THE LAURA FLANDERS SHOW

BLACK MATERNAL MORTALITY: HOW DO WE SAVE BLACK LIVES?

LAURA FLANDERS: Why is our medical system failing Black Americans? And who's listening, not to mention what can be done? Almost a year ago on this program, I talked with journalist Linda Villarosa about her book "Under the Skin," which investigates structural racism in our medical system and its effects on Black lives. Since then, Linda has won awards. Her book was a finalist for the Pulitzer Prize this year. The subject, especially of the sky-high rates of Black maternal mortality in this country, has gained visibility, but what's changed? This time for our monthly feature Meet the BIPOC Press, we're going to return to the topic of birthing while Black. Now, I've never been pregnant, but not because I feared going into labor would kill me. As a middle class white woman, the chances are slim, but death in childbirth is a stark reality for Black families. Providers hear from Black patients who start fearing dying as soon as they find out they're pregnant. Partners are terrified they will lose their loved ones. The fact is, giving birth in this wealthy modern nation of ours is three to four times more likely to kill you if you're African American than if you are of any other race or ethnic group. And as Linda Villarosa documented in that book, that's regardless of income, wealth, region, or education. It's about race and gender and the unique discriminations that Black women face. So who is listening? Who is caring, and what can be done? Atlanta health reporter Kenya Hunter at Capital B News is paying attention. She has been reporting on these stories week after week in Georgia. Marianne Fray leads the Maternity Care Coalition in Southeast Pennsylvania, which is involved in some community-centered responses to this crisis that just could be leading to a different future. To pull it all together, I am joined once again by our partner here at "The Laura Flanders Show," Sara Lomax of Philadelphia's WURD Radio who with Mitra Kalita is co-founder of URL Media, a national network of independently owned and operated Black and Brown media outlets who partner with us here every month. Sara, welcome to the program, and welcome, our guests.

SARA LOMAX: It's great to be here, Laura. I'm so thrilled that we are going to dive into critical issues that we are facing right now.

KENYA HUNTER: First of all, I appreciate you all for having me on.

MARIANNE FRAY: I also want to thank both Sara and yourself, Laura, for this opportunity to shine a light yet again on an epidemic.

LAURA FLANDERS: It's such an important story. I wish I could say more had changed in the last year.

SARA LOMAX: I know that Capital B has been on the front lines of reporting on Black maternal mortality in Georgia, and so I wanted to throw the first question to Kenya Hunter from Capital B. What are you seeing in your reporting in the state of Georgia?

KENYA HUNTER: I think the story of Black maternal death in Georgia is one that we've known about for decades, but recently, my colleague Margo Snipe, who I am always very proud of, just finished a really big investigation where we learned a lot more about Black maternal death specifically, which is, you know, more than a quarter of Black Georgians live in a county with little to no access to care. And also nearly half of Black counties are maternity care deserts compared with about a third of majority white counties. And since '94, we've lost so many labor and delivery units. I believe the number that we've lost since 1994 is 41 labor and maternity units, and most of those have closed in majority Black counties. We've also lost Atlanta Medical Center here in Atlanta, and Atlanta Medical Center was a 460-bed hospital that had a really big active labor and delivery unit. And with that closure, we now are seeing Grady Memorial Hospital, our only level-one trauma center, seeing an uptick of about 30% more labor and delivery patients. So that turns into Black women seeking care when care for us is dwindling, and it's been dwindling for decades. In Georgia, 22.7 white women per 100,000 live births died from pregnancy-related issues, and then that rate nearly doubles at 48.6 per 100,000 live births for Black women. But we're also seeing Black women try to take this issue into their own hands by hiring doulas and midwives and taking care of themselves and choosing not to go to hospitals and having their births at home.

LAURA FLANDERS: Let's throw that to Marianne Fray. I mean, you, too, are on the front lines of some of these efforts to address this crisis.

MARIANNE FRAY: Black women particularly are saying, "We're not taking this anymore." We are taking things into our own hands and creating more of a structure where there are Black birth workers who are supporting families that are learning about what a doula is, which is essentially a nonclinical comfort for a person who's going through birth. There is agency happening, but the fact that there is a persistent elevated rate of women, Black women dying points to a serious problem.

SARA LOMAX: I really want to dive into the racial dynamic a little bit more because recently there have been several high-profile media projects. There was a documentary called "Aftershock," which chronicled this in a very personal way, the impact of Black maternal mortality on families and communities. And recently there was another piece done on a major network about the South and the crisis in maternal mortality in the South, particularly for low-income and Black women. What are the issues? There's history, and there are all these other dynamics, but what can we point to specifically that are making it so deadly to be Black and a birthing person?

KENYA HUNTER: I think a lot of that, honestly, has to do with medical racism, in all honesty. Of those deaths that I mentioned earlier where the majority of those folks who died in the state were Black, most of those deaths were considered preventable by the state. About 83% of those deaths were considered preventable by the state. The other thing I think of is like when we're talking about medical racism, right, which is a, like racism in a system that keeps people of color, in this instance Black women, not as healthy as white people. And so I think about some of the biases that some people may hold when they work in the medical system. I also would argue that Black medical workers are not immune from that.

MARIANNE FRAY: I was 17 when I had an unplanned pregnancy, and I did not anticipate, I was coming from a private school, I had an education. I just was, I didn't plan to be in that situation in a, you know, high-regarded medical setting in Philadelphia and just treated like dirt because the perception was, "Why are you here? Were there individual, was there something that you did?" And when you have historic, or time and time again, there's something called weathering that has been determined as what happens to Black women over time when they're going through traumatic experiences over and over again. Our bodies are not responsive, they're not healthy. So when you look at that culturally and you ask yourself, "How in the world are, you know, why is this happening?" There are these cumulative effects that I think are contributing to or at the root cause, and where does that go back to? Like I said, we have to look at history. We have to look at the trauma that has happened over time and how that has an impact on the body. I really think systems are designed for the kinds of statistics that we're seeing.

LAURA FLANDERS: We've seen now almost a year go by since the Dobbs decision and abortion being banned in half the states and strictly restricted in others. Louisiana, you saw almost a total ban signed into law by a Democratic governor. What's the effect of that insofar as you're seeing changes with reminding people that, you know, Black families often didn't have access in the first place?

MARIANNE FRAY: Yeah, I think any restriction on healthcare is going to only amplify the fears that people have about going to seek care. So it is not going to be, it's not going to be helpful for any person of color. When you have this restriction that's placed, there's fear, and then doctors are leaving because they're afraid that they're going to be prosecuted if they do anything that possibly violates it. So then you've got less doctors in the system. You already have a payment problem. So there's reimbursement. Most of the birthing people are on Medicaid. They're not being reimbursed. The doctors are not being reimbursed at the same rate, so there's not a lot of incentive for them to stay. But if you add in now these restrictions, it means that you're going to have less people getting care that they're already not getting enough of. So when Kenya talked about the birthing hospitals or the centers being, departments being closed, a lot of it gets to the

fact that there's fear on both sides, the provider, the medical provider, and it's really creating a serious problem for folks that don't have a lot of choice as it is.

KENYA HUNTER: And then with abortion in Georgia, so in 2020, 65% of people who sought out abortions in Georgia were Black. So we're seeing that mostly Black people are seeking out abortion for a lot of reasons. Even though, you know, when I spoke to abortion providers about this, they weren't able to tell me a specific reason. But they did tell me that a lot of the people that come in are already parents, for example. Some patients have cancer, and they have to choose between getting, they're getting their chemotherapy or having a baby. So there are a lot of factors. I also know that when Roe v. Wade was overturned, there was a researcher from the University of Colorado Boulder who predicted a 21% jump in pregnancy-related deaths in the country if Roe v. Wade was overturned. But that number then jumps to 33% when you're talking about Black women. And so the more people who are giving birth, that obviously adds to, you know, the number of people who may have, experience complications, even deadly if they're in a situation where they have to give birth if it's not a life-threatening situation as defined by the state.

SARA LOMAX: I just want to go back to something that Marianne said about weathering and this notion of the historical context that Black women carry with them in terms of, you know we were actually bred as enslaved women to, you know, birth was a business practice in many ways, and children were ripped from us. And you know, Black women were experimented on. The quote, unquote, father of gynecology, Marion Sims, in the 1840s, he used Black women to experiment on gynecological procedures. So I do think that Black women are carrying a lot of historical trauma related to birthing and childbearing and things of that nature. That said, what are the things, and this is to you, Marianne, what are the things that organizations like Maternity Care Coalition are doing to make sure that Black and Brown women from this point forward are going to get the best possible care, the best possible outcomes in their pregnancy and their birthing experience?

MARIANNE FRAY: I think the first thing that we do, and I think any advocacy agency does, is start with listening. And so we can't, we being the organization, cannot approach any situation like this as though we have the answer. We are partners in the answer. So when we actually meet with a family, we meet them where they are. That's another thing is the first you could do is not be judgmental. There may be substance use disorder. The worst thing you can do is approach that person with the perspective that you know, "Why are you doing this? You know you're pregnant, why are you?" That will not be helpful. Listen, meet folks where they are, and then ask for what is your objective? What is your birth plan? What do you want to achieve in this? Some folks may say, "Put me out. Like, I don't want to deal with it." Some may say, "I really, like, I had three C-sections. I don't want to have any more C-sections. Like, I want to experience a natural birth." Listening, partnering with that individual to make those decisions in the context of a medical

setting where there's a distrust. And then another thing is, let's step right back, let's get back. We've gotta have a workforce that looks like the folks that we're serving. When somebody lives next door or they live down the block, and they're coming in or they're just saying, "Listen, I've been trained by Maternity Care Coalition to be a doula. I understand what you're going through." That is how we're at approaching this is to hire people that are from the community, pay them a living wage. How in the world could we ever advocate on behalf of of these inequities if we are not paying our staff a higher, a living wage? So we made business decisions to ensure that that would happen. During COVID, we closed down high-rent properties, and we redirected those funds into salaries, because if we truly believe that we're going to set an example, we're going to be partners, we can't be doing it and perpetuating the white supremacy practices that really shift the power dynamics and expect people to work for pennies.

SARA LOMAX: I wanted to just say something about that. All of that is incredible, but there's a policy aspect to all of this that has to be working hand in hand with the, you know, the on-the-ground work because there are policies in place that are making it harder for women of color, people of color to get access to quality care, maternal care and other healthcare. So where do we go on the policy front?

MARIANNE FRAY: Yeah, and I'm glad you asked that question, Sara, and you probably know having worked with Maternity Care Coalition, we have a very strong, we're a grassroots organization. So we had a success just last year getting the Medicaid postpartum extension passed, and we did that because we are part of a statewide coalition. We have a department that focuses exclusively on family-friendly legislation. We were responsible for making sure that women who are, people who are incarcerated and that are pregnant are would not be shackled while they were delivering, which shockingly was happening no more than 10 years ago, shockingly. So Maternity Care Coalition and our advocacy efforts in our advocacy department, we lobbied in Philadelphia, at Harrisburg. So there's a number of things we're doing on the advocacy level, and it's part and parcel to coalitions. That's why we're Maternity Care Coalition. We're working with other organizations to make sure that these legislators understand you cannot ignore us, you cannot. There are things that we really support in Philadelphia and Harrisburg is Morgan Cephas, the dignity bill. If you don't know about it, I'm glad to pass that along. And we really would love the Momnibus that has been advocated by Representative Underwood to be able to pass because those bills are what is going to start to shift on the legislative level, and so all of the organizations, because one organization alone can't do that.

LAURA FLANDERS: Well, you just wrote about this, Kenya. I mean, you just wrote a piece that said Black doulas can't solve the entire health problem in Georgia alone. You want to weigh in on this, Kenya?

KENYA HUNTER: I remember when we started writing that story, originally I just wanted to talk to doulas about the the easy parts and the difficult parts of being a doula, and then Elysia Douglas said something that just really stuck with me, which is that we can't solve this alone. She said that as Black women are taking Black maternal health into their own hands, it seems like we feel like if we get a doula, all of my problems should be solved. The doctor's going to listen to me because my doula's here. The nurses are going to listen to me because my doula's here. But the reality of it is that's not what happens. I know a lot of times doctors may not want to listen to doulas. I remember when I talked with Courtney Cage, who also gave birth at Emory University Hospital Midtown, who's told me that her doula was basically ignored by her doctor. You know, like Marianne said earlier, doulas are nonclinical helpers. So basically they're not in a place to help you medically, but they can help you advocate for yourself. But there are a lot of policy changes that do need to happen. In the Capital B analysis done by my colleague Margo Snipe around Georgia's issues with Black maternal death and Black maternal health, part of that, part of this system that keeps the status quo going and keeps labor and delivery units closed in Black counties but open in white ones is the Certificate of Need program. So that Certificate of Need center is this really demanding process to open a new healthcare facility. I know some states have repealed it, but in Georgia, the law remains. It's one of the most restrictive. If you want to open up a new care facility, basically it's really difficult, and not only is it difficult, but it allows existing hospitals around to object to the applications. I know that happened to one person in Augusta, Georgia, that Margo wrote about who was trying to open up a birth center. She projected that there would be maybe more than 200 births in that birth center, but because of the Certificate of Need program, she was blocked by neighboring hospitals. But also in Georgia, the other thing I'll say is it doesn't take much to close a facility. We all found out that Atlanta Medical Center was closing. It wasn't even because Wellstar told us, right? I know Wellstar was planning to tell us, but it ended up being leaked in the "AJC," but we weren't going to find out until maybe 30 days before the planned closure.

LAURA FLANDERS: While we're talking diversity and communication, I mean, I know Linda for a million years through kind of lesbian life, and we know across all women-identified groups that lesbian healthcare is rock bottom. I can only imagine that's true in Black lesbian circles, too. Have you done any research or reporting on the kind of queer aspect of all of this, Kenya?

KENYA HUNTER: That's something I'm actually working on. I do know that, one thing I've been so curious about is trans folks giving birth, because it's like as I hear Black women talk about our poor maternal health outcomes, I have been so curious about LGBTQ health. I identify as a queer Black woman, and so it's something that I need to be working on, right? But I do know that in Georgia, a lot of queer people call Georgia home, they call Atlanta home. I'm really curious about how queer women are experiencing birth as well.

LAURA FLANDERS: The lesbian stats are never good. Sara, you wanted to come back in?

SARA LOMAX: I think that this focus on Black maternal mortality is so vital, and I think that it's so sad that the statistics are what they are because I've had three healthy pregnancies. My deliveries were a little rough. I had three C-sections, but being pregnant and going through that process is quite miraculous. And so it, I just want to like make sure as we talk about the trauma and the fear and the crisis that we don't lose sight of the fact that we're talking about something that is actually very precious. I hope that we can remove all of these barriers and stigma and trauma that are associated with being pregnant as a Black person so that there is an opportunity to experience the beauty of pregnancy and childbirth and childrearing.

LAURA FLANDERS: Well, that makes me want to ask you, Marianne, about this fantastic Designing Motherhood project that you're part of, the narratives that are on your website and the mobile mom, the MOMobile project, which all of which we'll have links to at our website, and I encourage people to check out.

MARIANNE FRAY: Oh sure, the MOMobile started in 1989, and when I said earlier MCC is about coming to where you are in a non-judgmental way, instead of worrying about parents coming to some center, we bring our advocates to the homes of the people that we serve, and we go in, and we do health education. We'll bring essential supplies, you know, baby wipes and diapers, and what we do is we're coming to where folks are, and I think that that's a beautiful thing. That's why MOMobile, I think, is a sustainable kind of program. We want people to live. We want to be able to build a future that is promising for our children. Our parents, the parents are the children's first teachers. Without stability, you can't ever hope to break any cycles of poverty or trauma if we don't take care of the mamas. That's why I'm glad MCC has a two-generation approach, because it's not just the baby, it's not just the mom, it's both. And if we don't take care of both, we can't possibly impact the community, and then that's not going to work. If we don't help the community, we're not going to be able to effect change.

LAURA FLANDERS: Kenya, I think I'm going to let you end this conversation. We've gone all over the place, and we've ended in a kind of hopeful, I think, moment. Do you want to tell us about the story that you hope that you might be reporting, I don't know, five years from now, 10 years from now?

KENYA HUNTER: I hope that Georgia is no longer going back and forth with Louisiana on how many women die from childbirth. I hope that's a story that I'm reporting on soon. One thing that I really love that Capital B did recently, we had a Twitter space about the joys of Black motherhood. And I think I'd be remiss to not mention my mom, who I lost in 2019, but she was the pinnacle of my life when it came to what unconditional love means from a Black woman. I think the Black mothers, who I know so many of which are my friends now, are some of the bravest people I know. And so I hope that we continue to talk about the bravery that Black

birthing people are offering when they choose to have children. I also hope we talk to people who choose not to have kids, but I hope that when we're talking to those people, it's not because they're deathly afraid of giving birth. I hope that for Black trans people who give birth. I hope that for Black queer people who give birth. I hope that for everybody who chooses to give birth especially in Atlanta. We don't really take time to play a role in the solutions. It's like we leave it to our sources who are advocates to come up with the solutions. But if we are more solutions oriented, talk to people about what the limitations of certain solutions are versus, but also the hope in those solutions, I think that we would be a much better industry for that.

LAURA FLANDERS: Sara, you want to take it out? You are telling those stories at URL Network.

SARA LOMAX: Yes, this has been an amazing conversation and so timely and so needed as we are looking at ways that we can amplify the stories through URL Network, through, you know, what Capital B is doing, what we do at WURD in Philadelphia and the work that Maternity Care Coalition is doing on the ground in Philly. So we just have to all keep our shoulder to the grindstone and keep working and envisioning a better, more prosperous and healthy future.

LAURA FLANDERS: Beautiful, thank you, Sara Lomax, Marianne Fray, Kenya Hunter, another Meet the BIPOC Press episode of "The Laura Flanders Show." Thank you so much.

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