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# State Legislators Are Finally Doing Something About the Black Maternal Health Crisis

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Apr 12, 2019, Regina Mahone

State lawmakers have introduced more than 80 bills this session to address the disparity in Black maternal and infant mortality rates.

A number of bills seek to expand access to doula care, to address implicit bias in the health-care system, and to establish maternal mortality review committees.

Raena Granberry first became pregnant in her late 20s.

The Los Angeles resident had been employed on political campaigns, which was lucrative but inconsistent. After deciding to pursue a full-time job in her community, she began working at an after-school program.

"I was making very little money," she told *Rewire.News*. "Me and my partner, who is my husband now, were struggling [financially] to make it work—and now here I am pregnant. So I went down to the county building and got Medi-Cal," the state's health insurance program for residents with low incomes.

Even then, she was concerned about the standard of prenatal care she would receive. "I was like, I'm going to go to all the way to Beverly Hills," she said. "I'm going to get on the bus and I'm going to go to the top doctor I can find. So that's what I did."

Granberry said that is where she first began to feel "othered" as a patient, partly because of her income status but primarily because of her race. "From the very beginning, I didn't feel comfortable there," she said. "But I figured, all these other women are coming here and they've got lots of money. This has to be a great place to be."

It was little things. When she went to the clinic, she would see other patients spending time with the doctor and hear them laugh together. But when she had her exam, the relationship felt sterile. "I was really in and out, and I felt like my doctor was just somewhat cold and indifferent to me or any of my concerns," she said.

She tried to put it past her: “I didn’t want to accept it because I’m like, this is a medical professional and anybody who wants to deliver babies clearly has a heart for all babies, right?”

When she started feeling sick in her second trimester, she grew concerned and went to the doctor’s office. “They’d tell me, ‘Everything is OK.’ I’d have cramps and they’d say, ‘Oh, you know, some cramps are normal.’ And, again, this is my first pregnancy, so I’m just counting on them to, you know—I’m getting all of my information from them and I’m trusting it,” she said.

“There was a particular day I wasn’t feeling well and I called into my doctor’s office, and I said: ‘You know, I’m really cramping and I just don’t think something is right. Can I come in for some type of testing?’ And the nurses were like, ‘Oh, well, you have an appointment in a week. I wouldn’t worry about it: You’ve been complaining about certain things, but you’ve been fine. So just wait until the appointment,’” she said.

“That very night, my water broke,” Granberry said. “I was only 20 weeks.”

“I pretty much knew by then I had lost the pregnancy,” she said. “We went to the closest emergency room, and when I got there, the doctors told me that this baby will not be alive, ‘But you do have to deliver it. Like it’s large enough that, we’ve got to have you push the baby out.’ So, that’s when I delivered my stillborn baby: at 20 weeks.”

Granberry now works at Black Women for Wellness, a South Los Angeles-based multigenerational Black women’s health organization. The group is fighting alongside state legislators and other advocacy groups to pass the California Dignity in Pregnancy and Childbirth Act, which would help prevent the kind of racial discrimination that Granberry experienced during her first pregnancy.

Heard in the California Senate Committee on Health on Wednesday, the bill, SB 464, requires medical professionals involved in perinatal care receive implicit bias training to combat racial disparities in maternal and infant mortality rates. The bill mandates that they “complete initial basic training through the program and a refresher course every 2 years thereafter, or on a more frequent basis if deemed necessary by the facility.” Facilities would also report data on maternal deaths and provide patients with details on how to file complaints of discrimination based on their “race, gender, age, class, sexual orientation, gender identity, disability, language proficiency, nationality, immigration status, gender expression, or religion.”

SB 464 is not an anomaly. In just four months, legislators across the country have introduced more than 80 bills addressing the Black maternal and infant mortality crisis. Most of us have heard the statistics: Throughout the country, Black women are three to four times as likely to die from childbirth as their white counterparts. A *Rewire.News* analysis found legislators in three states—California, Illinois, and Texas—seeking to address the implicit racial bias in the health-care system that contributes to this disparity. Meanwhile, lawmakers in ten states have proposed measures expanding access to doula care, and, heeding U.S. congressional leaders’ call for maternal mortality review committees in the federal Preventing Maternal Deaths Act, lawmakers in 19 states have sought to establish some form of task force to investigate the crisis.

When asked about whether legislation like SB 464 goes far enough, Granberry said, “I don’t think anything that is happening [apart from eliminating racism] goes far enough, because the issue we’re dealing with is” so widespread. But, she explains, this legislation does call inthe broader medical community to address their role in the maternal and infant mortality rates Black women are seeing.

“What we have been doing for decades is putting all of the responsibility on Black mothers,” Granberry said. “You need to be healthier, you need to try to reduce your stress, you need to do this and that—and obviously the outcomes have not changed. It’s because nothing that we can do as Black women can change what our experiences are as a Black woman. I can’t change how people are going to treat me and what the world is like for me,” said Granberry, who also experienced complications during her second pregnancy with her now-6-year-old son that ended with her giving “uninformed consent” to an emergency c-section at 27 weeks. Prior to that surgery, she was made to feel “invisible again in my own body” after she was transferred to a hospital that specialized in preterm labor—all the while having flashbacks of her first pregnancy.

“A policy like this is how we begin the conversation, and how we make small cracks at it,” Granberry said.

## State trends

Research from the CDC Foundation suggests the majority of pregnancy-related deaths are preventable. In Texas, where lawmakers have gone out of their way to cut access to basic health-care services, nearly eight in ten pregnancy-related deaths in 2012 were preventable had there been “one or more reasonable changes to the circumstances of the patient, provider, facility, systems or community factors.”

So what are elected officials doing about that?

While some of their Republican colleagues are threatening women with the death penalty for having abortions, Texas Democrats have introduced a handful of bills aimed at improving the health and well-being of pregnant people. Although none of those proposals appear to be advancing in the legislature, several bills (HB 241, HB 411, and HB 610) would extend the length of time low-income women receive medical assistance following childbirth or an involuntary miscarriage. Companion bills in the house (HB 2618) and senate (SB 2301) would establish a maternal peer support pilot program, which in conjunction with other resources has been shown to improve outcomes for at-risk pregnant people. Another bill, HB 4301, would reimburse doulas for their services, including “childbirth education and emotional and physical support provided during pregnancy, labor, birth, and the postpartum period.”

New Jersey has also seen a flurry of proposals addressing maternal and infant mortality, but unlike in Texas, some of these bills are advancing through the New Jersey legislature. Three bills are waiting for Democratic Gov. Phil Murphy’s signature: A 1862, which will establish a maternal mortality review committee; S 1784, which will include doula care as part of the services covered by Medicaid; and S 3365, which will create a learning network of perinatal experts and providers, with the goal of improving maternal and infant health-care outcomes.

Massachusetts state Rep. Liz Miranda (D-Fifth Suffolk District), who spoke to *Rewire.News* on her 100th day in office, noted that data from March of Dimes showed the state zip codes with poor maternal and infant mortality outcomes, and that "a large majority of them were actually in the Fifth Suffolk District, which I represent."

One of three Black woman representatives in the state, Miranda "felt geographically, socially, racially, this was a call to action, and I wanted to elevate this as a public health crisis in our commonwealth."

Miranda has co-sponsored three bills on the issue, "a trifecta when it comes to discussing maternal care," she explained. H 1182 would cover doula services in the state's Medicaid program, MassHealth; H 1971 would authorize the state's public health department to conduct infant mortality reviews; and H 1949, would create a commission to reduce racial disparities in maternal health.

"What the data tells us is that regardless of income, geography, [or] educational attainment—which usually are markers for health outcomes—we found that actually it didn't matter when it came to Black women," Miranda said. "There's racism in our health care and biases that impact our care."

The state representative has also introduced several bills that would address maternal and infant health, though they don't explicitly say so. H 761 would implement policies around environmental justice; H 1517 aims to prevent mandatory minimum sentences of juveniles; and H 122 addresses adverse childhood experiences and childhood trauma. Asked about the connections between these bills, Miranda explained, "What we're really trying to do is address the root problems of some of the social ills we have in our communities."

"We don't live to be old because our zip codes are literally killing us," Miranda said.

Regarding maternal health, she said, "stress and PTSD of living in unsafe, unclean communities, where you don't have access to the type of prenatal care, postpartum care that you deserve, is leading women to pass away or their children not being at full term, right? So when you look at all the bills that I put forward, I see an interconnectedness between all of them with addressing and saving young people so that we can save them as adults."

## Measuring progress

With more than 80 bills introduced so far this year to address the maternal and infant mortality crisis, there are some clear trends. As noted above, a number of bills seek to expand access to doula care, to address implicit bias in the health-care system, and to establish maternal mortality review committees, which are bolstered by grants from the Centers for Disease Control and Prevention to "help standardize how maternal deaths are classified and accounted for across different states," as *Rewire.News* reported in March.

But at a glance, it may seem as if lawmakers are throwing everything against the wall to see what sticks. A bill in Georgia, SB 267, will license and regulate community midwives, while Minnesota lawmakers introduced a pair of bills aimed at bolstering child development.

Raena Granberry's tips for a safe and sacred birth include:

- **Trust your body.** "You don't need to be an expert, you don't need to have done a ton of research. If you feel like something is wrong in your body, you can sit there and demand to have all of the tests, all of the specialists, and things that you need, until you feel better."
- **Have a doula or birthing assistant**. "I always advocate for women to have a doula or some other type of birthing assistant who can always be there to advocate for you. Because what happens is, even with myself, I'm a strong advocate for myself and my health, but sometimes in that emotional state, physically, all of that, you can't really wrap your mind around every single thing and advocate for yourself to the level that you should. So you really need a birthing assistant, birthing partner, doula, somebody who can fully support you there."
- **Connect to the larger network**. "Nationally, we have the Black Mamas Matter Alliance, where you have Black women-led and run organizations around the nation that you can tap into that are absolutely committed to Black birthing persons—because we know all people experiencing these outcomes don't identify as women. So we have organizations that support all of that, and definitely tap into them because you're never alone with everybody that's working in this movement. There's so many people who are concerned, and care and want to ensure that you have a safe birth that somebody somewhere can help."

"On the one hand [this wave of legislation is] encouraging because this issue is getting more attention than it has in the past, dramatically more attention in some places," said Cynthia Pellegrini, senior vice president for public policy and government affairs at March of Dimes, a nonprofit organization working to improve the health of pregnant women and their infants. "On the other hand, there is so much going on and legislators are trying to go in so many different directions, that sometimes it's a little, not just confusing or overwhelming—it's sort of like we all need to take a deep breath here and figure out what are the best practices, what are the most appropriate ways to go on in different areas."

March of Dimes has been working with a number of states on their maternal and infant health legislation. Pellegrini noted that state lawmakers are in different phases of progress on the issue. Some states, like New York, Vermont, and Connecticut, have the basics in place and are "looking for the next big thing. Those are the states that are looking at things like doulas, that are looking at support for pregnant women, they are looking at training on implicit bias to help address disparities. They may also be looking broadly at things like social determinants, and saying, 'What do we need to think about with regard to housing? What do we need to think about with regard to economic support, things like paid family leave? How do we support working mothers and working families through this entire childbearing, child-rearing process?'" said Pellegrini.

And then there are other states that are in an earlier phase of development. These are the states "that are like, 'We just set up our maternal mortality review committee last year. It hasn't started working yet, [so] don't even talk to us about paid family leave because that's never going to fly," explained Pellegrini.

But even within the latter group, there are some unexpected opportunities. In Arizona, for example, Pellegrini says Republican Gov. Doug Ducey saw the March of Dimes report on maternity care deserts published last fall. The report identified 1,085 counties in the country that have no facilities that can provide for pregnant people—no OB-GYN or certified nurse midwife on staff. Such deserts "are everywhere," said Pellegrini. "They're in urban areas, they are in rural areas. They are all over, in practically every state in the union."

Ducey responded by including $2 million in his 2019-2020 budget for prenatal telemedicine care.

Pellegrini also noted that California offers an interesting model for other states to follow. "There are some states out there that say, 'Well, you know, we've got a very diverse population, or we have a lot of low-income people, or we have special challenges of one kind or another.' Well, guess what? Whatever you've got, California has got it too."

Despite those challenges, Pellegrini says the state has made progress on bringing down its preterm birth rate and maternal mortality rate. The state, however, continues to struggle with a gap in maternal mortality rates between Black and white women.

California lawmakers have stayed on the issue, something Pellegrini advises other legislators to emulate. "There is no silver bullet on reducing maternal mortality and infant mortality," noted Pellegrini. "It is a process and it is a sophisticated and multi-faceted problem that requires an equally complex solution to address all of the different pieces of it."

# "Somebody somewhere can help"

The sheer volume of bills show how ramped-up coverage of the issue has succeeded at catching the attention of lawmakers across the political divide. But one side effect has been the growing number of women who are approaching advocates concerned about pregnancy because they've heard some of the worst stories out there.

When asked what she tells Black people and families in her capacity as maternal and infant health program manager, Granberry said the first thing she says is: "You can and deserve to have a safe and sacred birth. It's absolutely possible for you."

"The best thing we can tell them is to trust your body, get a support system, have a doula/midwife/someone else who can help you navigate all of this, and then connect. Connect to the larger network," she said.

Granberry named Black Mamas Matter Alliance, which has raised awareness of the issue with its Black Maternal Health Week, as one such place where people can learn more about "Black

women-led and -run organizations around the nation that you can tap into that are absolutely committed to Black birthing persons—because we know all people experiencing these outcomes don't identify as women."

She added, "There's so many people who are concerned, and care and want to ensure that you have a safe birth that somebody somewhere can help."

*Brie Shea contributed to this reporting*.