants get when they first come here, um, is definitely, gone and, um, deleted by second-generation and so, there's something about being in this country, that, plays a negative role, physiologically for Black women, particularly as it pertains to pregnancy and related complications.

>> Awesome, let me stay with you Nnidi. The next question is for you, regarding disparities and funding, what are the 3 or 4 major reasons, do you have information about concrete steps or actions that have been taken to address those reasons?>>

Some of the major reasons are, just, um, you know, NIH is an old boy's club I say that meaning that the people around the table, making funding decisions are more likely to be older and likely to be white and male. So, we need to diversify the pool of, um, potential reviewers, I have been in the early career reviewer database myself for years and just got called to do my first ad hoc review in October 2019. I was so excited I went to DC I did all of my reviews I was just like Giddy to be at the table. I walked in the room I was like oh, it was just so stark how old and white the room was I think, no one -- you know, made any type of attempt to make me feel comfortable, no one welcomed me there was no -- there was no sense of, your presence is value. And in this space, finally enough my reviews were on par with the senior people must know what I'm doing I'm going down the same way they are. I told this story to say, until we diversify the pool of potential reviewers until we diversify people of color in leadership positions we'll not make any changes. One of the more concrete things we can do is, to pick reviewers, that are more diverse, pick Black and Brown reviewer at the table to make sure these applications that are getting, submitted, are representative of that, so in addition to having, um, earmarked early careers and, new stage investigators and those types of designations we should have designations for people of color that should count in the review and scoring process.

>> I need to add one quick thing this is a really important issue I think they have been doing, as you heard about, more recent research documenting how, underrepresented folks of color are in the pool, of the scholars one recent study looked at you know what is it? Is it about the same, for the same level of --you know forgive me I can't remember all the specifics but basically same educational level, same publication records same everything across the board, and what it looks like, is that -- that, that investigators of color are more likely to do things like health services research, things like -- researching and disparities, those kinds of topics which don't seem to red nature with review committees the same way and, I do want to give -- NIH positive mark in the sense they have been really trying to be active on the issue of recent putting in new, perimeters around, reviewers, who can be on committees things like that, they're trying to make -- diversity and major issue I know that there's a lot more, they have a lot more to do, but wanted to sort of applaud of these early efforts they have started to recognize this is an issue.

>> Yes.>> I'm going to have to step off the moderator role be Dr. Monica, that's just who I am I think that's a super important this is said as well, number one, the national institutes of health is one of the greatest funders, using tax dollars of biomedical research in United States, thus, should be representative of the people who live in the country. The other thing I will say is, I would like for any funders who are watching or who are listening, to-- make sure that you continue to put out, requests for

applications, not just during the pandemic and not just, specific to maternal health, but that becomes a priority on your agenda, because I think ,the people who have the expertise , actually could, you know, applied in the last 16 weeks we've been preoccupied trying to readjust ourselves to ur new reality in the context of COVID-19. And had to say that.

>> Um , anyone on the panel? Can you please speak to the status of research on epigenetics regarding multigenerational trauma, due to systemic racism we've heard about 9/11 --what about racism, trauma may get passed a down, accumulate through the times of slavery, police brutality et cetera of a million things I could say on this, but I would like to hear from the panelists.

>> Okay.>> I have a million things could say too I don't know if anyone else wants to go first I'll go with, what I learned from my, elders who were, um , have been working on Reparations for a longtime, part of the reasons there's a lot of research we have proven racism causes epigenetic harm, and weathering has been proven, Nancy Krieger and the folks at Harvard they have done a lot of work around it, for folks after 9/11the -- I saw some comments in the chat around Muslim population, and -- um, for Mexican Americans from Muslim anyone who is racialized minority or harmed by the policies we create racism and socio political construct they have worst outcomes including epigenetic and trauma A the worry we have focus on the biological impact test of racism, without undoing the racism, without believing that's is possible , I my elders when we talk about Reparations they talk about investing in biological research on the biological harms, from racism, because they don't believe, that white folks will stop being racist they don't believe that the systems are capable of undoing the racist part of this, the system we're in right now, is there's a moment of I have to believe, that it is apossibility , that we can undue, racism, I have to believe, that although my elders shake their head every time I say it, they said folks are not going to stop being racist, I have to believe someone here on the listening 3,000 people that signed up for this, really do understand, that, continue to just study the biological impact of the harm of racism, without actually undoing the harm of racism is actually racist itself. So that's my take .

>> Other thoughts. (Pause for comments) >> Okay.>> I might go around on that, if we have time later. Okay. This is for everyone. What are the best measures or proxy measures to quantify effects of racism of people with color, within reproductive health as a public health measure in general -- in general?

>> >> I think in the maternal world, in maternal and --I know Joia has been doing lot of work on this, she talked about respectful care and things I think that experience, I mean, even the whole field of quality measuring has recognized quality of care experience is an very important dimension of all this, we know satisfaction's tied to adherence --you know taking your medications, following up with your doctor, everything else and so experience, matters storying to measure that experience, around, racism how women, do they feel, heard do they feel listened to, and respected too they feel all of those know there are a number of different groups around the country trying to, come up with tools around you know , scales around this, so we can start to incorporate that, because think of it, some way we use the CAP survey for hospitals to understand, what the care was like and you know, that gets reported back to the hospitals and it is actually now publically reported something we Can do in that frameworks maternal care with one of these new scales, that could then, help people understand, -- what that experience is, you know, also -- how -- bam, right, understand where they might want to go for care. Because see how

people are doing, on these metrics I think that is, is, something that a lot of people are working on and -- is very important.

>> At the risk putting my foot in my mouth, I'm working with 3 different groups run a the country full disclosure we've heard Dr. Scott's name along with her colleague and her collaborator Dr. Davis they're rating patient reported experience measure of, Obstruct racism, which will get at some of those pieces warn of my other collaborators , Brittany Chambers, professor at USF, is really -- building out , measures move he wills of structural racism we have technology friends we have people like, Kim Alders the irthapp which is all about you know, birth you know, without the bias so that's why she takes the B off, tons of people in the space my only point in saying that is that, these-- you know, initiatives are all Black women live, Black women envisioned they are really doing the hard work of community engagement of really trying to get as many eyes and voices as many thoughts and ideas as possible into that work and I think they're setting a new standard. So, my answer to in question there are somethings we're trying out right now I think will be coming on board soon I'm really excited again, it goes back to why we need to be investing, in Black birthing people and people with the capacity for pregnancy.

>> Do you mind if I say one more thing on that?>> Yeah.>> Because it's important ,um when I get push back when people say I heard you talk about this biasing training I heard you talking about patient experience what's the real reason Black women are dying, they're dying in Africa, they're dying in other - - countries guess, isn't it something with their biology? I just want us to be really clear I'll keep saying it over and over again, it's in this chat today, it was in meeting I had yesterday. We have not agreed, we have not come to the end, of the fake news that race is biological. Right. So there's no biological basis of race. Race is a social and political construct. To the point that, we have been fantasized how it was created we have the mythology in our history that white folks were ileum and they came to United States, they swathe indigenous people, they made up racism they saw them in Europe, it wasn't like they didn't see other people of color before they got here. We have used this biology, taking the idea of racial hierarchy when we say colonized, we take a great field biology we can take this idea of a racial hierarchy and change the way we think about and talk about, and classify human beings. We should not look at people and think that because me and Ndiidi have the same color skin the amount of illness is based upon the amount of melanin we produce.

>> Thank you this is a question for Dr. Howell, can you, expand more on the concept of safety bundles? If a hospital, were to try and implement a bundle on reducing racial and ethnic disparities where should they start, have any hospitals implemented the patient safety bundle to reduce racial and ethnic disparities

>> It's a really important question and --um , the alliance -- have bunch of those safety bundles the ones clearer and easier in a lot of ways to implement or something like hemorrhage bundle have a hemorrhage card, have trainings make sure you have all the -- you know everything you need for, if a woman comes in and the bundle we developed for the -- the disparities bundle was much more complex requires lot more infrastructure, um and -- you know, resource towards infrastructure. I'm going to give you the example of -- a hospital that I've been, at for the last number of years, have we, incorporated the entire thing? No but could weave pieces of it? Yes. I think that's where a lot of people have been

doing, for example, we have a very really robust implicit bias training component I work with colleague who is a --major champion for this, um, and -- Dr. Tony Stern, does our experience and she has been working with me we have been trying to implement a disparities dashboard for -- the OB service. I showed you all these different points, um being and that's what we've been doing, and I think that's, what I have seen many other hospitals, try to do. But if you looked overall it is overall it is a small proportion I think we need to, have more people, more funding, to sort of figure out, and help hospitals that are less resourced, implement, this bundle .

>> I will be the person that jumps in on every question I have to say --I have to plug the respectful maternal care work it is really where we evolve the work with ACOG around the bundles to think about how do we have respectful maternal care controls all of the working hemorrhage and hypertension and in, blood clots right how do we think about, what would implicit how would you have a data dashboard, no matter whack-sections how would you do the things that Dr. Howell mentioned across all the work but then also have an really deeply, um, a commitment, that you're not going to have the data and, doing the training but your goalies actually to, ensure that all people thrive you have to invest in the people you don't normally invest in, invest in their care in a very different way.

>> Thank you.>> This original question, was directed towards clinicians but -- since I sort of reject that framework I'm going to ask it to all of us, um, how do we hold professionals and, physicians accountable for their biases and I would add nurses and unit clerks staff at hospital and health care institutions onto that lustrums, thoughts about that ?

>> >> Go ahead -- >> Ok,um, well I mean I think many ways to hold them accountable I think you know, one in the actual moment is address what is happening and to call it out and away that is clear and direct and just address the racism right there as it is happening. Two, I like documentation. And -- gummi really believe in the purpose of documenting what is happening and getting it up the chain, getting the case reviewed by the QI board, I believe in hop on twitter any way you can publically, document the process and to make sure that things are going to happen on a back end I think the patients should do that I think also knowledge is power right. Like I think, the same way that we have Yelp for a restaurant we need a directory or process for picking providers. Women's lives at stake, women are literally dying because of racism and at the hands of the providers anything we can do to document the providers to make sure it gets in front of the review boards and hospital, to make sure it is in the public space, so women know the dangers at delivering at the hospital this is how affect change when you start getting a hospital's bottom line their revenue, that's when things start to change and I think those are some of teething I can say I don't I know my colleagues have others those are things I would do.

>> So I just add that , in the bundle, we said, mechanism for reporting, similar what you do for safety, so, people --hospitals have a ways which people can do anonymous reporting. For safety and events that is - - you know, have adjusted learning culture you want -- you that's the way you get the safety I have environment I think something that in moments could be very helpful. A lot of hospitals have professionalism committees some of those are, multidisciplinary it's not just, physicians or nurses it is combined, different people's staff, all part of that. That -- those, events whether it's a patient, whether

it's a student, whether it's a resident or physician or a nurse ,anyone, should be able to have that mechanism for reporting and then there has to be something done on the other side, to address that and their haste be a nice loop back I think that's what we tried to get at the bundle I think there's promise, because there's a model already, for a safety culture to do this I think, that might be something, that could be, pretty easily adopted , in many hospitals.

>> And that's a great lead up to our work because the point is to add discrimination and racism to the safety culture. That the point is, to understand that the reason Black birthing people are dying, and that things that make it unsafe it's not that you count laps or that you -- are able to do a blood pressure correctly but your actual your ability as a nurse or a --provider or a front desk clerk that your treatment of that patient, is safety issue. So, the same mechanisms that exist inside of hospitals, to work on safety around, if the patient went back to the emergency -- to the operating room because you, um , because she is bleeding in her abdomen, event she is ignored around her pain is a safety issue she will die from that as well. So really learning to ulu that, really thinking about that as fundamentally same thing there's no quality improvement without undoing racism no safety without undoing racism, they're many one in the same conversation so when people ask for --initiatives or things too, this is it. There's no other thing. We're not looking for kidneys, filtration rates to be different we're not looking for our lung sides to be different. None of those -- all these things were based in eugenics and false and fake and not real science. But the real science is, that it is harmful and deadly, when you are racist to patients.

>> With that, that's goings-on the last word. I could talk to all of you, all day. But we are at time I want to be respectful of everyone's time. I want to thank you all for presenting today and -- providing, such informative and enriching presentations, and thank you to the APHA staff who worked tirelessly to produce this event and to support us. Thank you all for participating, and your thoughtful questions there were more questions and we will get answers to them. Reminder recording the slides everything will be available at APHA.org --lastly please complete the two minute webinar survey it's really important, you will be redirected to it shortly .>> Thank you fortuning in today and this concludes the webinar. Thank you everyone. (session conclude) >>