CREATING HEALTH EQUITY & JUSTICE IN REPRODUCTIVE HEALTH:

A WAY FORWARD FOR CLINICIANS

Madeline Y Sutton, MD, MPH, FACOG
January 18, 2023
Dept of OB/GYN, Morehouse School of Medicine
Founder & CEO, One Brain 4Health

OVERVIEW

- How did we get here?/Historical context of systemic racism in reproductive health
- Defining sexual and reproductive justice and social determinants of health
- Contributing factors and conceptual models
- Reproductive disparities data
- Maternal mortality, contraception and abortion access
- What can we do to move toward health equity?

LEARNING OBJECTIVES

- Describe historical context of racial/ethnic disparities in reproductive health and how it relates to systemic racism in healthcare
- Describe racial/ethnic gaps in common reproductive health measures
- List 3 action steps that you can implement to help improve reproductive health outcomes

CME INFORMATION

- Physician Accreditation Statement

  Curi is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

- Physician Credit Designation

  Curi designates this live activity for a maximum of 1.0 *AMA PRA Category 1 Credit*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

- Instructions to Receive Credit

  In order to successfully complete the activity, participants must participate in the live activity, complete an activity evaluation, and claim credit commensurate with their participation in the activity.

CME INFORMATION

- Contact Information
  - For information about the accreditation of this program, please contact the Curi CME Team at 800.662.7917 or at CMETeam@curi.com.
- Disclosure of Relevant Financial Relationships
  - Curi adheres to the policies and guidelines, including the Standards for Integrity and Independence in Accredited CE, set forth to providers by the Accreditation Council for Continuing Medical Education (ACCME) and all other professional organizations, as applicable, stating those activities where continuing education credits are awarded must be balanced, independent, objective, and scientifically rigorous. Curi requires all persons in a position to control the content of an accredited continuing education activity to disclose all financial relationships with any ACCME-defined ineligible company within the past 24 months. All financial relationships reported that are identified as relevant by Curi are mitigated in accordance with the Standards for Integrity and Independence in Accredited CE in advance of delivery of the activity to learners. The content of this activity was thoroughly vetted by Curi to assure objectivity and that the activity is free of commercial bias.

CME INFORMATION (CONT.)

All relevant financial relationships have been mitigated by Curi.

The following individuals had no relevant financial relationships to disclose:

- Madeline Y Sutton, MD, MPH, FACOG – *Speaker*
- Kahlia Keita, MA, JD, Advisor, Curi – *Planner*
- Tamara Johnson, BSN, RN, CPHRM, RHIA, Program Director, Clinical Risk Management and Patient Safety, Curi – *Reviewer*
- Sharon Nichols, BSN, RN, CPHRM, Sr. Advisor, Curi – *Planner*
- Jaime Askew, Director, Marketing and Public Relations, Curi – *Planner*
- Whitley Paige, Manger, Risk Solutions, Curi – *Planner*
- Ernestine Webb, Senior Coordinator, Curi – *Planner*

LUCY, BETSEY, AND ANARCHA (MOTHERS OF MODERN GYNECOLOGY)

- Dr. J. Marion Sims conducted experiments on enslaved Black women from 1845-1849 (with anesthesia and without consent)
- "But to modern eyes, Sims's record looks far more complicated. The vesicovaginal fistula treatment he developed, for example, came as a result of experiments he performed on enslaved black women. In response to growing public outcry, New York City removed the statue of Sims from Central Park in April, while activists are urging the removal of a similar statue from the Alabama Capitol. But removing symbols that venerate Sims will be most effective only if this step fosters broader conversations not only about his career but also about how its historical context still influences modern medicine. We must address the ways racism and slavery shaped American medicine, not only to right past wrongs but also to confront how that influence continues to affect how patients are treated today."
  -Kathleen Bachynski, The Washington Post, 6/4/2018

https://www.washingtonpost.com/news/made-by-history/wp/2018/06/04/american-medicine-was-built-on-the-backs-of-slaves-and-it-still-affects-how-doctors-treat-patients-today/

Illustration of Dr. J. Marion Sims with Anarcha by Robert Thom. Anarcha was subjected to 30 experimental surgeries.

Pearson Museum, Southern Illinois University School of Medicine

HISTORY • CIVIL RIGHTS

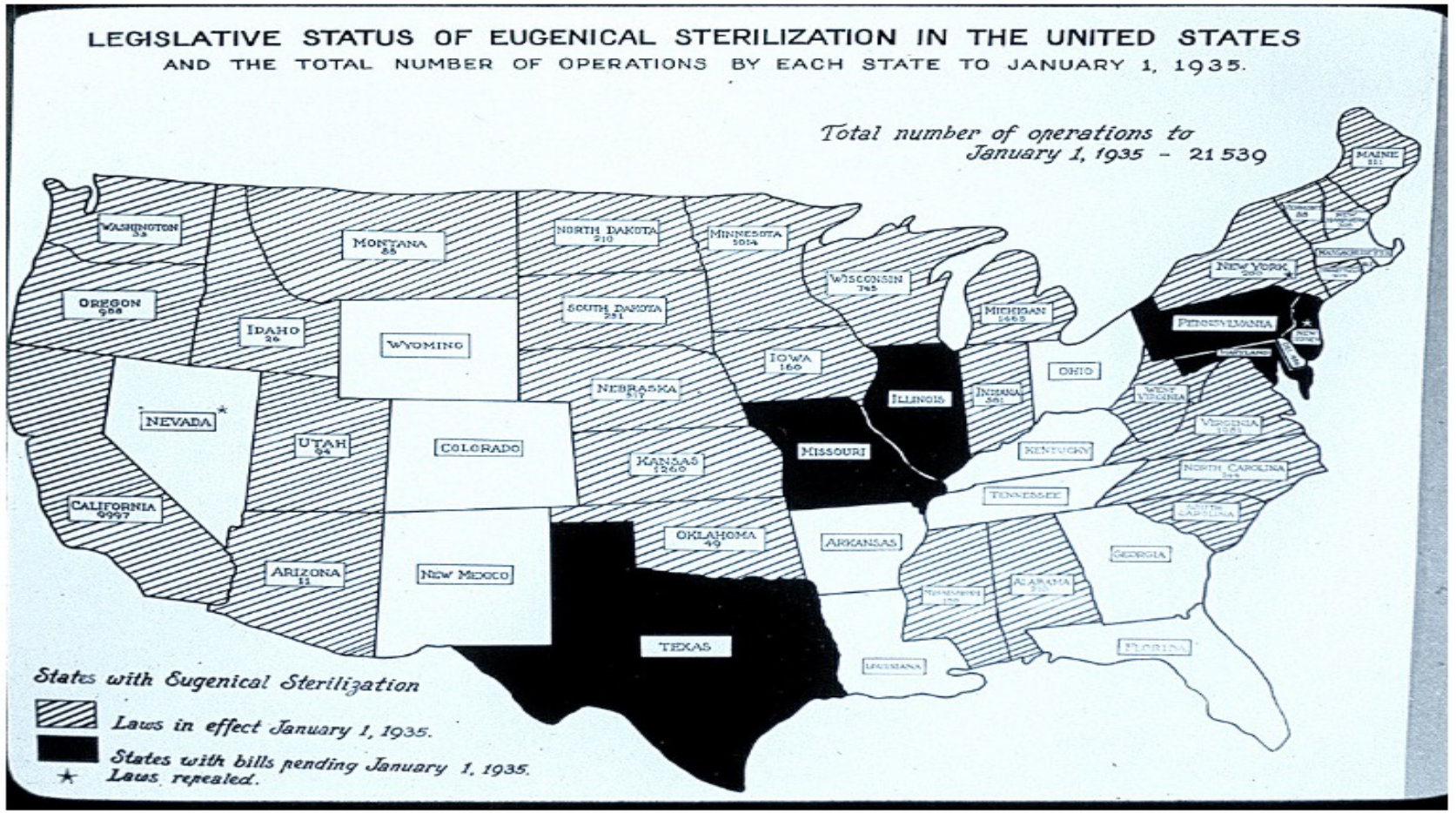
New York City Just Removed a Statue of Surgeon J. Marion Sims From Central Park. Here's Why

A statue of J. Marion Sims, who was a prominent gynecologist, is loaded onto a New York City Department of Parks & Recreation truck after being taken down from its pedestal bordering Central Park on East 103rd Street on April 17, 2018. 2018 Getty Images

TIME

https://time.com/5243443/nyc-statue-marion-sims/

Eugenics was a commonly accepted means of protecting society from the offspring (and therefore equally suspect) of those individuals deemed inferior or dangerous – the poor, the disabled, the mentally ill, criminals, and people of color.



Eugenical Sterilization Map of the United States, 1935; from The Harry H. Laughlin Papers, Truman State University


relating
Right
unfairreproductive
Freedom
care
right
terms
Individuals
gender
being
take
one
everyone
health
sex
children
term
people
regards
freedom
moms
body
free
information
going
sexual
Method
equality
isms
sexuality
Having
Abortion
culturally
Fighting
Broad
choose
full
control
affect
intersection
reproductive
knowing
doing
choices
education
SEXUAL
shared
services
resources
decisions
ones
women
justice
over
Justice
Equal
rights
each
truly
activity
trauma
options
make
works
abuse
bodiesreproductive
decide
feels
Access
woman
related
including
access
ability
quality
Knowing
males
power
legal
system

HISTORICAL CONTEXT

- James Marion Sims, known as the "father of Modern Gynecology' and former president of the American Medical Association

- U.S. policies forced sterilization of Native Americans, Puerto Ricans, and African Americans (through 1970s-1980s)

Health Equity
Volume 2.1, 2018
DOI: 10.1089/heq.2017.0045

Health Equity

Mary Ann Liebert, Inc. publishers

NARRATIVE REVIEW Open Access

Racism, African American Women, and Their Sexual and Reproductive Health: A Review of Historical and Contemporary Evidence and Implications for Health Equity

Cynthia Prather,[1,*] Taleria R. Fuller,[2] William L. Jeffries, IV,[1] Khiya J. Marshall,[3] A. Vyann Howell,[1] Angela Belyue-Umole,[1] and Winifred King[4]

Abstract

Background: The sexual and reproductive health of African American women has been compromised due to multiple experiences of racism, including discriminatory healthcare practices from slavery through the post-Civil Rights era. However, studies rarely consider how the historical underpinnings of racism negatively influence the present-day health outcomes of African American women. Although some improvements to ensure equitable healthcare have been made, these historical influences provide an unexplored context for illuminating present-day epidemiology of sexual and reproductive health disparities among African American women.

Methods: To account for the unique healthcare experiences influenced by racism, including healthcare provision, we searched online databases for peer-reviewed sources and books published in English only. We explored the link between historical and current experiences of racism and sexual and reproductive health outcomes.

Results: The legacy of medical experimentation and inadequate healthcare coupled with social determinants has exacerbated African American women's complex relationship with healthcare systems. The social determinants of health associated with institutionalized and interpersonal racism, including poverty, unemployment, and residential segregation, may make African American women more vulnerable to disparate sexual and reproductive health outcomes.

Conclusions: The development of innovative models and strategies to improve the health of African American women may be informed by an understanding of the historical and enduring legacy of racism in the United States. Addressing sexual and reproductive health through a historical lens and ensuring the implementation of culturally appropriate programs, research, and treatment efforts will likely move public health toward achieving health equity. Furthermore, it is necessary to develop interventions that address the intersection of the social determinants of health that contribute to sexual and reproductive health inequities.

RECENT US HISTORY AND SOCIAL AND STRUCTURAL DETERMINANTS OF HEALTH

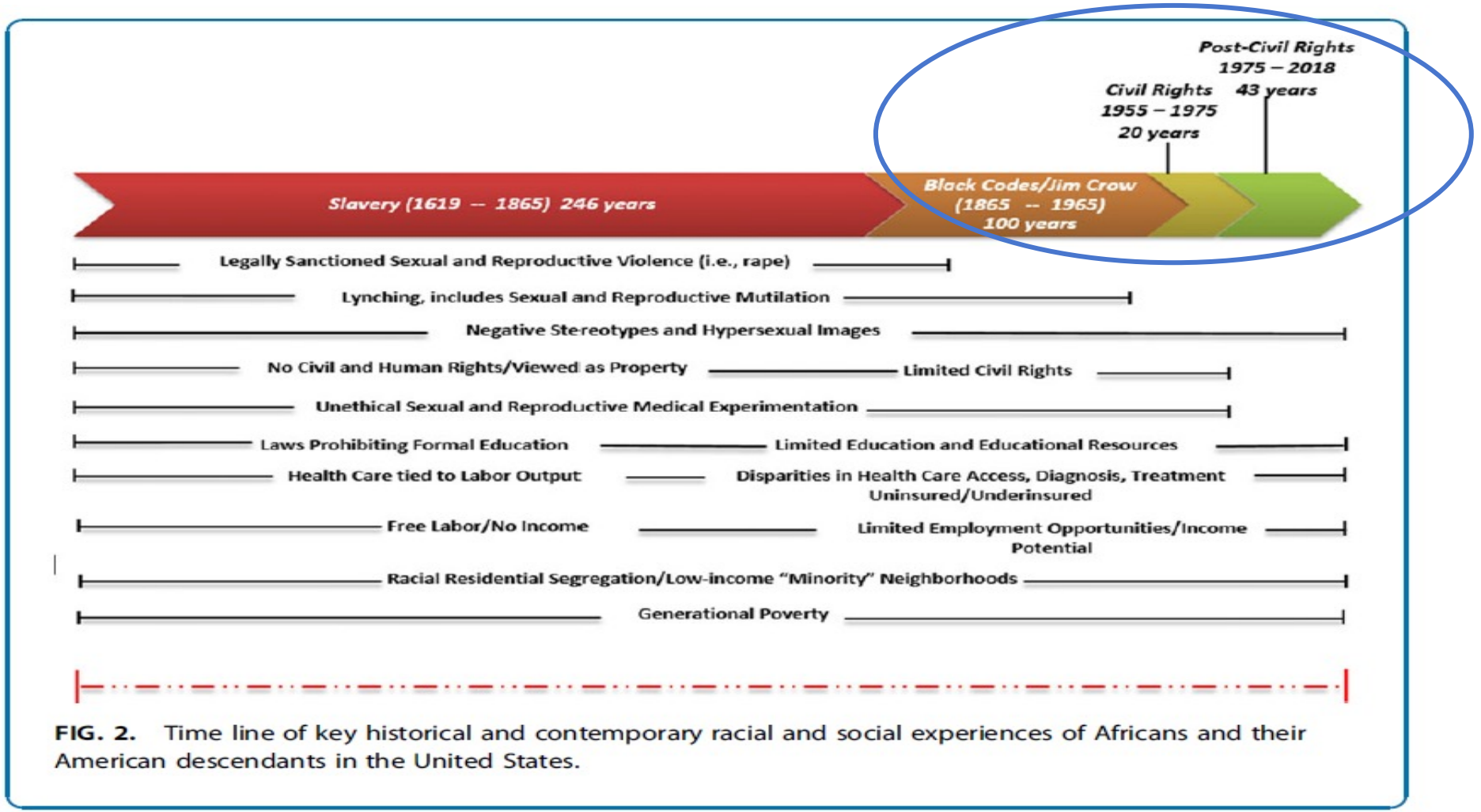


FIG. 2. Time line of key historical and contemporary racial and social experiences of Africans and their American descendants in the United States.

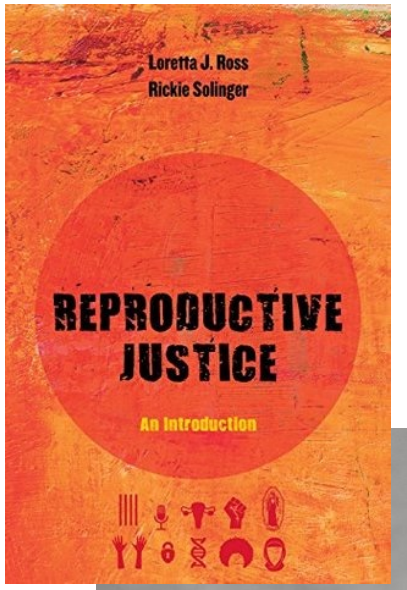
So the context of sexual and reproductive justice, especially for women of color, has to be considered based on centuries of slavery and Jim Crow for people of color and mere decades of the post-civil rights era.

In the US and globally, we see more and more that what affects women of color affects all women. So, moving toward health equity for women moves us all forward.

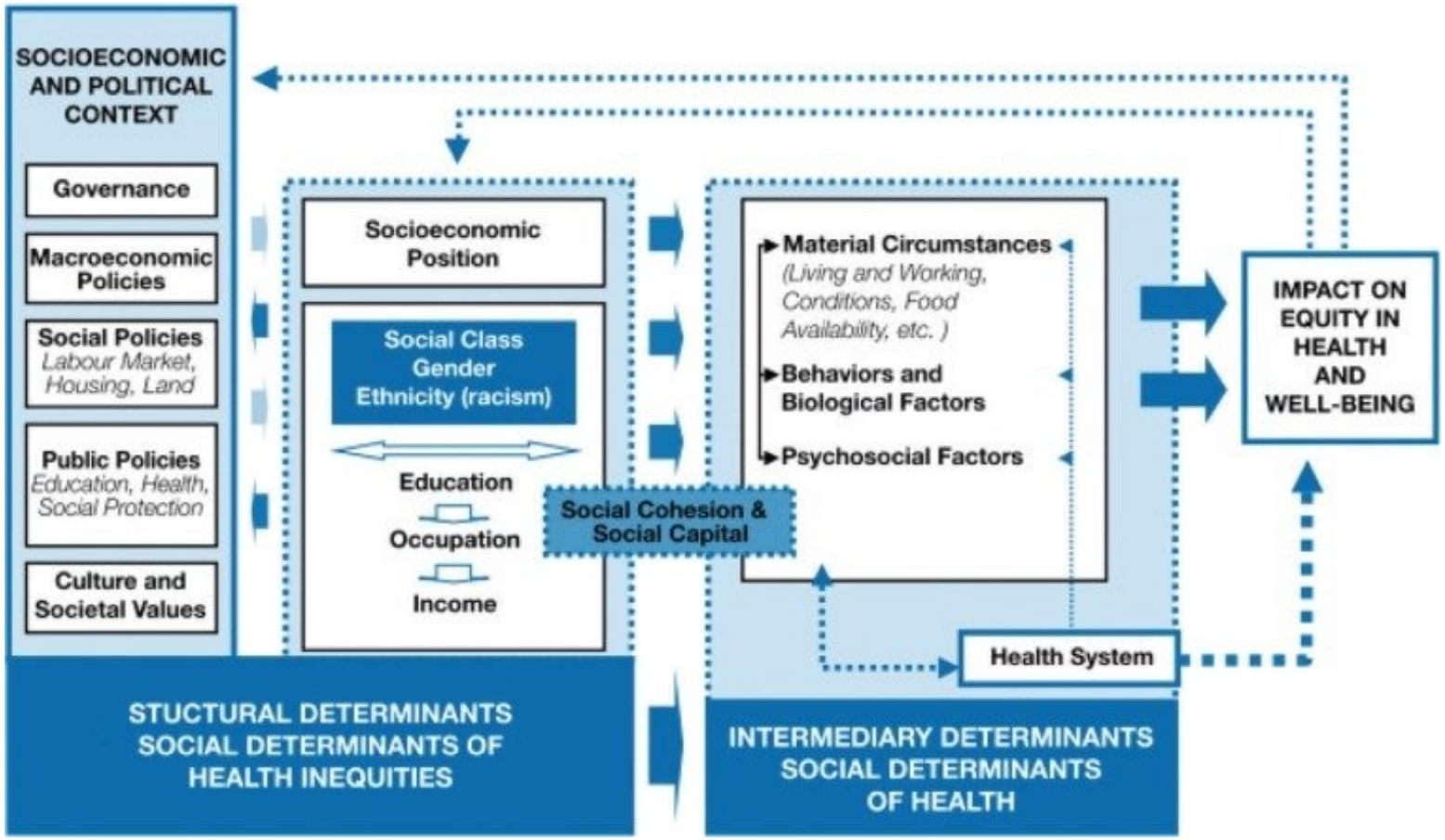
WHAT IS SEXUAL REPRODUCTIVE JUSTICE? (1994)

Sexual and Reproductive Justice

- Sexual and reproductive justice exists when **all people have the power and resources to make healthy decisions about their bodies, sexuality and reproduction.** That means every person has the right to:
  - Choose to have or not have children.
  - Choose the conditions under which to give birth or create a family.
  - Care for their children with the necessary social support in a safe and healthy environment.
  - Control their own body and self-expression, free from any form of sexual or reproductive oppression.



REPRODUCTIVE HEALTH + SOCIAL JUSTICE + SDH = REPRODUCTIVE JUSTICE



DIVERSIFYING THE PHYSICIAN WORKFORCE CAN HELP REDUCE REPRODUCTIVE HEALTH DISPARITIES

Public Health & Policy > Medical Education

Study Backs Flexner Report's Negative Impact on Black Physicians

— JAMA editors call for more studies addressing racism in medicine

by Elizabeth Hlavinka, Staff Writer, MedPage Today August 20, 2020

- Five of 7 Black/African American medical schools closed, leaving only Howard University and Meharry.
- An estimated 28,000 Black physicians could have been trained between the 1920s and 2019.
- In 2022, there are four US Black medical schools, with plans for a 5th underway.

An early 20th century report that equipped medical schools with a framework to teach the next generations of physicians also debilitated the Black physician workforce, suggested a modeling study.

This Issue Views 7,312 | Citations 11 | Altmetric 90

Viewpoint

January 5, 2021

Diversity in Medical Schools
A Much-Needed New Beginning

Valerie Montgomery Rice, MD[1]

» Author Affiliations

JAMA. 2021;325(1):23-24. doi:10.1001/jama.2020.21576

Editorial Comment | Interviews | Multimedia

The disproportionate effect of the novel coronavirus on African Americans and communities of color has s new light on the more than century-old struggle to increase the number of Black physicians in the US. Toc cording to the Association of American Medical Colleges (AAMC), Black physicians account for 5% of all pl cians even though African Americans comprise 13% of the US population. Only 1626 (7.4%) of the 21 863 s dents who entered medical school in 2019 were Black, roughly the same ratio as the last 15 years.[1]

GETTING TO A MORE DIVERSE WORKFORCE

IT'S ALL CONNECTED…

- The rise of the social determinants of health (SDH) discourse on the basis of statistical evidence that correlates ill health to SDH and pictures causal pathways in comprehensive theoretical frameworks led to widespread awareness that health and health disparities are the outcome of complex pathways of interconnecting SDH.

- To transform generic SDH models into useful policy tools and to prevent them to transform in SDH themselves, in depth understanding of the unique interplay between local, national and global SDH in a local setting, gathered by ethnographic research, is needed to be able to address structural SD in the local setting and decrease reproductive health inequity.

REPRODUCTIVE HEALTH IN THE USA

Racial/ethnic disparities are noted in most reproductive health measure categories, including prenatal care access, mammogram screening, Pap tests, STDs, HIV, contraceptive use, and unintended pregnancies.

Estimated Rates of Selected Reproductive Health Measures by Race/Ethnicity, 2018

Measure	Percentages or Rates for Women by Race/Ethnicity		
	Non-Hispanic Black/African American	Hispanic/Latina	Non-Hispanic White
Contraceptive use (percentage of unmarried women, ages 18-29 years); (Rocca, 2012)	54.9%	62.4%	76.3%
Unintended pregnancy (per 1,000 women ages 15-44 years); (Finer, 2011)	67	53	40
Elective abortions (per 1,000 women ages 15-44 years); (Jones, 2011)	40.2	28.7	11.5
Late or no prenatal care (percentage of mothers among those who gave birth); (Child Trends Data Bank, 2014)	9.8%	7.5%	4.3%
Pap tests (percentage of women age 18 years and older who report having a Pap within the previous 3 years); (Kaiser, 2014)	90%	89%	83%
Mammogram screening (percentage screened among women age 40 years and older); (Njai, 2011)	59%	N/A	65%
Chlamydia screening (percentage of asymptomatic women ages 15-25 years tested for chlamydia during outpatient visit); (Hoover, 2008)	12.7%	12.9%	2.2%
HIV Diagnoses (rate of diagnoses per 100,000 population of women); (CDC, 2015)	30.0	6.5	1.7
HIV treatment (percentage achieving suppressed viral load after diagnosis); (Mahle Gray, 2013)	60.2%	70.3%	77.4%
Breastfeeding Initiation (percentage of mothers ever initiating breastfeeding); (CDC, MMWR, 2013)	58.9%	80.0%	75.2%

OBSTETRICS & GYNECOLOGY

Current Commentary

OPEN

Racial and Ethnic Disparities in Reproductive Health Services and Outcomes, 2020

Madeline Y. Sutton, MD, MPH, Ngozi F. Anachebe, MD, PharmD, Regina Lee, MD, and Heather Skanes, MD

Table 1. Estimated Rates of Selected Reproductive Health Measures by Race–Ethnicity, 2020

Measure	Percentages or Rates for Women by Race–Ethnicity		
	Non-Hispanic Black or African American	Hispanic or Latina	Non-Hispanic White
Access and services			
Contraceptive use (% of all females 15–49 y)[37]	59.9	64.0	67.0
Pap tests (% of women 18–64 y who report having a Pap test within the previous 3 y)[38]	79	74	73
Mammogram screening (% screened among women 40 y and older who had a mammogram in the past 2 y)[39]	78	72	72
Late or no prenatal care (% of mothers among those who gave birth)[48]	10.0	8.0	5.0
Chlamydia screening (% of nonpregnant females 15–21 y tested for chlamydia during physician office visit)[54]	5.8	4.9	3.9
HIV treatment (% of females 13 y and older with a viral load test result of fewer than 200 copies/mL at the most recent test during 2015)[59]	55.5	61.6	59.6
Outcomes			
Unintended pregnancy (per 1,000 females 15–44 y)[61]	79	58	33
Induced abortions (per 1,000 females 15–44 y)[66]	25.1	11.7	6.6
Preterm births (less than 37 wk of gestation) (% of live births)[69]	14.1	9.7	9.1
Breastfeeding initiation (% of mothers ever initiating breastfeeding)[71]	74.0	82.9	86.6
Maternal mortality (pregnancy-related deaths per 100,000 live births)[74]	40.8	11.5	12.7
Cervical cancer (age-adjusted rate per 100,000 women)[85]	8.3	8.9	7.3
Endometrial cancer deaths (per 100,000 women, age-adjusted)[86]	9.0	4.6	4.0
HIV diagnoses (rate of diagnoses per 100,000 population of women)[55]	23.1	5.2	1.7

Rates of human immunodeficiency virus (HIV) infection among all women have declined since 2010, but rates among black women remain higher than do those among white women. (CDC, 2019)

Morbidity and Mortality Weekly Report

Disparities in Incidence of Human Immunodeficiency Virus Infection Among Black and White Women — United States, 2010–2016

Erin L.P. Bradley, PhD[1,2]; Austin M. Williams, PhD[3]; Shana Green, PhD[1,2]; Ashley C. Lima, PhD[1,2]; Angelica Geter, PhD[1,2]; Harrell W. Chesson, PhD[3]; Donna Hubbard McCree, PhD[1]

Incident human immunodeficiency virus (HIV) infections among adolescent females and women declined during 2010–2016, with the largest decrease (21%) occurring among black women (*1*). However, in 2016, although black women accounted for 13% of the U.S. female population, 60% of new HIV infections among women were in black women, indicating persisting disparities (*1*). CDC used the population attributable proportion (PAP) disparity measure to describe the proportional decrease in HIV infection among black and white women combined that would be realized if the group with the higher rate (blacks) had the same rate as did the group with the lower rate (whites) (*2*). Analyses indicated that an estimated 3,900 of 4,200 (93%) incident HIV infections among black women in 2016 would not have occurred if rates were the same for black and white women. The PAP disparity measure decreased from 0.75 in 2010 to 0.70 in 2016, suggesting that if incidence rates for black women were the same as those for white women, the annual number of incident HIV infections

the nearest hundred, the estimated number of incident HIV infections was derived by dividing the surveillance report rate by 100,000, then multiplying by the number of females aged ≥13 years. Rates of HIV infection were defined as the estimated number of incident infections divided by the number of HIV-negative females aged ≥13 years, then multiplied by 100,000. This calculation was carried out for each year from 2010 to 2016. To assess changes in the PAP disparity measure between the beginning and the end of the study period, a z-statistic was calculated to test for statistically significant differences between the 2010 and 2016 measures. The z-statistic was cal-

culated as the a
PAP disparity
standard error
10,000 calculat
random draw o
bution (approx
the surveillanc

What is added by this report?

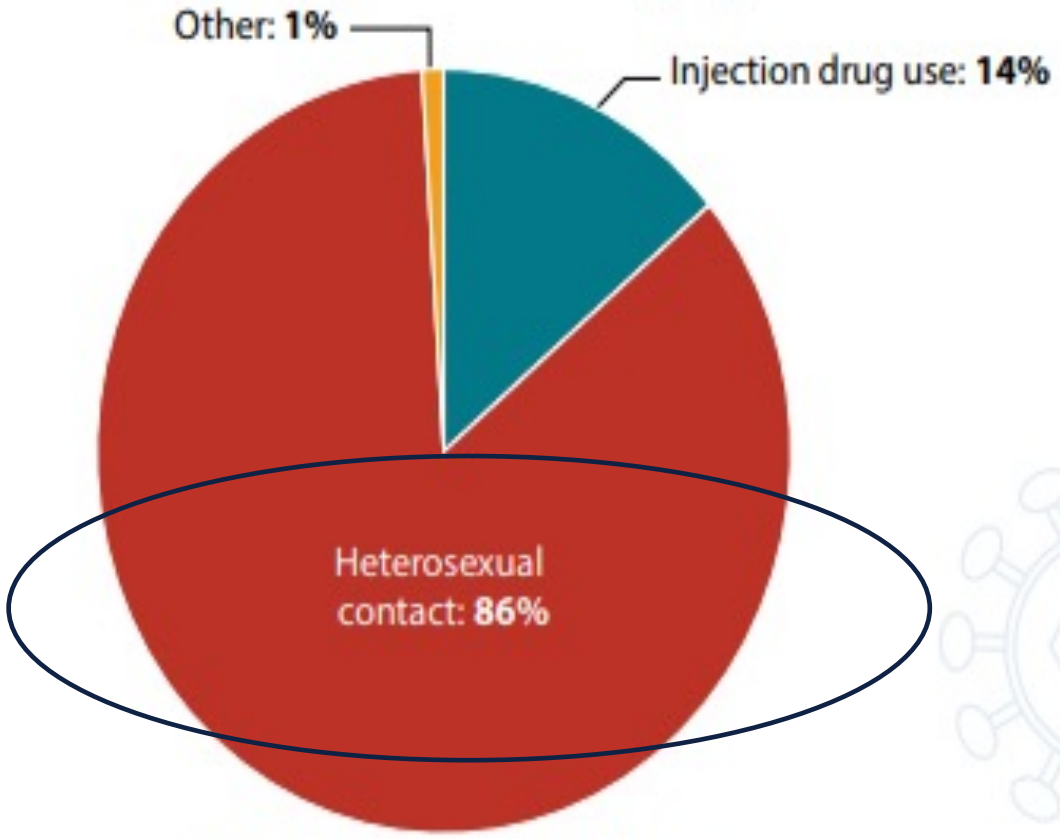
A population attributable proportion analysis found that in 2016, an estimated 3,900 of 4,200 (93%) incident HIV infections among black women would not have occurred if the incidence for black women were the same as that for white women.

What are the implication for public health practice?

Reducing racial disparities among women is needed to achieve broader HIV control goals. Addressing social and structural determinants of health and applying tailored strategies to reduce HIV incidence in black women and their partners are important elements to achieving health equity.

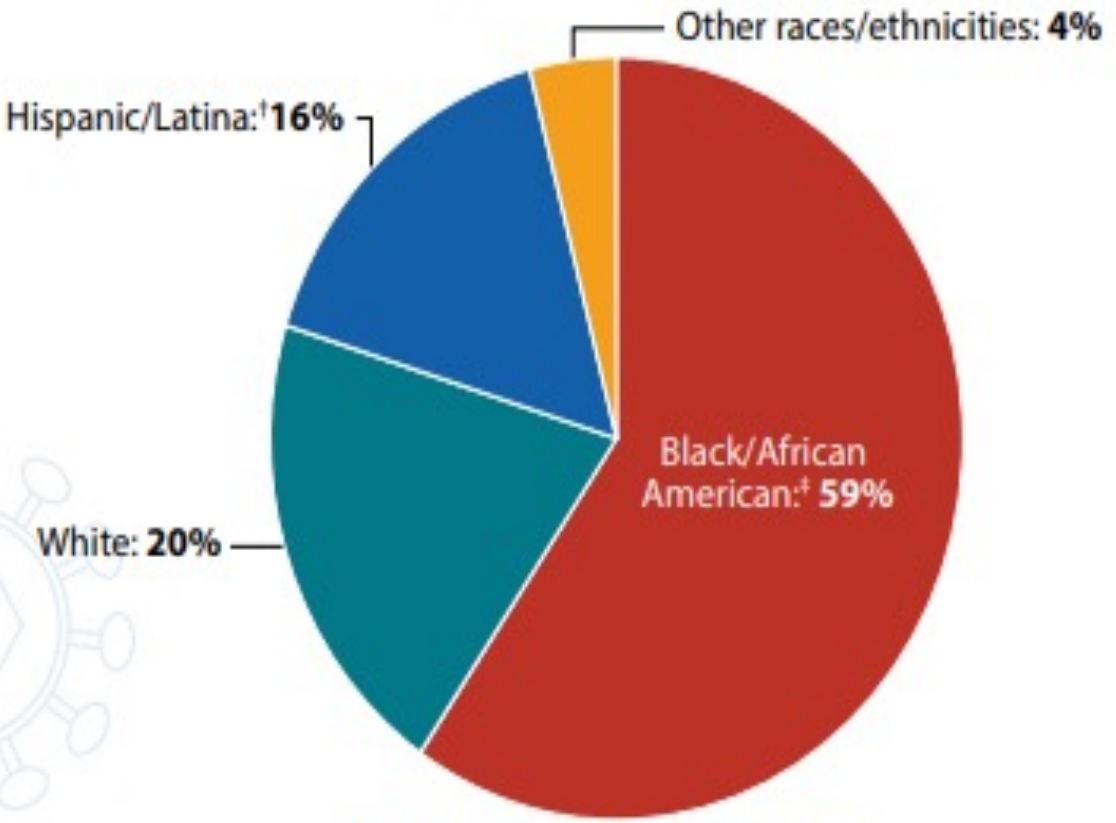
New HIV Diagnoses Among Women in the US and Dependent Areas in 2017

By Transmission Category



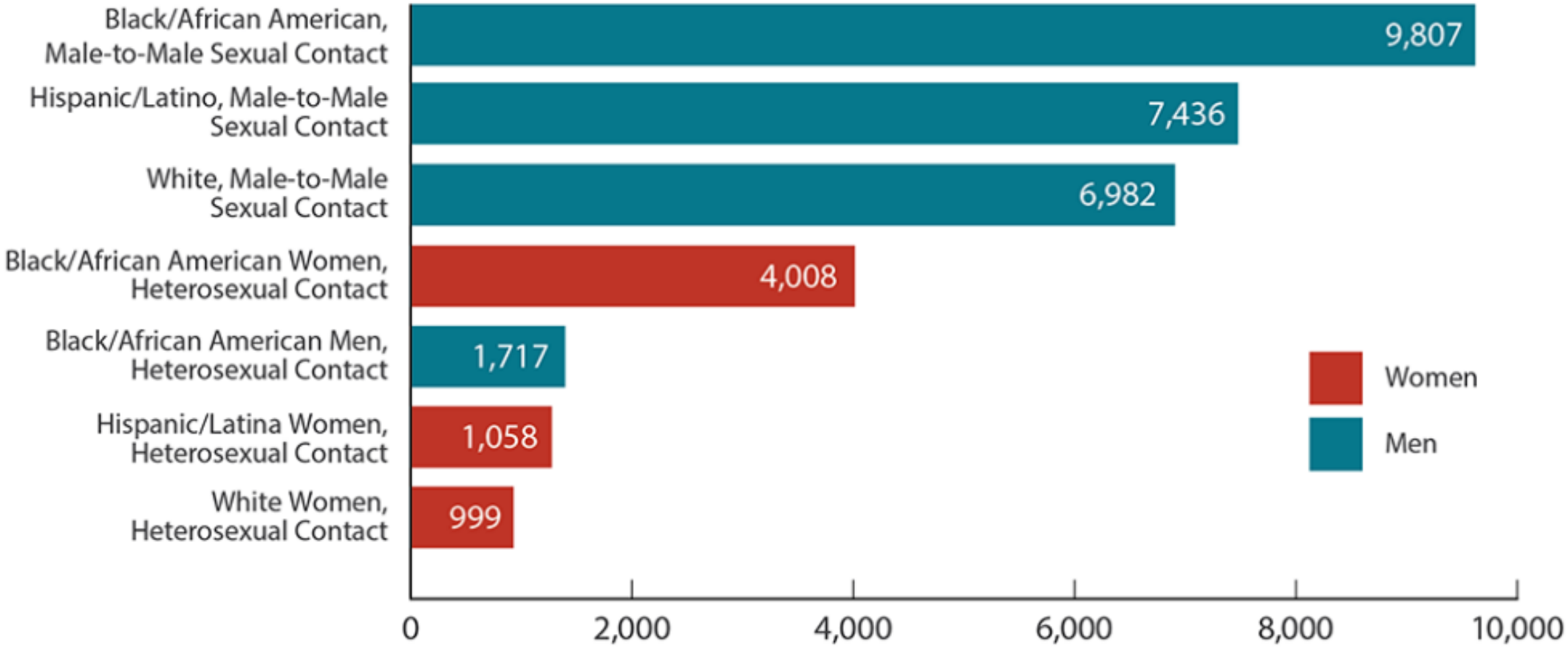
Total may not equal 100% due to rounding.

By Race/Ethnicity



Total may not equal 100% due to rounding.

New HIV Diagnoses in the US and Dependent Areas for the Most-Affected Subpopulations, 2017



Subpopulations representing 2% or less of HIV diagnoses are not reflected in this chart.

Source: CDC. Diagnoses of HIV infection in the United States and dependent areas, 2017 . *HIV Surveillance Report* 2018;29.

REDUCING STIGMA AMONG PROVIDERS HELPS IMPROVE HIV CARE AND UTILIZATION BY PATIENTS.

AIDS Patient Care and STDs, VOL. 32, NO. 10 | Behavioral and Psychosocial Research

normal

HIV-Related Stigma by Healthcare Providers in the United States: A Systematic Review

Angelica Geter, Adrienne R. Herron, and Madeline Y. Sutton

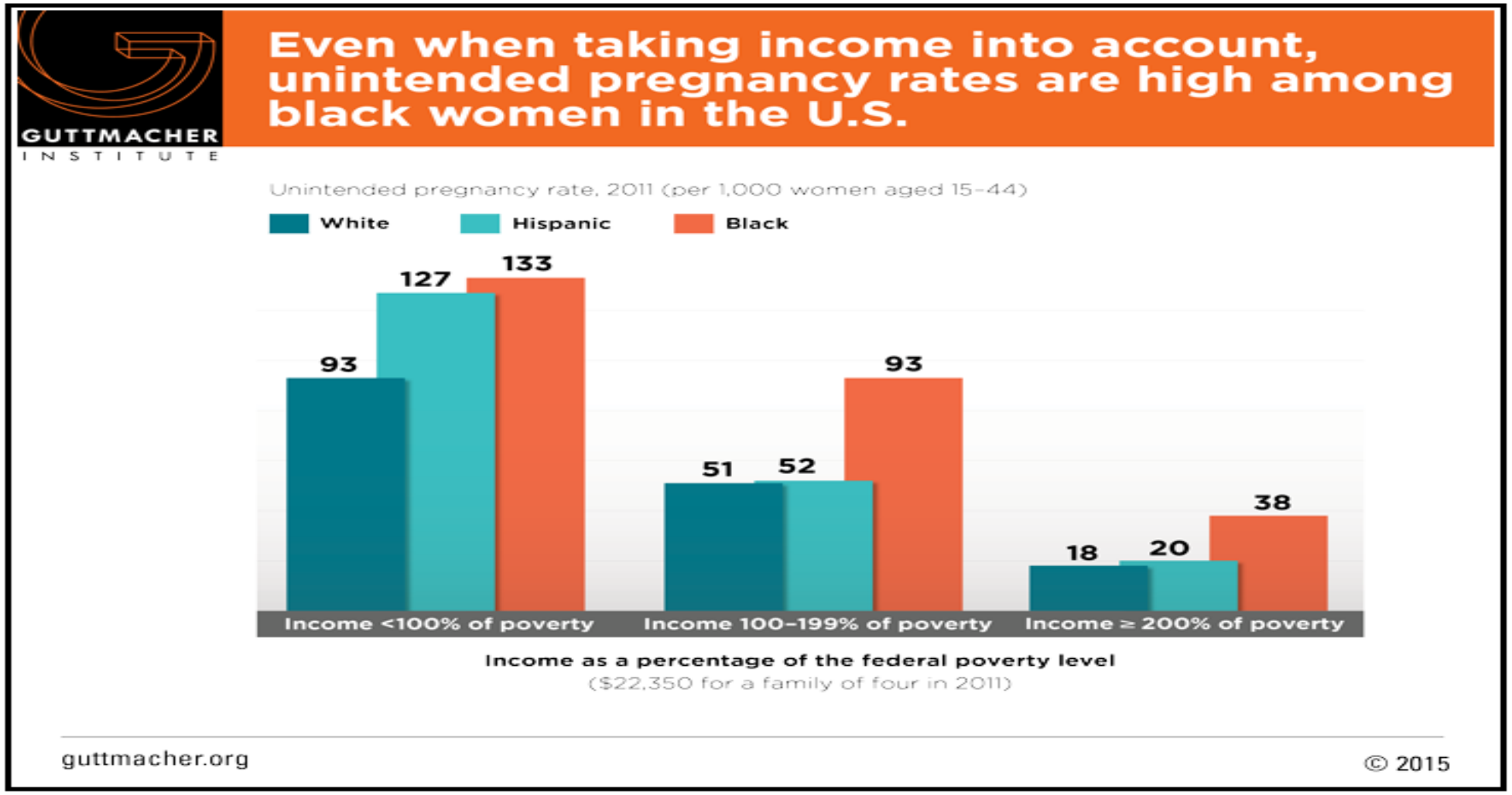
Published Online: 2 Oct 2018 | https://doi.org/10.1089/apc.2018.0114

Tools Share

Abstract

Reducing HIV-related stigma may enhance the quality of HIV prevention and care services and is a national prevention goal. The objective of this systematic review was to identify studies of HIV-related stigma among healthcare providers. For studies published between 2010 and 2017, we: (1) searched databases using our keywords, (2) excluded nonpeer reviewed studies, (3) limited the findings to the provider perspective and studies conducted in the United States, (4) extracted and summarized the data, and (5) conducted a contextual review to identify common themes. Of 619 studies retrieved, 6 were included, with 3 themes identified: (1) attitudes, beliefs, and behaviors ($n = 6$), (2) quality of patient care ($n = 3$), and (3) education and training ($n = 2$). Factors associated with HIV-related stigma varied by gender, race, provider category, and clinical setting. Providers with limited recent HIV-stigma training were more likely to exhibit stigmatizing behaviors toward patients. Developing provider-centered stigma-reduction interventions may help advance national HIV prevention and care goals.

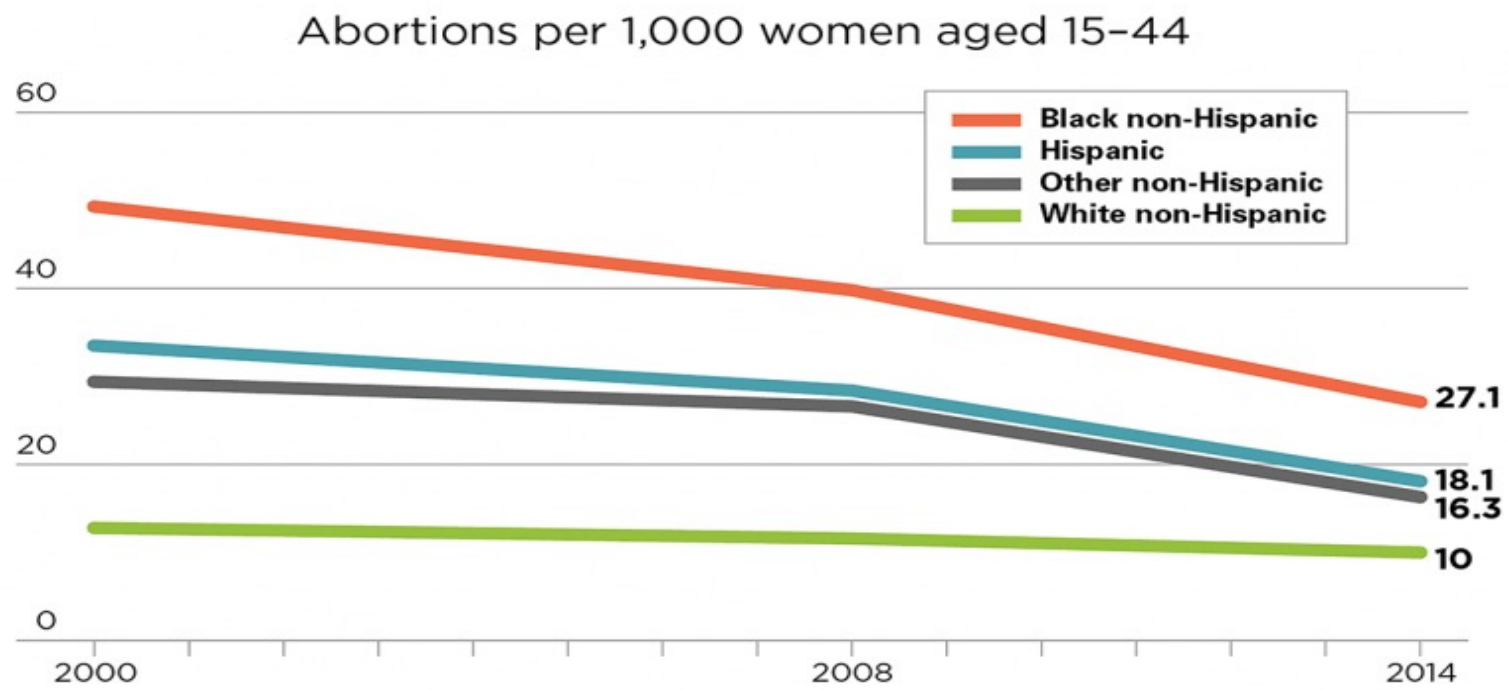
RATES OF UNINTENDED PREGNANCY BY INCOME AND RACE AND ETHNIC GROUP, 2011 (FINER & ZOLNA; N ENGL J MED 2016; 374:843-852)



GUTTMACHER INSTITUTE

Abortion rates continue to vary by race and ethnicity

Lack of access to health insurance and health care plays a role, as do racism and discrimination



gu.tt/Abortion2014

CONTRACEPTIVE CARE AND USE DISPARITIES

Disparities in Contraceptive Care

Venis Wilder, Georgia Bromfield, Gabrielle deFiebre, Linda Prine

Journal of Health Care for the Poor and Underserved, Volume 25, Number 2, May 2014, pp. 451-459 (Article)

Published by The Johns Hopkins University Press
DOI: 10.1353/hpu.2014.0088

Table 2
Percentage of current contraceptive users by method and selected user characteristics, 2008–2014, and significant differences between years from logistic regression among US women ages 15–44

	Female sterilization			Male sterilization			IUD			Implant			Withdrawal			Natural family planning		
	2008	2014		2008	2014		2008	2014		2008	2014		2008	2014		2008	2014	
	%	%	p	%	%	p	%	%	p	%	%	p	%	%	p	%	%	p
Total	27	22	.01	10	6	<.01	6	12	<.01	0.5	3	<.01	5	8	<.01	1	2	<.01
Age																		
15–19	0.1	0	NA	0.1	0	NA	3	4	.59	0.3	6	<.01	7	4	.10	0.3	0	NA
20–24	3	2	.62	1	1	.84	6	13	<.01	1	6	<.01	6	9	.08	0.3	1	.03
25–29	16	10	<.01	4	1	<.01	7	15	<.01	1	4	.01	6	12	<.01	1	4	<.01
30–34	30	28	.49	10	5	.04	7	15	<.01	0.2	1	.23	5	6	.26	2	2	.70
35–39	37	32	.17	17	11	.03	6	14	<.01	0.4	0.4	.94	5	10	.05	2	2	.55
40–44	51	46	.23	20	16	.23	3	7	.01	0.0	0.3	NA	3	6	.11	1	3	.28
Race/ethnicity																		
White, non-Hispanic	24	21	.22	13	8	<.01	6	11	<.01	0.3	2	<.01<.001	5	8	<.01	1	2	.01
Black, non-Hispanic	37	25	<.01	2	2	.68	5	12	<.01	1	3	<.01	4	7	.13	1	2	.09
Other or multiple races, non-Hispanic	24	19	.32	5	7	.64	4	11	<.01	2	3	.68	8	11	.48	2	4	.14
Hispanic	32	25	.06	6	4	.50	7	15	<.01	0.3	3	<.01	6	8	.11	2	1	.13

Women of color remain more likely to be affected by negative outcomes even when they carry a pregnancy to term…

MATERNAL MORTALITY AND PREGNANCY-RELATED DEATHS

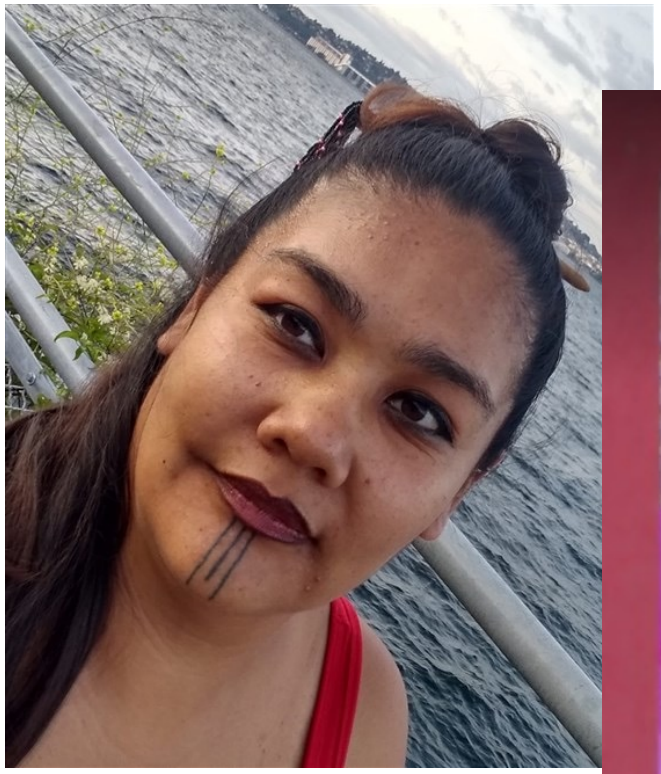
Maternal Mortality: "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes." (World Health Organization/WHO)

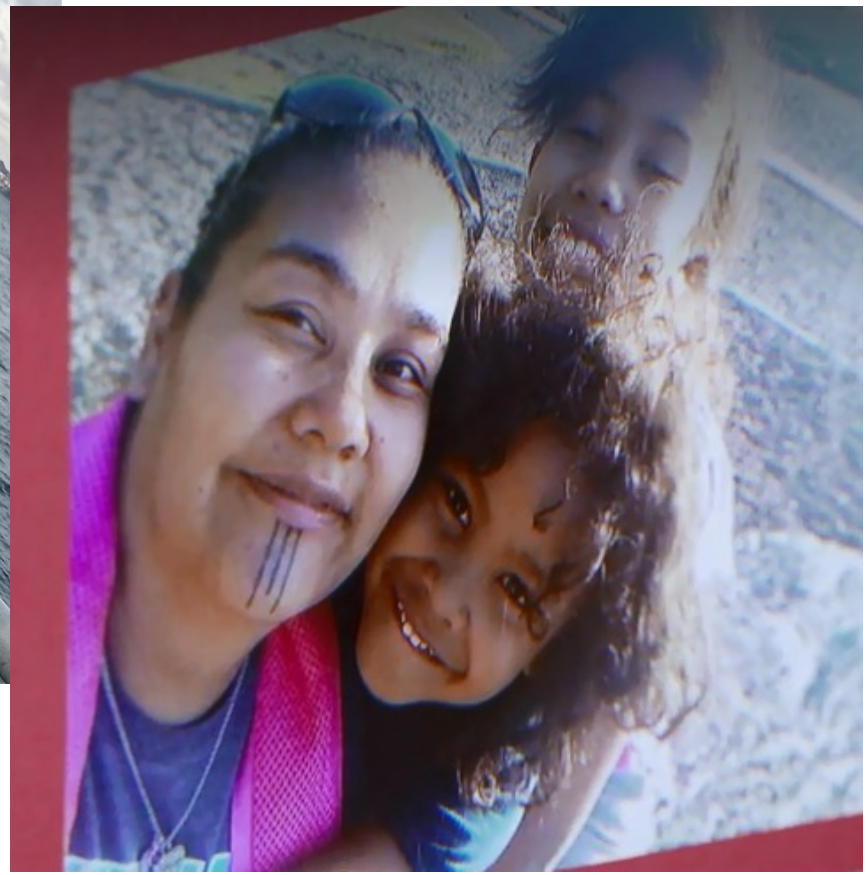
Pregnancy-related deaths: "the death of a woman while pregnant or within 1 year of termination of pregnancy, irrespective of the cause of death." (WHO)

BLACK MOTHERS KEEP DYING AFTER GIVING BIRTH, SHALON IRVING'S STORY (NPR; 12/7/2017)

KIRA JOHNSON'S STORY: ARE BLACK WOMEN'S REPORTS OF SYMPTOMS AND SIGNS RECEIVED THE SAME BY PROVIDERS?

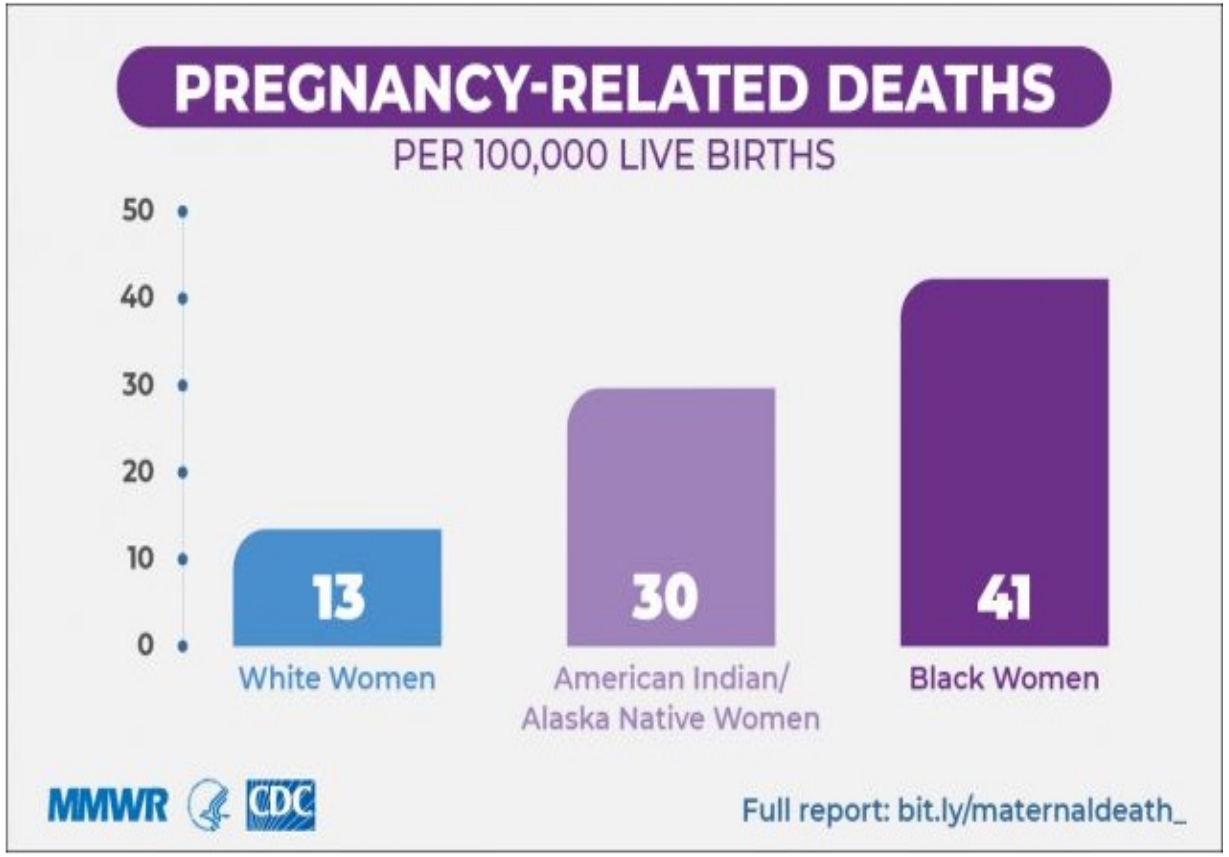
PREGNANT WOMAN DIED WHILE BRINGING ATTENTION TO NATIVE AMERICAN MATERNAL MORTALITY (NBC NEWS, 2/6/2020)





- Black and indigenous women are disproportionately affected: Black mothers are three to four times more likely to die of pregnancy-related causes than white women.
- American Indian and Alaska Natives are 2.3 times more likely to die than white mothers; in urban settings, they are 4.5 times more likely to die.

MATERNAL MORTALITY



Morbidity and Mortality Weekly Report

Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016

Emily E. Petersen, MD[1]; Nicole L. Davis, PhD[1]; David Goodman, PhD[1]; Shanna Cox, MSPH[1]; Carla Syverson, MSN[1,2]; Kristi Seed[1,2]; Carrie Shapiro-Mendoza, PhD[1]; William M. Callaghan, MD[1]; Wanda Barfield, MD[1]

Approximately 700 women die in the United States each year as a result of pregnancy or its complications, and significant racial/ethnic disparities in pregnancy-related mortality exist (*1*). Data from CDC's Pregnancy Mortality Surveillance System (PMSS) for 2007–2016 were analyzed. Pregnancy-related mortality ratios (PRMRs) (i.e., pregnancy-related deaths per 100,000 live births) were analyzed by demographic characteristics and state PRMR tertiles (i.e., states with lowest, middle, and highest PRMR); cause-specific proportionate mortality by race/ethnicity also was calculated. Over the period analyzed

chain of events initiated by pregnancy, or aggravation of an unrelated condition by the physiologic effects of pregnancy. U.S. natality files were the source of live birth data (*3*).

PRMRs were analyzed by age group, highest level of education, and calendar year for women who were non-Hispanic white, black, AI/AN, Asian or Pacific Islander (A/PI), and Hispanic. Per the PMSS assurance of confidentiality, state-specific data are not authorized to be released. States were anonymously classified by PRMR and grouped into low-

est, middle, and highest tertiles by PRMR; the PRMR was

MATERNAL MORTALITY

PETERSEN EE, DAVIS NL, GOODMAN D, ET AL. RACIAL/ETHNIC DISPARITIES IN PREGNANCY-RELATED DEATHS — UNITED STATES, 2007–2016. MMWR MORB MORTAL WKLY REP 2019;68:762–765. DOI: HTTP://DX.DOI.ORG/10.15585/MMWR.MM6835A3

Summary

What is already known about this topic?

Approximately 700 women die annually in the United States as a result of pregnancy or its complications; racial/ethnic disparities exist.

What is added by this report?

During 2007–2016, black and American Indian/Alaska Native women had significantly more pregnancy-related deaths per 100,000 births than did white, Hispanic, and Asian/Pacific Islander women. Disparities persisted over time and across age groups and were present even in states with the lowest pregnancy-related mortality ratios and among groups with higher levels of education. The cause-specific proportion of pregnancy-related deaths varied by race/ethnicity.

What are the implications for public health practice?

Identifying factors that drive differences in pregnancy-related deaths and implementing prevention strategies to address them could reduce racial/ethnic disparities in pregnancy-related mortality. Strategies to address racial/ethnic disparities in pregnancy-related deaths, including improving women's health and access to quality care in the preconception, pregnancy, and postpartum periods, can be implemented through coordination at the community, health facility, patient and family, health care provider, and system levels.

CDC DATA SHOW THAT 60% OF THESE DEATHS ARE PREVENTABLE.

700

About 700 women die from pregnancy-related complications each year in the US.

3 in 5

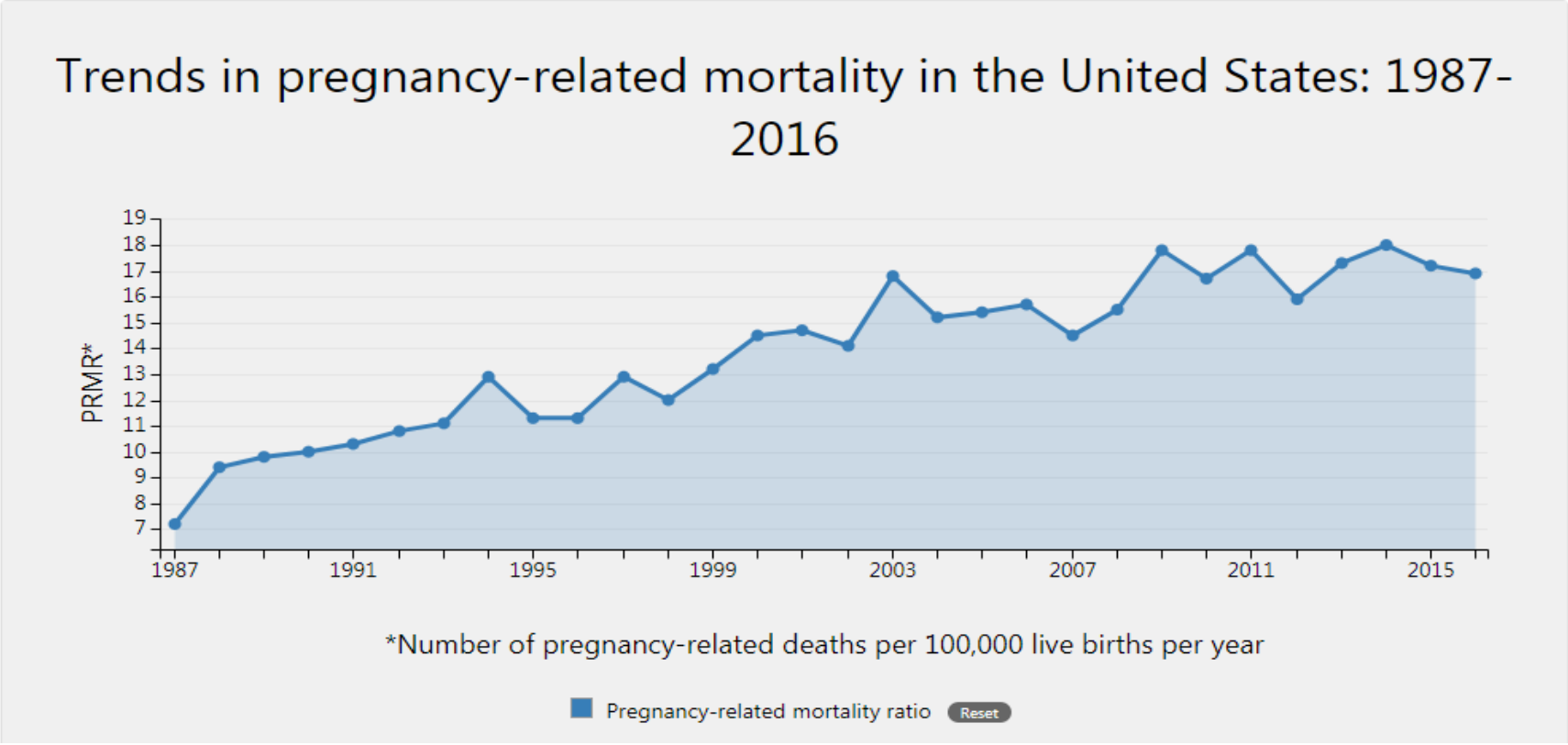
About 3 in 5 pregnancy-related deaths could be prevented.

1 in 3

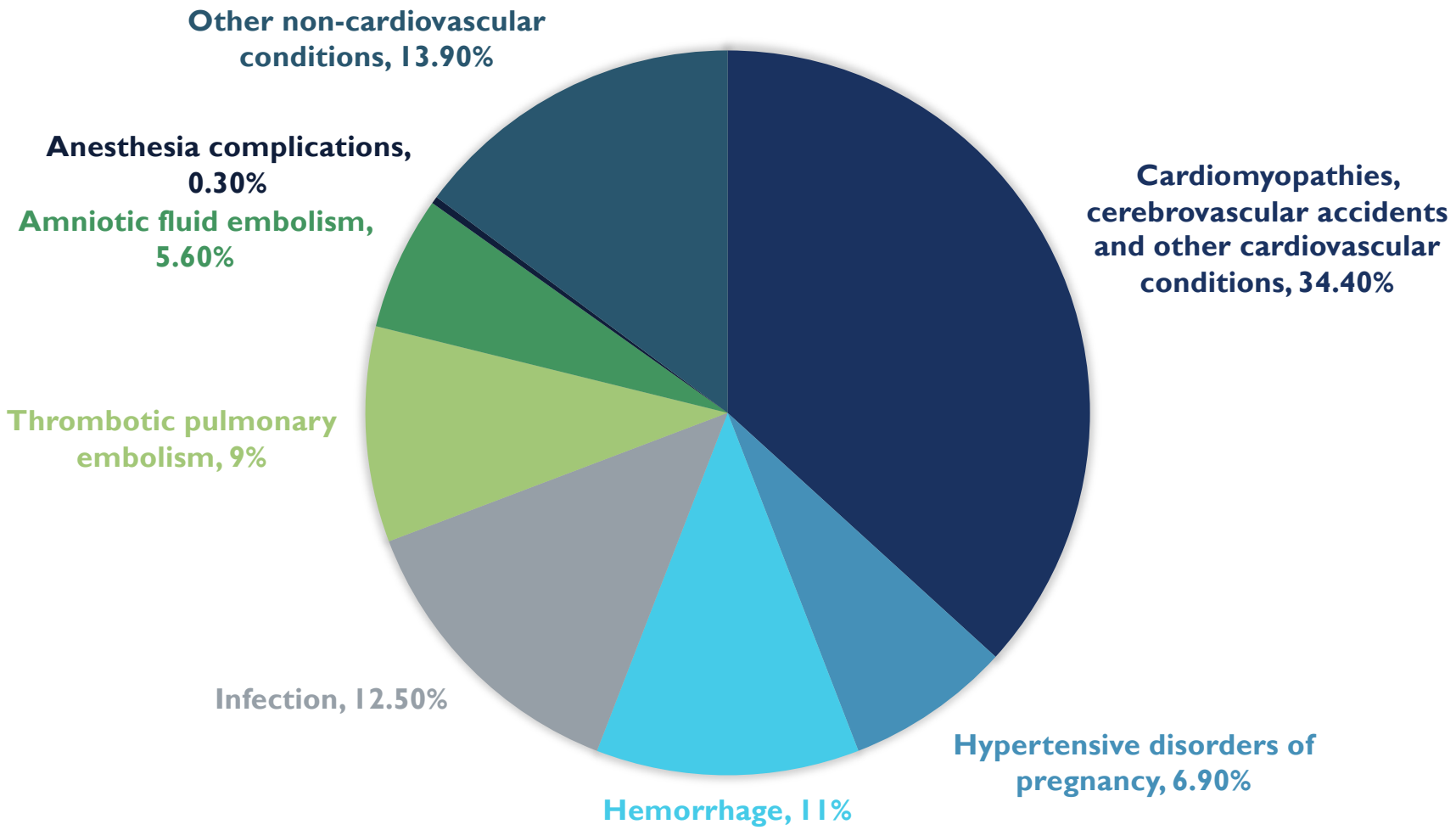
About 1 in 3 pregnancy-related deaths occur 1 week to 1 year after delivery.

TRENDS IN PREGNANCY-RELATED DEATHS (https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm)

Since the Pregnancy Mortality Surveillance System was implemented, the number of reported pregnancy-related deaths in the United States steadily increased from 7.2 deaths per 100,000 live births in 1987 to 16.9 deaths per 100,000 live births in 2016. The graph below shows trends in pregnancy-related mortality ratios defined as the number of pregnancy-related deaths per 100,000 live births in the United States between 1987 and 2016 (the latest available year of data).



CAUSES OF PREGNANCY-RELATED DEATH IN THE UNITED STATES: 2011-2016 (https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm#causes)



H.R. 1318 (115TH): PREVENTING MATERNAL DEATHS ACT OF 2018
(SIGNED INTO LAW ON DECEMBER 20, 2018)

One Hundred Fifteenth Congress of the United States of America

At the Second Session

Begun and held at the City of Washington on Wednesday, the third day of January, two thousand and eighteen

H. R. 1318

AN ACT

To support States in their work to save and sustain the health of mothers during pregnancy, childbirth, and in the postpartum period, to eliminate disparities in maternal health outcomes for pregnancy-related and pregnancy-associated deaths, to identify solutions to improve health care quality and health outcomes for mothers, and for other purposes.

Section 1. Short title

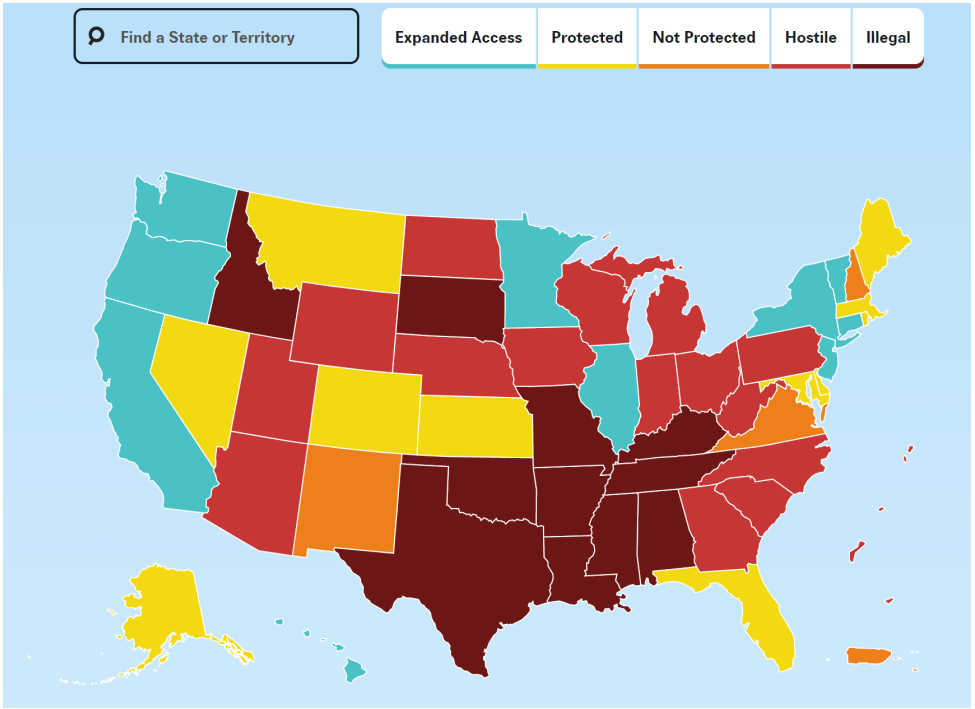
This Act may be cited as the "Preventing Maternal Deaths Act of 2018".

Sec. 2. Safe motherhood

POST-ROE AND RACIAL/ETHNIC AND REGIONAL DISPARITIES: HOW WILL DISPARITIES IN ACCESS IMPACT MATERNAL MORBIDITY AND MORTALITY?

What are Potential Racial Disparities in Access to Abortions now that *Roe v. Wade* has been Overturned?

Over four in ten (43%) of women between ages 18-49 living in states where abortion has become or will likely become illegal are women of color. As of May 2022, 17 states had laws in place intended to immediately ban abortion, including four that had a law banning abortion in place predating *Roe v. Wade.* Overall, 18.1 million or 28% of women ages 18-49 live in these 17 states. Among women ages 18-49 living in these states, 22% are Hispanic,14% are Black, and 4% are Asian (Figure 4). (See Appendix Table 1 for the racial/ethnic distribution of women ages 18-49 by state.) Overall, nearly half (49%) of all AIAN women ages 18-49 live in these states, as do nearly three in ten White (29%), Hispanic (28%), and Black (28%) women in this age group, while less than one in five NHOPI (19%) and Asian (15%) women live in these states.



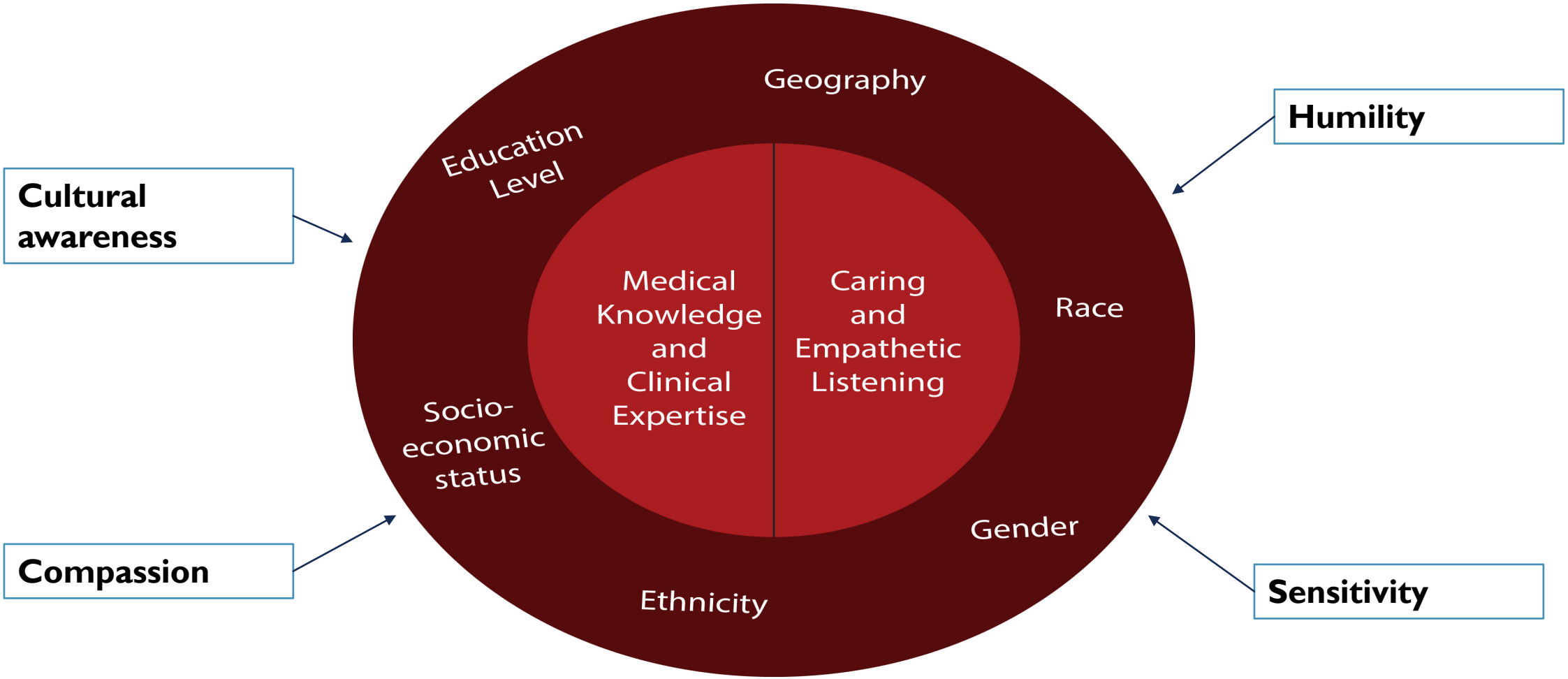
https://reproductiverights.org/maps/abortion-laws-by-state/

WHAT ELSE CAN WE DO?

Strategies to address racial/ethnic disparities in pregnancy-related deaths, including improving women's health and access to quality care in the preconception, pregnancy, and postpartum periods, can be implemented through coordination at the community, health facility, patient and family, healthcare provider, and system levels.

What else can we do for and with women to help improve their sexual and reproductive health outcomes?

CONSIDER A MEDICINE AND SOCIAL JUSTICE FRAMEWORK



KEY ACTION STEPS

- Support the leadership and power of those most excluded groups of women and girls within a culturally-relevant context that recognizes and addresses the multi-layered impact of oppression on their lives.
- Advance a concrete agenda that wins real individual, community, institutional and societal changes for poor women and girls of color.
- Integrate grassroots issues and constituencies that are multi-racial, multi-generational, and multi-class into the national policy arena.
- Build a network of allied social justice organizations who integrate a reproductive justice analysis and agenda into their work.

STRUCTURAL COMPETENCY: 85% OF PHYSICIANS FELT THAT SOCIAL NEEDS WERE AS IMPORTANT TO ADDRESS AS MEDICAL ONES…

- …yet 80% felt they were not confident in addressing social needs.
- Tools have been developed to assist clinicians in screening for some conditions, such as food insecurity and housing instability, and to incorporate these questions into electronic medical records.
- Including social indicator prompts in physician encounter tools has been shown to increase referrals to social services. Providing referrals to housing or food services while patients are in the clinic can improve their healthcare usage.

Table 1. Sample Screening Tool for Social Determinants of Health ⇦

Domain	Question
Food	In the last 12 months, did you ever eat less than you felt you should because there was not enough money for food?
Utility	In the last 12 months, has your utility company shut off your service for not paying your bills?
Housing	Are you worried that in the next 2 months, you may not have stable housing?
Child care	Do problems getting childcare make it difficult for you to work, study, or get to health care appointments?
Financial resources	In the last 12 months, have you needed to see a doctor but could not because of cost?
Transportation	In the last 12 months, have you ever had to go without health care because you did not have a way to get there?
Exposure to violence	Are you afraid you might be hurt in your apartment building, home, or neighborhood?
Education/health literacy	Do you ever need help reading materials you get from your doctor, clinic, or the hospital?
Legal status	Are you scared of getting in trouble because of your legal status? Have you ever been arrested or incarcerated?
Next steps	If you answered yes to any of these questions, would you like to receive assistance with any of those needs?

Modified from Health Leads. Social needs screening toolkit. Boston (MA): Health Leads; 2016; and Bourgois P, Holmes SM, Sue K, Quesada J. Structural vulnerability: operationalizing the concept to address health disparities in clinical care. Acad Med 2017;92:299–307.

OTHER PRACTICAL TOOLS FOR PROVIDERS…

- Screening for Social Determinants of Health—Provide patient-completed intake questionnaires, expanded medical history questions, and integrated electronic medical records prompts.
- Medical–Legal Partnerships—Obstetrician–gynecologist practices that are part of a community health care clinic or network should encourage the facility to establish medical–legal partnerships.
- Liaisons with Community-Based Social Needs Programs—Obstetrician–gynecologists and other health care providers should develop partnerships with social workers and local community advocates who provide assistance with basic resources such as food pantries and home utility bills.
- Interpreter Services—Language barriers can be partially addressed by having professional interpreters available when the patient's language is not the clinician's language.
- Transportation and Logistics—Access to public transportation should be considered when planning office locations.

ACOG COMMITTEE OPINION

Number 736 • May 2018

(Replaces Committee Opinion Number 666, June 2016)

Presidential Task Force on Redefining the Postpartum Visit
Committee on Obstetric Practice

The Academy of Breastfeeding Medicine, the American College of Nurse-Midwives, the National Association of Nurse Practitioners in Women's Health, the Society for Academic Specialists in General Obstetrics and Gynecology, and the Society for Maternal–Fetal Medicine endorse this document. This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Presidential Task Force on Redefining the Postpartum Visit and the Committee on Obstetric Practice in collaboration with task force members Alison Stuebe, MD, MSc; Tamika Auguste, MD; and Martha Gulati, MD, MS.

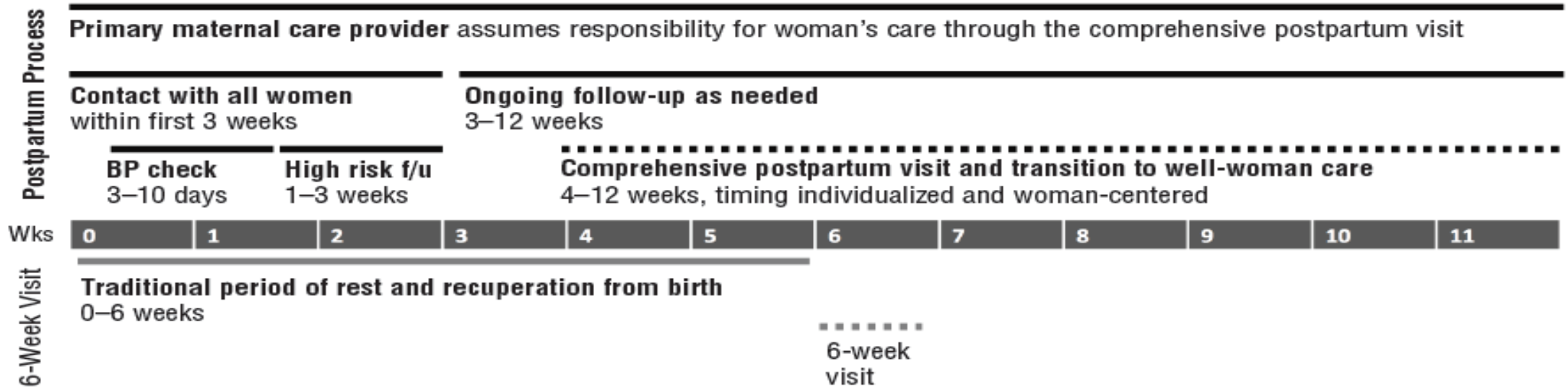


Figure 1. Proposed paradigm shift for postpartum visits. The American College of Obstetricians and Gynecologists' Presidential Task Force on Redefining the Postpartum Visit and the Committee on Obstetric Practice propose shifting the paradigm for postpartum care from a single 6-week visit (bottom) to a postpartum process (top). Abbreviations: BP, blood pressure; f/u, follow-up. ⇦

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

ACOG COMMITTEE OPINION

Number 729, January 2018

(Replaces Committee Opinion Number 493, May 2011)

Recommendations

- ACOG makes the following recommendations for obstetrician–gynecologists and other health care providers to improve patient-centered care and decrease inequities in reproductive health care:
- Inquire about and document social and structural determinants of health that may influence a patient's health and use of health care such as access to stable housing, access to food and safe drinking water, utility needs, safety in the home and community, immigration status, and employment conditions.
- Maximize referrals to social services to help improve patients' abilities to fulfill these needs.
- Provide access to interpreter services for all patient interactions when patient language is not the clinician's language.
- Acknowledge that race, institutionalized racism, and other forms of discrimination serve as social determinants of health.
- Recognize that stereotyping patients based on presumed cultural beliefs can negatively affect patient interactions, especially when patients' behaviors are attributed solely to individual choices without recognizing the role of social and structural factors.
- Advocate for policy changes that promote safe and healthy living environments.

ADULT IDENTITY MENTORING SUPPORTS DECREASED TEEN PREGNANCY…

- Increasing motivation for safer sex choices (where free choice is possible)
- Envision a positive future and discuss options in support of that future
- Present action
- Safeguarding one's future
- Good framework for LARC discussions (for those interested in long-acting reversible birth control options)

Clark, L. F., Miller, K. S., et al. Adult identity mentoring: Reducing sexual risk for African-American seventh grade students. Journal of Adolescent Health; 2005; 37(4), 337e1-337e10.

REACHING REPRODUCTIVE HEALTH EQUITY

"The best contraception is education."

-Dr. Joycelyn Elders,

15th Surgeon General of the U.S.A,

1993-1994

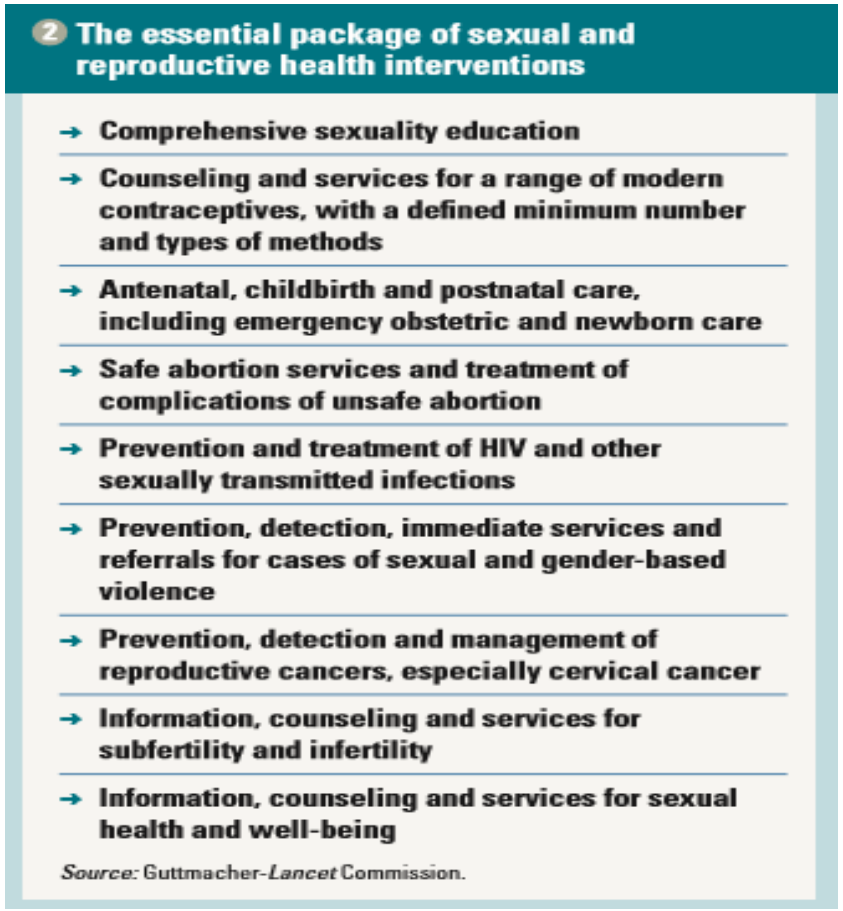
ACTION STEP:

- Every clinical encounter is an opportunity to **discuss family planning desires and options:**
  - Prenatal and postpartum visits
  - Emergency department
  - Routine GYN visits
  - Inpatient encounters
  - Transgender health care

GUTTMACHER-LANCET COMMISSION, SEPTEMBER 2018 EXPANDED DEFINITION OF SEXUAL AND REPRODUCTIVE JUSTICE

The definition includes the rights of all individuals to:

- have their bodily integrity, privacy and personal autonomy respected;
- freely define their own sexuality, including sexual orientation and gender identity and expression;
- decide whether and when to be sexually active;
- choose their sexual partners;
- have safe and pleasurable sexual experiences;
- decide whether, when and whom to marry;
- decide whether, when and by what means to have a child or children, and how many children to have; and
- have access over their lifetimes to the information, resources, services and support necessary to achieve all the above, free from discrimination, coercion, exploitation and violence.



For those who want to do more…

FOR THOSE WHO WANT MORE FORMAL ADVOCACY TRAINING, CONSIDER PHYSICIANS FOR REPRODUCTIVE HEALTH (HTTPS://PRH.ORG/)

(DISCLOSURE: FORMER BOARD MEMBER)

What we can all do…

The AMA now recognizes that VOTING is a social determinant of health.

The American Medical Association (AMA) House of Delegates adopted a resolution calling voting a social determinant of health, a term used to describe non-medical factors that affect health and wellbeing. Co-sponsored by the National Medical Association, the resolution also recognizes that gerrymandering limits access to care and leads to worse health outcomes.

Vot-ER @Vot_ER_org · Jun 13

Breaking News!🔔🥳

The @AmerMedicalAssn adopted Resolution 422, recognizing **voting** as a **social determinant** of health!

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 422
(A-22)

Introduced by: Minority Affairs Section, National Medical Association

Subject: Voting as a Social Determinant of Health

Referred to: Reference Committee D

Whereas, Social determinants of health are the non-medical unavoidable patient life conditions that directly influence healthcare risks and account for 30%-55% of healthcare outcomes[1-3]; and

Whereas, Citizens from historically excluded backgrounds are more affected by barriers to voting than White citizens: in states that have strict voting ID laws, Latino turnout drops by 9.3%, Black turnout by 8.6%, and Asian turnout by 12.5% after implementation of these laws compared to previous voter turnout statistics[4]; and

Whereas, Experiencing barriers to participating in the electoral process is correlated with an increased likelihood of being uninsured. In a national study on disparities in voter access, it was demonstrated that an increase in barriers to voting access is associated with a 25% overall greater probability of being uninsured[5-9]; and

Whereas, Individuals who experience voter suppression have disproportionately worse health outcomes, and these disparities largely affect people of color. Given that Healthy People 2020 identified civic participation as a social determinant of health[6,10-13]; and

Whereas, Inequitable distribution of resources and disproportionate negative health outcomes are closely associated, such that socioeconomic variables in a community can predict low voter turnout, including but not limited to demographics, household income, age, and residential mobility[6,11]; and

WHAT ELSE ARE FEASIBLE ACTION STEPS?…

- Medical-legal partnerships to support women and reduce disparities
- Partnerships with prenatal and postpartum doulas to help reduce maternal morbidity and mortality
- Establishing protocols that standardize patient care in certain scenarios, so that subjectivity and potential biases are reduced in clinical care situations
- Create ticklers in the medical record that remind providers to ask certain questions related to SDH, especially those that relate to equitable clinical outcomes
- Strengthen and expand social support systems that allow tangible resources to be in place when SDH issues are identified.

THANK YOU!

Email: drmadeline@onebrain4health.com