



Executive Report

The State of Black Women In Texas: Maternal Mortality

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Introduction

She stood in the corner of her salon and cried. She knew it was time to go to the hospital and deliver her baby but she was scared. Dee had attended a Maternal Mortality community education event offered by The Afiya Center and knew that there were no protections for Black women when it comes to Maternal Mortality. Dee shared that she had health insurance, had a normal pregnancy, was healthy and had made all her prenatal visits. She was just scared. Scared that although she had done everything in her power to make sure she was safe and had a healthy pregnancy, she knew that when it came to delivering her baby and after, she could die and there was nothing she could do. Her life was in the hands of a health care system that did not listen, a provider that may not show up for her and a staff that may ignore her concerns and let her die.

The Afiya Center has actively worked to share healthcare information with the larger Black community; especially women who may be at risk for experiencing Maternal Health concerns. This *State of Black Women in Texas: Maternal Mortality* will be intersectional and will highlight the continued health disparities associated with Maternal Morbidity and Maternal Mortality in the state of Texas. The Afiya Center submits this Blackpage Report as a compilation of the results we have collected including personal stories from some of the families we have met over the last few years. We will also share recommendations that we believe will help save our community from experiencing the dreadful impact of Maternal Mortality and Maternal Morbidity. As said by our Executive Director, “We can’t watch Black women die”. We must work as a community to end the loss of our Black mothers.

Overview

It seems like yesterday that The Afiya Center held The State of Black Women in Texas and released a report that held our views on the impact of HIV and Maternal Mortality. We are releasing this Blackpage report because we want to offer some additional information on Maternal Mortality while also introducing ways the community can engage their own lives, their community and their elected officials. The Afiya Center realizes that there are many health disparities that impact the lives of Black women, but we are actively focusing on Maternal Mortality because of its impact on Black mothers and the entire Black community. The loss of each mother impacts so

many more individuals than just that one woman. The loss is significant to that woman's family as well as her entire community.

Situating the national climate in which Black women suffer overwhelmingly poor health outcomes and inequities, Dr. Avis Jones Weever stated the following in the 2016 Black Women's Report, "Black women continue to suffer, now facing a reality [in] which they are not only likely to find themselves on the wrong side of health statistics, but also at the mercy of state political actors..."¹ The same is true for Black women in the state of Texas and in Dallas County. Although Black women's health disparities remain unacknowledged as a political priority for most in Texas, they are a priority to The Afiya Center. We hope to show why they should be a priority to you. We endeavor to share that the answers are in fact complex while also being quite simple. As Black folk, the stressors of everyday living impact our health and put us at great risk for experiencing negative health outcomes. Yes, life is stressful for women and for the poor. However, Black folk have the compounding of these realities that is made more challenging because of racism and its manifestation as stress in our everyday lives. This reality manifests itself as Maternal Health risks which can end in Maternal Mortality.

Maternal Mortality

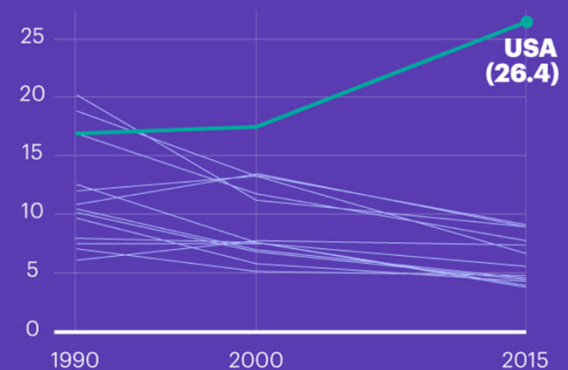
We have a maternal health crisis in the US, the state of Texas and sadly Dallas is no exception. According to the *March of Dimes* stats, 'our rate of maternal death is one of the highest among developed nations and it's been increasing over the past 25 years. What is even more disturbing is that Black women are three times more likely than other women in the U.S. to die from pregnancy-related causes.

In 2016 a report was released that shared that Black women were approximately 40% per 100,000 live births to experience maternal deaths in the state of Texas. There was much news coverage and alarm among health officials and policymakers. Texas has a maternal death rate worse than any country in the developed world. Earlier this year, the Department of State Health Services released a study that says "Texas' maternal mortality rate for 2012 was actually much lower, potentially ranging from 14.6 to 18.6 deaths per 100,000. The national average was 15.9 per 100,000 in 2012. (Which is shocking in itself when compared with countries like Germany and Canada, with rates of 7 and 8 per 100,000, respectively.)"⁴

For some, this news suggests that maternal mortality is not a problem but the physicians who care for pregnant women, the women who are experiencing maternal morbidity and the family members that have lost a loved one know differently. Patrick Ramsey, MD, a San Antonio obstetrician-gynecologist and maternal-fetal medicine specialist says, "I think it's important to not let our guard down, thinking, 'Oh, the numbers are wrong, and we're actually doing well'... Women are still dying."⁵ Furthermore, Shana Combs, MD a Fort Worth OB-Gyn who chairs the Texas Medical Association's

Maternal deaths in the U.S. are increasing as they decrease in other countries.

Deaths per 100,000 live births:



Compared to:

UK, Portugal, Germany, France, Canada, Italy, Spain, Australia, Ireland, Sweden, Denmark, Finland and the Netherlands.

Source: The Lancet
Credit: Rob Weychert/ProPublica

WE CAN'T WATCH BLACK WOMEN DIE.

MARSHA JONES, EXECUTIVE DIRECTOR
THE AFIYA CENTER

Committee on Reproductive, Women’s and Perinatal Health, “pointed out that the data in the original 2016 study were always considered suspiciously high and were expected to be revised. But she said even the updated data show that certain groups of women – especially African-American women and those over the age of 35 – still face extremely high maternal death rates.”⁶

One of our supporters shared her story of both Maternal Morbidity and the death of her sister after having her son. On November 8, 2016, she welcomed a beautiful baby girl in to the world. Her and her husband were extremely excited. She began hemorrhaging unknowingly and loss over 2 liters of blood. She was rushed into surgery and needed four blood transfusions. She shared it took four to five hours to stop the bleeding. In the process she was told she would lose her uterus but thankfully she reports, she was able to keep it. Finally, five days later, she and the baby were released from the hospital. When she got home, she began pumping breast milk and was actively getting used to the new addition to her family. Three weeks after her daughter’s birth, she noticed her heart racing. She asked her husband to listen. He agreed it was fast, but they attributed it to just having a baby. She states she began coughing. On the evening of Christmas, she recalls she had a hard time sleeping, she was gasping for air lying down. On the morning of December 26th, she called her dad and he said it sounded serious and suggested that she go to the hospital. After the lab work and receiving a Lasix to urinate any extra fluid, she felt better. She learned that she had an enlarged heart and they would need to run test overnight.

The next day, December 27th, they brought up the echo machine just to base things off the history they saw in my file. You see, my oldest sister died of a cardiac arrest from heart failure, and also three months after having her 2nd baby just three years before. The cardiologist further explained that her heart was functioning at 15 to 20% and further told her that she was in heart failure and that this was the same illness that caused the death of her sister just three years earlier. The news was quite shocking, but she was given a 50/50 chance. A year later the tools they gave her are still working and her heart ef is up to 40%.⁸ Ms. Henderson was fortunate but her sister not so. This families’ story speaks to what Dr. Hollier stresses about maternal mortality. Dr. Hollier stresses that “all but a handful of maternal deaths and severe illnesses are preventable. She said 41% have a good to strong chance of prevention, while 48% have some chance of being prevented. Only 11% have no chance at all.”⁹

**BLACK WOMEN
ARE 243%
MORE LIKELY**

to die from pregnancy-related causes than white women in the U.S.

*According to the
Department of State
Health Services (DSHS):*

*White women have a
maternal death rate of
13.6 per 100,000*

*Black women have a
maternal death of rate
27.8 per 100,000*

*For women over 35, the
rate is 32.2 per 100,000⁷*

We understand that maternal health care, like the rest of care, have no entitlement and therefore can only be obtained on the basis of ability to pay. Medicaid has historically covered poor women and most insurance plans cover maternal health. The Affordable Care Act made many who are not in either of those categories eligible for coverage that now is in jeopardy of being lost if it is overturned. This is especially true in Texas since there is no expansion of Medicaid. Even in the deliberations that ultimately led to the blockade of the Republican’s initial health care bill (American

Health Care Act), the question about whether insurance providers should be required to cover prenatal care was something that had not yet been asked.¹⁰ Dr. Lisa Hollier, Director of the Maternal Mortality and Morbidity Task

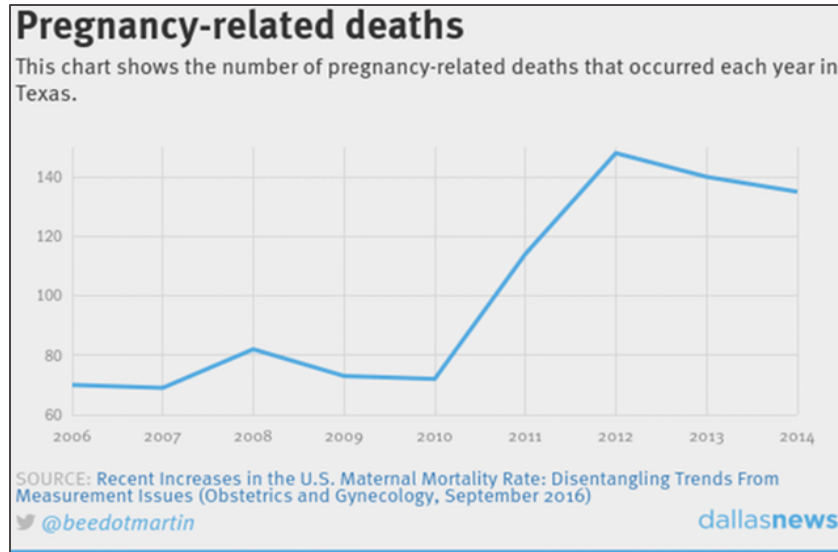
Force, says, “We need to work hard to make sure that the issue of maternal mortality is not forgotten. The problem has been here for a while, and I think sometimes when problems are chronic, they can be easier to ignore.”¹¹

The trends in Texas, however, mirror national trends. Chronic diseases seem to be the source of blame; especially comorbid conditions that make pregnancy more complicated, such as Type II diabetes, obesity and hypertension. There is also a large racial disparity in the world of maternal deaths. State statistics demonstrated a steady climb in such deaths beginning in approximately 2003 according to the Joint Biennial Report produced by the Maternal Mortality and Morbidity Task Force and the Department of State Health Services.¹² Maternal deaths in Texas have been mentioned sparingly during the legislative session, overshadowed by issues such as child welfare, additional unnecessary abortion restrictions, the so-called ‘bathroom bill’ and sanctuary cities.

After some squabbling between state leaders killed numerous bills, including legislation on maternal mortality, Gov. Greg Abbott called a special session. At the behest of a junior representative, Governor Abbott named the crisis as one of the agenda items lawmakers could tackle. A bill from state Sen. Lois Kolkhorst, R-Brenham, to offer specific instructions and expand the lifetime of the Maternal Mortality and Morbidity Task Force was signed in to law by Abbott in August. . .Houston Democrat Shawn Thierry co-authored Kolkhorst’s bill in the House and was a vocal proponent of the issue. During debates on the bill, she frequently shared her own experience with childbirth and said she experienced complications with an epidural when she had her daughter in 2012. Thierry was particularly concerned with statistics that showed Black women have a higher risk of maternal death than other ethnic groups. The new state study had the same findings. For Thierry, the report still revealed that the rates of mortalities for Black women remain higher than other groups. We should keep moving the ball down the field in order to provide the best care for our Texas moms and families.¹³ We are hopeful that the trend to prioritize maternal mortality, which had some legislative success during the Special Session, will continue in the 86th Legislative Session. There is currently legislation focusing on Medicaid expansion from 60 days to 1 year after pregnancy, creating a Maternal Mortality registry and auto enrollment in Healthy Texas Women.

Here is a bit of history as to how we got here. For many years, Texas maintained reasonable investments in family planning services. In 2007, Texas joined with other states in the U.S. in expanding Medicaid eligibility, specifically for contraceptive and related care, by creating the Women’s Health Program for low-income adult women. (“Low income” is defined as income below 185% of poverty.) The state took several major steps in 2011 to reverse course, motivated largely by the goal to put Planned Parenthood out of business in Texas. First, the state moved to ban Planned Parenthood health centers from participating in the Women’s Health Program, based solely on the fact that these centers were associated with other sites where abortions were provided. Planned Parenthood Centers had been serving about four in 10 women in the program statewide, and some sites served as many as eight in 10 women within their service areas.¹⁴ The Obama administration made clear that Texas’ action violated federal law by discriminating against qualified providers. Governor Rick Perry remained insistent, which led to the state of Texas losing all federal support for the Women’s Health Program - \$9 for every dollar spent. As of January 2013, the program is an entirely state run effort with a more limited provider network and significantly fewer enrollees, and delivered thousands fewer contraceptive and related services during the first months of operation.¹⁵

Also in 2011, the legislature reallocated two-thirds of the budget for the state’s family planning program (separate from the Women’s Health Program) to other efforts, which resulted in an annual budget of approximately \$19 million. In addition to this reallocation, Texas lawmakers tiered types of providers that could receive these remaining funds. Health departments have top priority, followed by community health centers. Specialized family planning centers are disadvantaged as they are only able to apply for any funds that remain. According to the Texas Department of State Health Services, in 2013, the state’s family planning program served less than one fourth of the women it had served in 2011.¹⁶



According to researchers at the Texas Policy Evaluation Project, dozens of clinics closed in 2012, about half of them family planning – focused sites; dozens of the remaining open clinics have had to reduce their hours, patient loads and service delivery to accommodate their smaller budgets.¹⁷ In addition to limiting family planning

Government Duties to Ensure Safe and Respectful Health Care

Respect: Governments must refrain from interfering, either directly or indirectly, with women's access to the health care services they need, or to the underlying determinants of health (safe communities, affordable housing, employment, social support, etc....)

Protect: Governments must prevent third parties from interfering with the right to safe, respectful maternal health care and must investigate and sanction those who violate this right.

Fulfill: Governments must

services, the cuts have also limited Texans' ability to obtain related services, including HIV/STI tests, Pap tests and other preventive reproductive care, from trusted providers who specialize in the administration of these sensitive and confidential services. There is no measure of a direct link between abortion clinic regulations and maternal mortality. Given that the definition of maternal mortality is the death of a woman due to conditions that are directly related to pregnancy, it can be reasonably inferred or at least correlated that limiting access to abortion forces women to remain at risk for maternal death from conditions that evolve as a pregnancy continues. Hence, there is likely a relationship with abortion access.¹⁸ Furthermore, the Lancet reports that during period from 1990 to 2013, the most common causes of maternal death are postpartum bleeding (15%), complications from unsafe abortion (15%), hypertensive disorders of pregnancy (10%), postpartum infections (8%), and obstructed labor (6%). Other causes include blood clots (3%) and pre-existing conditions like HIV (28%).¹⁹

In response to public outcry, in 2013, legislators attempted to restore some of the lost funding for the state's family planning program. Legislators also created a new program to deliver primary care to women aged 18-65. However, there is some skepticism about how much progress can be regained because of the extreme disruption lawmakers caused to the delivery of family planning care and because the resources have not been completely restored.

At the same time, the cycle for the Title X grant administered by the state came to an end in 2013, which required the state to reapply and created the opportunity for other entities to apply. The Title X grant is now administered by the Women's Health and

Family Planning Association, which means the tiered provider requirement is no longer relevant. This change may be particularly beneficial in more remote, economically depressed communities such as the Rio Grande Valley, where after four Planned Parenthood health centers closed in the wake of budget cuts, one has been able to reopen with the restoration of Title X support.²⁰

“This confirms what we feared – that many of these deaths could be prevented,” said state Rep. Armando Walle, D-Houston, the House author of the 2013 bill that created a Department of State Health Services Maternal Mortality Task Force and charged it with producing biennial reports and recommendations. “It’s a travesty that this is happening.”²¹ The Maternal Mortality and Morbidity Task Force (MMMFT) discovered trends that were more alarming than the maternal death rates, particularly the severe maternal morbidity rates. The MMMFT indicated the complications were “so serious that more mothers might have died without major medical and technological intervention or sheer luck. Such cases were more common than deaths and far more common among African American women.”²² The reasons for the deaths and the severe maternal morbidity are complex. Researchers point to numerous contributing factors. For Texas, the main causes for the deaths have been cardiac problems followed by substance use and mental health issues. For severe maternal morbidity, the main causes are hypertension, heart problems, obesity and drug overdoses.

Many women’s health advocates point to the 2011 state cuts to Planned Parenthood and other family health clinics along with the lack of Medicaid expansion. Nationally, experts say multiple causes such as obesity; age and inequitable access to health care all play a role. But the overall maternal mortality rate and the actual number of maternal deaths remain uncertain, as does the underlying reason for the sudden jump in 2011 and 2012. Among the challenges encountered by task force members as they try to find answers are recent changes aimed at keeping better track of maternal deaths, such as checked boxes on death certificates noting that a woman was recently pregnant. These changes have led to confusion and more inaccuracies. “The short answer is, I don’t know” what caused pregnancy-related deaths to rise sharply in that period, Hollier said. “The longer answer is I think it’s unlike that there is a single explanation. The problem is complex, and the increase is likely due to a multitude of factors.”²³ Marian MacDorman, who co-authored the 2016 Obstetrics & Gynecology study questioning Texas’ alarming increase in maternal mortality, was pleased with the latest study in Texas – but she cautioned in an editorial that there are still many questions unanswered. As an example, since the study only focused on 2012, it is still unclear at what are maternal mortality truly increased from 2010 to 2012 and why. MacDorman also cast doubt on the true mortality rate in a follow-up study published in January in the journal *Birth*. Again, in the past study and the one released earlier this year, Black women were still severely disproportionately affected.²⁴

An October 2017 article in the Los Angeles Times on high rates of Black maternal mortality rates stated Texas has the largest number of uninsured people in the United States, and there have been substantial cuts to women’s health programs that offer family planning and other routine services to low-income women, including screening for diabetes, hypertension and cervical cancer, which if left untreated could play a role in maternal deaths. The article went on to further state that Black Texan women had the highest rate of being hospitalized for hemorrhaging and blood transfusions, common causes of maternal deaths in the state of Texas.²⁵

No matter the cause, the issues associated with maternal mortality and severe maternal morbidity are of great concern. “Maternal Mortality is a human rights crisis in the United States. The 2014 *Trends in Maternal Mortality* report issued jointly by WHO, UNICEF, UNFPA, the World Bank and the UN Population Division shows that the maternal mortality ratio (MMR) in the U.S. increased by 136% between 1990 and 2013, from 12 to 28 maternal deaths for every 100,000 live births.”²⁶ In the new study, the rate for Black women is still twice the overall rate of 14.6% per 100,000 live births at 27.8% per 100,000 live births.²⁷ The causes of maternal mortality are multiple and complex²⁸ but the problem must be understood in the context of pervasive racial and socioeconomic disparities.²⁹

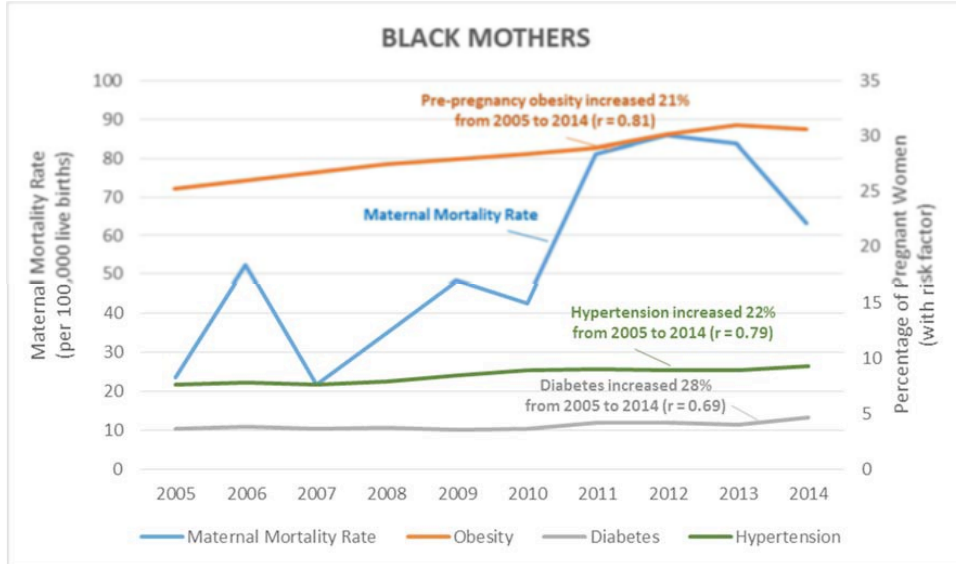
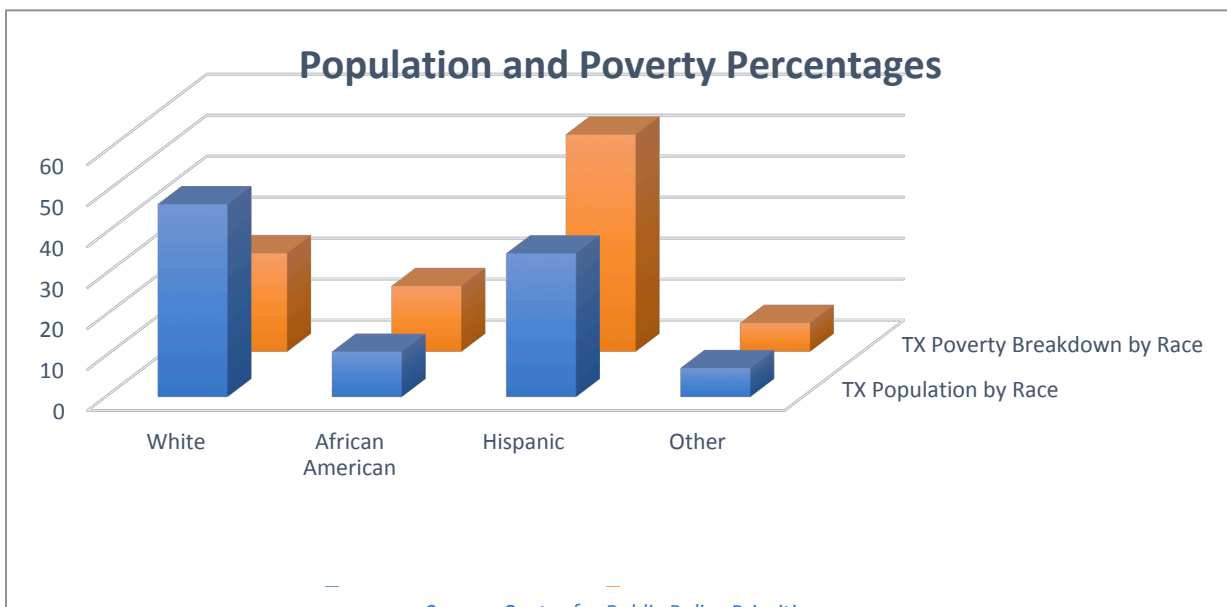


Photo: Maternal Mortality and Morbidity Task Force

Economic Disparities

Socioeconomic factors and geography also drive disparities. Women of color comprise more than half the women in the U.S. women living in poverty³⁰ and the poverty rate for both Black women and Latinas is three times that of Whites.³¹ In the state of Texas, Black women and other women of color represent 72.4% of those in poverty. In addition, more than half of the female-headed households in Texas are living in poverty.³²

Poverty has a very negative impact on health disparities. Mothers living in poverty are more likely to have limited access to appropriate healthcare. Seventeen percent of Texas women aged 18 and older live in poverty; more than the surrounding of Denton and Collin. Black women are experiencing more poverty than their white counterparts. Seventy-eight percent of Texas’ women aged 18 to 64 have health insurance coverage, which is below the national average for women (89.4%). Fewer than three in four women in Dallas County have health insurance (74%). According to parent reports, people living in poverty experience higher rates of chronic illness such as asthma, diabetes and heart disease. Children born into poverty are more likely to live in poverty and less likely to have consistent employment as adults.³²



Source: Center for Public Policy Priorities

While women in the state of Texas have access to Medicaid during pregnancy, they lose access to coverage shortly after having their child. A lack of postnatal care is also a contributor to maternal mortality. Some lawmakers are quick to point out to the legislature funding of Health Texas Women Program in July of 2016. The program focuses on helping women receive cancer screenings, post-partum depression screenings, family planning services, STD testing, contraceptives and more. Legislators also point out that low-income mothers are auto-enrolled in the program just as their Medicaid benefits expire 60 days after giving birth, saving them from a lapse of coverage. Neither auto-enrollment nor the Healthy Texas Women Program has turned the tide in maternal mortality in Texas. Strengthening continuity of care from obstetric to primary care is one way to ensure risks continue to be assessed and managed so that women can enter pregnancy in optimal health, subsequently increasing likelihood of a positive pregnancy and birth outcomes. The task force found that nearly 60% of maternal deaths occurred after 42 days postpartum to 52 weeks after delivery when, for many women, access to health care is limited.³³ The awareness that more than half the deaths occurred 60% past 42 days, when the MMMTF looked at the data again, they did not consider deaths that happened past 42 days of delivery.³⁴

The 2012 Report of the Agency for Healthcare Quality and Research found that access to health care is decreasing, especially for people of color and low-income groups. As a result, low-income and uninsured Black women are already at high risk of maternal death by the time they become pregnant. Compared to white women, Black women and other women of color are more likely to struggle with diabetes, obesity, heart disease and hypertension. These conditions are exacerbated during pregnancy and are a driving force behind preventable maternal deaths. The Texas Department of State Health Services shares that an analysis of Texas data for all mothers and for each racial/ethnic group shows that these chronic disease risk factors are highly related with maternal mortality, such that increased pre-pregnancy obesity diabetes, and hypertension are each significantly correlated with an increased maternal mortality rate.³⁵

HEALTH CARE CRISIS

Inequalities affect a black woman's health before, during and after her pregnancy.

ACCESS:

Black women are less likely than white women to have health insurance, preventing them from getting crucial care.

QUALITY OF CARE:

Black women are more likely to visit hospitals with a lower quality of care and a higher rate of life-threatening complications.

TREATMENT:

Black women receive less medical attention than white women with the same symptoms.

One of the more significant disparities identified as a result of all the focus on maternal mortality is that while poverty, living conditions, age, and pre-existing conditions do impact maternal death rates, the impact of racism is also linked to maternal mortality. In an emailed statement made in recognition of the first Black Maternal Health Week, Dr. Aisha Wagner of the Physicians for Reproductive Health stressed the systemic inequalities that contribute to high rates of Black maternal mortality.

The numbers give us just a glimpse of the unjustifiable disparities that exist: in the United States today, pregnancy-related deaths for Black women are three times more likely than for White women. This is one of the widest racial disparities across health-care. As advocates and health care providers work to close this gap, it's critical to shed light on the reasons the gap exists to begin with: structural, institutional and interpersonal racism. While health care technology and access have been improving, these improvements exist mainly for white patients, in turn, this widens the maternal health gap. From unconscious biases among health care providers to the health repercussions of living a lifetime experiencing structural and interpersonal racism.³⁶

care providers to the health repercussions of living a lifetime experiencing structural and interpersonal racism.³⁶

Socio-Economic Status

As access to education has increased, Black women have increased their resources. According to the 2017 State of Black America report released by the National Urban League, Black America has seen a modest increase in its economic position. The modest increase of Black America at a national level was matched by the state of Texas.

Blacks in Texas showed a 4.1% increase in overall income. While we acknowledge the increase for Blacks compared to their white counterparts, the income increase is less than modest. Looking at the Texas cities examined in the report, there is an approximate \$30,000 difference in wages for Blacks compared to Whites.

Even with the increase in overall income, we remain behind our White counterparts. To put a dent in the health disparities that plague black women, we need a more equitable piece of the current economic reality in Texas. We do not want it as an entitlement. We want the chance to participate in equitable pay.

Summary

We believe every woman deserves the right to health care. Taking a human rights-approach is one way the legislature, constituents, and community stakeholders in Texas can work together to address the health disparities noted in this report.

A human rights-based approach to responding to health disparities is especially critical to ensuring equality and non-discrimination. Its purpose is not limited to avoiding isolated clinical pathologies, like morbidity and mortality. Instead, this approach empowers all women to claim their full set of human rights in order to live the healthiest lives possible.³⁰

A human rights-based approach recognizes that discrimination plays a role in undermining women and girls' access to health care. It also requires attention to groups that are experiencing disparities.

A human rights-based approach to maternal health in the U.S. therefore requires the government to directly confront racial discrimination in the context of maternal health, and to specifically address the harm and inequalities experienced by Black women during pregnancy and childbirth.³²

All women need the resources, opportunities and support that will enable them to protect their human right to health and life and to make the best decisions for themselves and their families.

These needs are important as a woman chooses to become a parent and remain important throughout her life and the life of her child. At a minimum, protecting her rights requires she have access to comprehensive reproductive health services and information, freedom from discrimination and bias, and living conditions that support health rather than risk. The same is true for responding to all health disparities. There is a connection to the concomitant health issues that impact women to their being able to parent, not parent and live to raise the children they have.

Finally, we must establish public health practices that improve maternal health and use measures that empower women.³³ We believe implementing a framework that values the human rights of women can be done through administrative measures, legislation, allocation of resources and comprehensive policies and programs that support women and their health. A human rights-based approach to maternal health and other health disparities incorporates principles and methodologies into government policy and practice. By integrating mechanisms that promote accountability, transparency, participation, empowerment, non-discrimination, universality, and equity, governments can ensure the health policies they create are meeting people's core needs and respecting their human dignity.

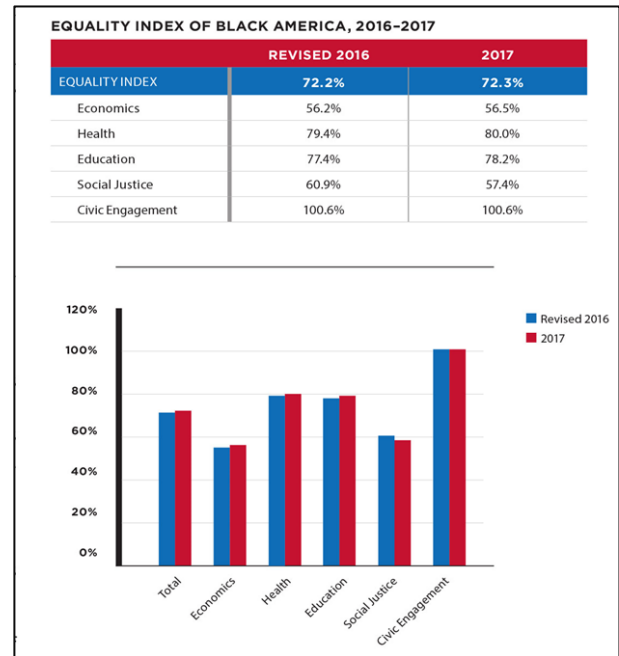


Photo: State of Black America 2017, soba.iamempowered.com/2017-report

As a community partner and community stakeholder, we are willing to work with our elected officials to identify policies in need of reform, propose policy solutions rooted in human rights and hold our government accountable to human rights standards. Understanding that our priorities will vary based on the current needs of the state of Texas, we believe we should give effect to the right to health through the measures listed below:

Improve Health Care Access & Quality

- Remove existing barriers to care during and after pregnancy and throughout the lifespan of a child
- Develop a more diverse health care workforce that is trained in human rights standards and engaged in generating solutions to maternal health problems
- Ensure that every woman receives quality care, regardless of the site or setting of care
- Facilitate greater availability of obstetric care and family planning services

Address Underlying Determinants of Health

- Prioritize social support for Black women and Black communities
- Address nutrition and food security for pregnant women
- Ensure adequate, safe housing and safe communities
- Facilitate healthy occupational and environmental conditions

Eliminate Discrimination in Law and Practice

- Reform discriminatory laws and policies that impact Black women's health and well-being
- Take proactive measures to address discrimination in practice, particularly for groups that have faced historical discrimination or injustice
- Address racial bias, stereotypes, stigma, discrimination, and disrespect in health care encounters, specifically
- Eliminate disparities in maternal health safety and survival outcomes for Black women

Ensure Accountability

- Collect and disseminate adequate, disaggregated data on maternal mortality and morbidity
- Set targeted goals and benchmarks for improved maternal health outcomes
- Design state plans to improve maternal health that consider the specific needs of vulnerable populations, especially Black women and girls

A Human Rights Based Approach to Improving Maternal Health³²

Accountability: Governments must create mechanisms of accountability to enforce the right to safe and respectful maternal health care, including monitoring and evaluating policies and programs, taking corrective action when violations are found, and implementing remedies for women and families.

Transparency: People should have access to information that enables them to make decisions about their health care choices or helps them to understand how decisions affecting their health are made. This includes transparency in budgeting and funding allocation.

Participation: All people have a right to participate in decision-making processes that affect their right to safe and respectful maternal care, including decisions about government policies and distribution of health resources.

Empowerment: Women and girls must be valued and engaged as agents and rights-holders when it comes to decisions or actions that affect their sexual and reproductive lives.

Non-Discrimination: The right to safe and respectful care should be ensured without discrimination of any kind, regardless of whether the discrimination is committed purposefully or results from seemingly neutral policies and practices that have a discriminatory effect on Black women.

Equity: Health care resources, goods, and services must be distributed and accessed based on a model of equity, which is based on need and remedying historical injustice—

Universality: Health care goods and services must be available to everyone, without exception or distinction based on any discriminatory grounds.

- Develop policy solutions aimed at the conditions that make it likely for maternal health violations to reoccur
- Provide remedies for violations of the right to access safe and respectful maternal health care

Include and Empower

- Encourage human rights education and outreach to Black women regarding their sexual and reproductive health and rights
- Involve Black women, especially at the community level, in maternal health policy design, budgeting, monitoring and review processes
- Build partnerships between government, civil society, and other key stakeholders to assess maternal health needs and devise solutions³⁴

Improving health outcomes alone does not solve the persistent health disparities of Black women. We cannot take for granted that constituents understand access. The health of Black women and their families is impacted by all the social determinants associated with health. With these strategic interventions, we believe we can work together to ensure that no Black woman is disposable and that the state of Texas is a place where Black women and their families are able to thrive without the impact of systemic violence.

As of the writing of this report, The Afiya Center has formed a Doula collective. We have held a Full Spectrum Doula training in Dallas, TX. This is one of the ways we hope to respond to Maternal Mortality in the State of Texas. We will not watch Black women DIE!

References

- ¹ Jones-De Weever et al., Black Women's Roundtable, *Black Women in the US 2017: Moving Our Agenda Forward in a Post-Obama Era, 2017*, 4th Annual Report.
- ² Parker, Willie, Personal Interview, May 2017.
- ³ Rewire, *Texas Legislators 'Ignore Spiking Black Maternal Mortality Rates*, March 14, 2017, 5:22, Teddy Wilson, rewire.news/article/2017/03/14/texas-legislators-ignore-spiking-black-maternal-mortality-rates/.
- ⁴ New York Times, *Maternal Mortality Rate in US, Defying Global Trend Study Finds*, Sabrina Tavernise, <https://nytim.ms/2cShjiS>.
- ⁵ *Maternal Mortality and Morbidity Task Force and Department of State Health Services (MMMTF), Joint Biennial Report*, July 2016, www.dshs.texas.gov/mch/maternal_mortality_and_morbidity.shtm.
- ⁶ Ku LC et al., *Deteriorating access to women's health services in Texas: potential effects of the Women's Health Program affiliate rule*, Policy Research Brief, No. 31, Washington, DC: George Washington University, 2012, http://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1000&context=sphhs_policy_ggrchn.
- ⁷ Janek K et al., *Presentation to Senate Committee on Health and Human Services: Texas women's health and family planning programs*, 2014, <<http://www.hhsc.state.tx.us/news/presentations/2014/022014-2014>.
- ⁸ Texas Department of State Health Services, Council agenda memo for State Health Services Council, 2013, <http://www.dshs.state.tx.us/council/agendas/Nov2013/4c-Family-Planning.pdf>
- ⁹ White K et al., *Cutting family planning in Texas*, *New England Journal of Medicine*, 2012, 367 (13):1179-1181.
- ¹⁰ Parker, Willie, Personal Interview, May 2017.
- ¹¹ Guttmacher Institute, *The State of Sexual and Reproductive Health and Rights In the State of Texas: A Cautionary Tale*, March 2014, <https://www.guttmacher.org/gpr/2014/03/state-sexual-and-reproductive-health-and-rights-state-texas-cautionary-tale>.
- ¹² Houston Chronicle, Todd Ackerman, August 22 2016, Updated: August 23, 2016, 12:19pm, Report: *Black Women in Texas Face the Greatest Risk from Pregnancy Related Death*, www.houstonchronicle.com/news/health/article/Report-Black-women-in-Texas-face-the-greatest-9178447.php.
- ¹³ Mother Jones, *Maternal Mortality in Texas is a "National Embarrassment"*, Nina Martin, ProPublica, August 24, 2016, 1:35pm EDT, <http://www.motherjones.com/pring/312331>.
- ¹⁴ Mother Jones, supra note 13
- ¹⁵ World Health Organization (WHO), et al., Trends in Maternal Mortality: 1990 to 2013, 43(2014), http://apps.who.int/iris/bitstream/10665/112682/2/9789241507226_eng.pdf?ua=1 (hereinafter WHO Trends in Mortality). See also Nicholas Kassebaum et al., *Global, Regional, and National Levels and Causes of Maternal Mortality During 1990-2013: A Systemic Analysis for the Global Burden of Disease Study 2013*, *The Lancet* (May 2, 2014), [http://dx.doi.org/10.1016/S0140-6736\(14\)60696-6](http://dx.doi.org/10.1016/S0140-6736(14)60696-6).
- ¹⁶ Gaskin, Ina May, *Maternal Death in the United States: A Problem Solved or a Problem Ignored?*, 17 J. Perinatal Edu., 9-13, (2008), [http://www.ncbi.nlm.nih.gov/prnc/articles/PMC2409165/pdf/JPE170009/pdf](http://www.ncbi.nlm.nih.gov/prnc/articles/PMC2409165/pdf/JPE170009.pdf); Francine Coeytaux et al., *Maternal Mortality in the United States: A Human Rights Failure*, 83 *Contraception*

189-93 (2011), <http://www.arhp.org/UploadDocs/journaleditorialmar2011.pdf>; Berg Cynthia et al., *Pregnancy-Related Mortality in the United States, 1998 to 2005*, 116(6) *Obstetrics & Gynecology* 1302-09 (2010), <http://www.cdph.ca.gov/data/statistics/Documents/MO-CAPAMR-PregnancyRelatedMortality-Berg2010-1998-2005.pdf>.

¹⁷ Nat'l Women's Law Ctr., *Poverty Rates by State, 2012* (Sept. 2013), http://www.nwlc.org/sites/default/files/pdfs/final_compiled_state_poverty_table_2012.pdf.

¹⁸ Farah Ahmad & Sarah Iverson, *The State of Women of Color in the United States*, *Ctr for Am. Progress*, 12(Oct. 2013), <http://www.americanprogress.org/wp-content/uploads/2013/10/StateofWomenColor-1.pdf>.

¹⁹ Center for Public Policy Priorities, http://www.forabettertexas.org/images/EO_2014_ACSPovertyIncome_Charts.pdf, US Census Community Survey Data.

²⁰ MMMTF, *supra* note 5, 16.

²¹ Texas Department of State Health Services (TXDSHS), *Black women and HIV in Texas*.pdf.

²² Texas Department of State Health Services (TXDSHS), *Black women and HIV in Texas*.pdf.

²³ Texas Department of State Health Services (TXDSHS), *Black women and HIV in Texas*.pdf.

²⁴ www.BWHI.org/breastcancer

²⁵ Adapted from *Human Rights Council*, Rep. of the Office of the United Nations High Commissioner for Human Rights on Preventable Maternal Mortality and Human Rights (14th Sess., 2010), para. 12, U.N. Doc. A/HRC/14/39 (2010).

²⁶ CDC Data Visualizations: Cancer Burden: Dallas County, Texas.

²⁷ www.BWHI.org/health-matters

²⁸ www.BWHI.org/health-matters

²⁹ Texas County Elects Black Woman Sheriff and Votes for Trump, *The Associated Press*, Nov12, 2016, fortune.com/2016/11/12/zena-stephens-texas-sheriff/

³⁰ Universal Declaration of Human Rights, adopted Dec. 10, 1984, art. 3, G.A. Res. 217A (III), U.N. Doc. A/810 at 71 (1948); International Covenant on Civil and Political Rights, adopted Dec. 16, 1966, art. 6, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171(entered in force Mar. 23, 1976); Convention on the Rights of the Child, adopted Nov. 20, 1989, art. 6, G.A. Res. 44/25 Annex. U.N. GAOR, 44th Sess., Supp. No. 49, U.N. Doc. A/44/49 (1989) (entered in force Sept. 2, 1990); Convention on the Rights of Persons with Disabilities, adopted Dec. 13, 2006, art. 10, G.A. Res. A/RES/61/106, U.N. GAOR, 61st Sess., U.N. Doc. A/61/611 (entered into force May 3, 2008).

³¹ Center for Reproductive Rights, *Advancing Maternal Health As A Human Rights Issue*, *Black Mamas Matter: A Toolkit for Advancing the Human Right to Safe and Respectful Maternal Health Care*.

³² Adapted from the following sources: National Economic and Social Rights Initiative (NESRI), *What are the Basic Principles of the Human Rights Framework?*, <http://www.nesri.org/programs/what-are-the-basic-principles-of-the-human-rights-framework>; Human Rights Council, Technical Guidance, *supra* note 26, Center for Health and Gender Equity (CHANGE), *The Right to Safe Motherhood: Opportunities and Challenges for Advancing*

Global Maternal Health in U.S. Foreign Assistance, 10-13 (2015),
http://www.genderhealth.org/files/uploads/change/publications/The_Right_to_Safe_Motherhood_.pdf.

³³ *Human Rights Council*, Technical Guidance, *supra* note 26

³⁴ Center for Reproductive Rights, *Advancing Maternal Health As A Human Rights Issue*, *Black Mamas Matter: A Toolkit for Advancing the Human Right to Safe and Respectful Maternal Health Care*, *supra* note 27.