VIRGINIA COUNCIL ON Women

Executive Summary 2020

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2020-2021 Virginia Council on Women

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About the Virginia Council on Women

The Virginia Council on Women (Council) is established by § 2.2-2630 as an advisory council in the Executive branch of state government. The purpose of the Council is to identify ways in which women can reach their full potential and make their full contribution to society and the Commonwealth.

The Council consists of 18 members from around the state, who are appointed by the Governor, as well as one of the Governor's Secretaries who serves as an ex-officio member with full voting privileges. Members serve a term of three years and may be reappointed. Over the past several years, the Council has focused its efforts on engaging and empowering women through STEM, healthcare, and convening.

Purpose

1. Determine the studies and research to be conducted by the Council;
2. Collect and disseminate information regarding the status of women in the Commonwealth and the nation;
3. Advise the Governor, General Assembly, and the Governor's Secretaries on matters pertaining to women in the Commonwealth and the nation;
4. Establish and award scholarships pursuant to regulations and conditions prescribed by the Council;
5. Review and comment on all budgets, appropriation requests, and grant applications concerning the Council, prior to their submission to the Secretary of Health and Human Resources or the Governor; and
6. Develop programs and projects on matters pertaining to women in the Commonwealth and the nation through public-private partnerships.

The Council focuses its work on three key areas that are important to the prosperity of the women and girls in the Commonwealth. Board members serve on committees to help advance these areas.

Committees

Science, Technology, Engineering and Mathematics (STEM) Initiative Subcommittee

- The Science, Technology, Engineering, and Mathematics (STEM) Initiative Subcommittee is focused on encouraging women to become more involved in STEM-related fields. The subcommittee's most notable contribution is its annual STEM Essay Contest. Each year, the Council awards a scholarship to a high school junior or senior girl planning to pursue a STEM major at an institution of higher education. Today, the contest continues, and the Council has awarded more than $150,000 in scholarships to women-identifying high school girls across the state since its establishment in 2012.
    - Stem Essay Contest: Each year, the Virginia Council on Women (Council) will provide one scholarship to a high school senior in each of five geographic regions across the Commonwealth. Award amounts may vary and are determined by the Council annually.
- 2019-2020 Chairwoman: **Jill Gaitens, Ed.D.**
- 2020-2021 Chairwoman**: Da'Shaun Josephs**

Healthcare Initiative Subcommittee

- The Healthcare Initiative Subcommittee was created to take a closer look at the issues affecting women's healthcare in Virginia. The subcommittee develops recommendations on what the state government can achieve to improve access to quality healthcare for women and families across the state since its establishment in August 2013.
- 2019-2020 Chairwoman: **Michelle Strucke**
- 2020-2021 Chairwoman: **Michelle Strucke**

Community Engagement Committee

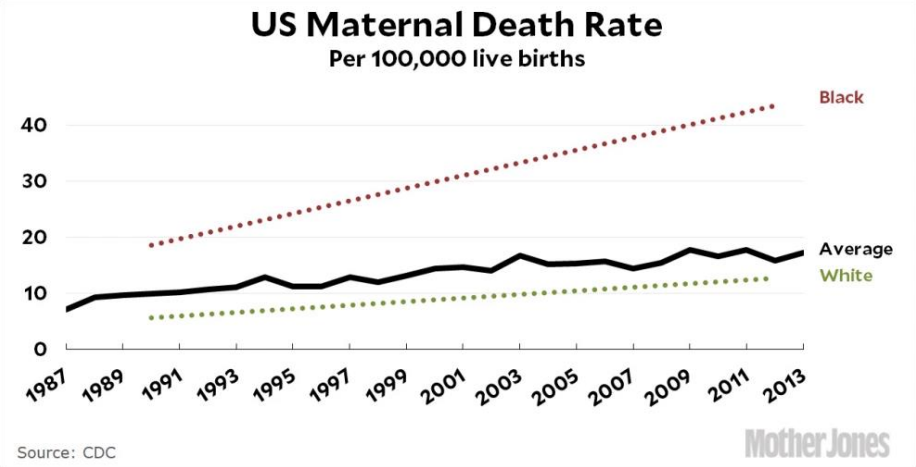
- The Community Engagement Committee assesses the engagement of women and girls within the Commonwealth in the areas of public services and programs, voter engagement, and civic participation. We explore the barriers to awareness and access and work to improve communication between the Administration, service and program providers, and our disparate communities
- 2019-2020 Chairwoman: **Caryn Foster Dunham**
- 2020-2021 Chairwoman: **Aisha Johnson**

Executive Summary

Pursuant to Section 2.2-2630 of the Code of Virginia, the Virginia Council on Women (VCW) is pleased to submit to the Honorable Ralph S. Northam this annual executive summary of its activities, findings, and recommendations which will be focused on the Council's 2019-2020 Health Care focus on maternal morbidity and mortality.

Introduction

UNICEF defines maternal mortality as "deaths due to complications from pregnancy or childbirth."[1] Between 200-2017 world maternal mortality declined by 38 percent per 100,00 live births from 342 deaths to 211 deaths.[2] This equaled a worldwide rate of reduction of 2.9 percent, yet in the US, the world's wealthiest nation, rates are rising.[3]



[4]

Currently, the United States has the highest maternal mortality rate in the developed world, at more than two deaths per day if averaged over the year and rising.[5] This means a woman born in 1989 will have twice the likelihood of dying in childbirth compared with her mother - but only if she lives in the United States. Annually, roughly 700-900 women die from causes related to pregnancy and childbirth, and even if a mother survives more than 50,000 women will experience severe complications.[6]

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[1] UNICEF. (2019, September 03). Maternal mortality. Retrieved October 19, 2020, from https://data.unicef.org/topic/maternal-health/maternal-mortality/

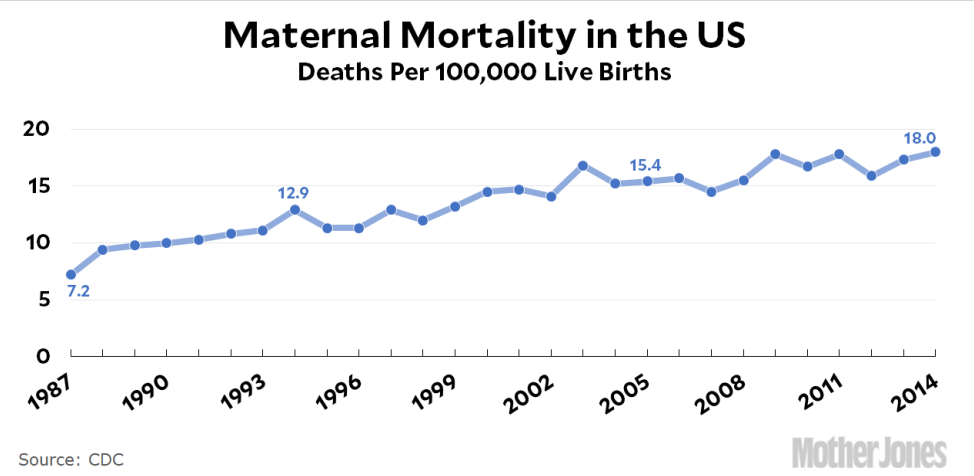
[2] UNICEF 2019.

[3] UNICEF 2019.

[4] Waldman, A. (2017, December 27). How Hospitals Are Failing Black Mothers. Retrieved October 19, 2020, from https://www.propublica.org/article/how-hospitals-are-failing-black-mothers

[5] The United States ranked 138 out of 184 nations and territories, according to 2015 data in the CIA World Factbook, available at https://www.cia.gov/library/publications/the-world-factbook/rankorder/2223rank.html

[6] Waldman, A, 2017.



[7]

The U.S. Department of Health and Human Services (DHHS) and the Centers for Disease Control and Prevention (CDC) published a comprehensive report looking at pregnancy-related deaths from 2011-2015 in May 2019.[8] In the DHHS and CDC study, researchers found that a total of 3,410 pregnancy-related deaths occurred in the United States between 2011-2015.[9] Further, overall the publication noted that pregnancy-related deaths occur not only during childbirth but also occur during pregnancy and up to 1 year postpartum. Within their time-bound study, it was revealed that nationally the leading cause of death varies by the timing of the death. For illustration, the study noted that women who passed on the day of their delivery suffered from acute obstetric emergencies such as hemorrhaging; hypertension disorders were often a cause of death 0-6 days postpartum, and thrombotic pulmonary embolisms being common causes of death both 1-42 days postpartum as well as during pregnancy.[10]

Unfortunately, DHHS and CDC also reported that three in every five pregnancy-related deaths were preventable and that preventability ran across race/ethnicity lines and timing of death[11]. The fact that these deaths are preventable suggests the strong possibility that public health interventions could turn the tide.

Factors impacting women's health can have seemingly surprising origins. For instance, research has linked women's political participation with infant mortality rates, estimating that compared with conditions of gender parity, women's underrepresentation in legislative office was associated with nearly 3,500 excess infant deaths per year.[12] And

[7] Waldman, A. 2017.

[8] Petersen, E. E., MD, Davis, N. L., PhD, Goodman, D., PhD, Cox, S., MSPH, Mayes, N., Johnston, E., MPH, . . . Barfield, W., MD. (2019, May 09). Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States, 2013–2017. Retrieved September 30, 2020, from https://www.cdc.gov/mmwr/volumes/68/wr/mm6818e1.htm?s_cid=mm6818e1_w

[9] Petersen et al., 2019

[10] Petersen et al., 2019

[11] Petersen et al., 2019

[12] Homan, Patricia. Structural Sexism and Health in the United States. 2018. Available at https://dukespace.lib.duke.edu/dspace/bitstream/handle/10161/16879/Homan_duke_0066D_14513.pdf?sequence=1

women exposed to more sexism at the state and marital levels were more likely to report more chronic health conditions, worse physical functioning, and worse self-rated health.[13]Further, the negative trend and the disparities within have broader implications for our health system. The disparity in maternal mortality represents the largest disparity amongst conventional population perinatal health indicators.[14] These indicators are tracked by health authorities to determine the health of a population and its children and include maternal-infant health status indicators, such as preterm birth and low birth weight, infant mortality, and maternal morbidity and mortality. Together, they tell us a story of how well a health system is functioning, since the individual clinical interventions needed to improve each area are well known, yet to make a difference, they require a robust and functioning system around each intervention. They are therefore considered "sensitive indicators" of an entire health system and can be used to monitor health progress more broadly.[15] Seeing maternal mortality increase is an alarming trend that signals broader breakdowns in our health system that require immediate attention.

Maternal Health and Black[16], Indigenous and Persons of Color

Digging more deeply, we find that maternal health outcomes amongst people of color are even more devastating. A September 2019 report by the CDC[17] stated that maternal mortality rates are four to five times higher for non-Hispanic Black and American Indian or Alaska Native women. DHHS and CDC found that the highest pregnancy-related deaths were 3.3 times as high for Black women as White women (42.8 PRMS per 100,00 live births in Black women versus 13 PRMS per 100,000 live births in White women), and 2.5 times higher for American Indian/Alaska Native mothers than White Women (32.5 PRMS per 100,000 live births in American Indian/Alaska Native women versus the 13 PRMS for White Women).[18] The National Partnership for Women & Families reported in 2018 that Black women are three to four times more likely to experience a pregnancy-related death

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[13] Homan, Patricia, 2018.

[14] Howell, Elizabeth A. Reducing Disparities in Severe Maternal Morbidity and Mortality. Clin Obstet Gynecol. 2018 Jun; 61(2): 387–399. Retrieved October 13, 2020 from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5915910/

[15] Graham, Cairns, Bhattacharya, et al, Chapter 26, Maternal and Perinatal Conditions, in Jamison DT, Breman JG, Measham AR, et al., editors. Washington (DC): The International Bank for Reconstruction and Development / The World Bank; New York: Oxford University Press; 2006. Retrieved October 13, 2020 from https://www.ncbi.nlm.nih.gov/books/NBK11742/

[16] The Council on Women will use the term Black and African-American in this document. The reasoning for this is not all Black persons in the Commonwealth are African-American which is a common term for current descendants of those Africans who were enslaved in America since 1619. The use of the word Black recognizes our African and Caribbean citizens whose family has now settled in the Commonwealth. Please see this article for a discussion on this topic: Eligon, J. (2020, June 26). A Debate Over Identity and Race Asks, Are African-Americans 'Black' or 'black'? Retrieved October 23, 2020, from https://www.nytimes.com/2020/06/26/us/black-african-american-style-debate.html
Further we capitalize the "b" in Black per the AP Guidebook. The Associated Press. (2020, June 20). AP changes writing style to capitalize ''b'' in Black. Retrieved October 23, 2020, from https://apnews.com/article/71386b46dbff8190e71493a763e8f45a

[17] Centers for Disease Control. (2019, September 06). Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths. Retrieved October 19, 2020, from https://www.cdc.gov/media/releases/2019/p0905-racial-ethnic-disparities-pregnancy-deaths.html

[18] Petersen et al., 2019

than White women and are more likely to experience preventable maternal death than White women.[19] Black women were 60% more likely to experience preeclampsia than White women and experienced poorer outcomes from the condition.[20] Preeclampsia, a serious hypertensive disorder defined as new-onset high blood pressure after twenty weeks gestation, is one of the leading causes of maternal mortality and is considered the most preventable cause of maternal death.[21] Black mothers are also twice as likely to have an infant die by their first birthday.[22]

While oftentimes communities attempt to resolve health inequities using community-based programs which most frequently target populations who receive assistance such as Medicaid and Children's Health Insurance Program (CHIP), this approach misses women who surpass the income limits for these programs and are experiencing health disparities.[23] Evidence shows that the issue of increased maternal morbidity and mortality is not socioeconomically driven within Black mothers. The New York City Department of Health and Mental Hygiene published a report which showed that Black college-educated mothers still fared worse than women of all other races who never completed high school.[24] Also, Black women who lived in some of the wealthiest neighborhoods in the study continued to have worse outcomes than White, Hispanic, and Asian mothers in the poorest ones.[25] Altogether, the American Academy of Family Physicians states that these outcomes are a result of decades of systemic racism.[26]

Structural racism is defined as "a system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity. It identifies dimensions of our history and culture that have allowed privileges associated with "whiteness" and disadvantages associated with "color" to endure and adapt over time. Structural racism is not something that a few people or institutions choose to practice. Instead, it has been a feature of the social, economic, and

[19] National Partnership for Women & Families. (2018, April). Black Women's Maternal Health. Retrieved September 15, 2020, from https://www.nationalpartnership.org/our-work/health/reports/black-womens-maternal-health.html
[20] Fingar, Hernandez, et al. (2017, April 25). "Delivery Hospitalizations Involving Preeclampsia and Eclampsia, 2005-2014" Retrieved October 19, 2020 from https://hcup-us.ahrq.gov/reports/statbriefs/sb222-Preeclampsia-Eclampsia-Delivery-Trends.jsp?utm_source=ahrq&utm_medium=en-1&utm_term=&utm_content=1&utm_campaign=ahrq_en4_25_2017
[21] Fingar, Hernandez, et al. 2017
[22] Marian F. MacDorman and T.J. Matthews, "Understanding Racial and Ethnic Disparities in U.S. Infant Mortality Rates" (Atlanta: Centers for Disease Control and Prevention, National Center for Health Statistics, 2011), retrieved October 13, 2020 from https://www.cdc.gov/nchs/data/databriefs/db74.pdf.
[23] AAFP letter, 2020
[24] Waldman, A. (2017, December 27). How Hospitals Are Failing Black Mothers. Retrieved October 19, 2020, from https://www.propublica.org/article/how-hospitals-are-failing-black-mothers
[25] (Waldman, 2017)
[26] American Academy of Family Physicians (AAFP) letter in response to request for information released by the Centers for Medicare and Medicaid Services on February 12, 2020, dated May 31, 2020, retrieved October 8, 2020 from https://www.aafp.org/dam/AAFP/documents/advocacy/prevention/women/LT-CMS-RuralMaternalHealth-053120.pdf

political systems in which we all exist."[27] For public policies to effectively address structural racism, policymakers can apply social justice frameworks which deliberately address power imbalances between predominantly white power structures and people of color.[28]

What is missing from this review is any overwhelming evidence as to how communities can assist women of color to have safe and healthy pregnancies, births, and postpartum experiences. This could be attributed to the larger issues of health inequalities that touch communities of color. These larger health inequality issues include clear evidence showing that Black and African-American patients are treated differently than White patients in such areas as cardiovascular medicine, HIV treatment, and cancer treatment.[29] Research from the University of Virginia in 2016 suggests that there are also health disparities in the area of pain management.[30] Their study of medical students and residents revealed that a substantial number of White participants held incorrect beliefs about the biological differences between Black and White people. These beliefs included ideas that Black people's skin is thicker than white people, and that Black people's blood coagulates more quickly.[31] The issue is that these beliefs, which also couple with beliefs that Black patients are more prone to medication abuse, could impact the appropriate medical treatment of pain in Black patents. Another possible issue that could continue to perpetuate health inequities for people of color is that there is a clear lack of equity in providers, as even in 2014 Black Americans made up only 4% of the nation's physicians.[32]

Proposed Federal Legislation

This problem is gaining attention nationwide. In 2018, Senator Kamala Harris introduced legislation titled the *Maternal Care Access and Reducing Emergencies (Maternal CARE) Act* that would address racial disparities in maternal health.[33] Virginia Senator Tim Kaine also

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[27] The Aspen Institute, "Glossary for Understanding the Dismantling Structural Racism/Promoting Racial Equity Analysis," Retrieved October 19, 2020 from https://assets.aspeninstitute.org/content/uploads/files/content/docs/rcc/RCC-Structural-Racism-Glossary.pdf

[28] Jamila Taylor, Cristina Novoa, Katie Hamm, and Shilpa Phadke, Center for American Progress, May 2, 2019, Eliminating Racial Disparities in Maternal and Infant Mortality: A Comprehensive Policy Blueprint. Retrieved October 19, 2020 from https://www.americanprogress.org/issues/women/reports/2019/05/02/469186/eliminating-racial-disparities-maternal-infant-mortality/

[29] Jones, S. (2019, April 25). There's a Problem With Elizabeth Warren's Maternal Mortality Plan. Retrieved October 19, 2020, from https://nymag.com/intelligencer/2019/04/the-problem-with-elizabeth-warrens-maternal-mortality-plan.html

[30] Samarrai, F. (2016, April 4). Study Links Disparities in Pain Management to Racial Bias. Retrieved October 19, 2020, from https://news.virginia.edu/content/study-links-disparities-pain-management-racial-bias

[31] Samarrai, 2016.

[32] Jones, S. (2019, April 25). There's a Problem With Elizabeth Warren's Maternal Mortality Plan. Retrieved October 19, 2020, from https://nymag.com/intelligencer/2019/04/the-problem-with-elizabeth-warrens-maternal-mortality-plan.html

[33] S.1600, *Maternal Care Access and Reducing Emergencies (Maternal CARE) Act*, available at https://www.congress.gov/bill/116th-congress/senate-bill/1600/text

cosponsored this bill.[34] The bill would provide funding for implicit bias training for medical professionals, and pilot the Pregnancy Medical Home program based on a similar North Carolina offering where a case manager is assigned to expediting Medicaid beneficiaries who are at high risk of complications. Further, financial incentives are provided to encourage physicians to enroll in the program and maintain a standard of care throughout the participating woman's pregnancy.[35] The model focuses on assisting women, most often Black women, with the burdens that can impact healthy pregnancies such as poverty, access to preventative health care, as well as food and housing insecurity.[36]

Specific to the Commonwealth's federal representation, Virginia Senator Kaine introduced legislation aiming to tackle maternal mortality at the federal level titled the *Mothers and Newborns Success Act* in July 2020 alongside Senators Lisa Murkowski and Congresswoman Terri Sewell.[37] Senator Kaine engaged in roundtables in the Commonwealth including in the cities of Hampton, Oakton, and Lynchburg to learn more about the Black maternal health crisis in the Commonwealth. If passed and enacted, this legislation would establish a pilot program through HRSA to support women's health in the postpartum period, establish a National Maternal Health Research Network at NIH to support research to reduce the United States maternal mortality and promote maternal health; and support HRSA's Rural Maternity and Obstetric Management Strategies (RMOMS) Program to improve access to and continuity of obstetrics care in rural communities including through telehealth, along with providing a competitive grant fund for states using innovation to reduce racial disparities in maternal health.[38]

Commonwealth of Virginia Statistics and Efforts

Women in Virginia today are more likely than their mothers to die a pregnancy-related death[39], either during pregnancy, during childbirth, or within one year of having a child or terminating a pregnancy. Virginia rates are similar to overall US rates and feature the same

[34] Kaine, Murkowski, Sewell Introduce Legislation To Reduce Maternal And Infant Mortality, Address Racial Inequities In Maternal Health. (2020, July 22). Retrieved October 19, 2020, from https://www.kaine.senate.gov/press-releases/kaine-murkowski-sewell-introduce-legislation-to-reduce-maternal-and-infant-mortality-address-racial-inequities-in-maternal-health

[35] Jones, 2019

[36] Jones, 2019

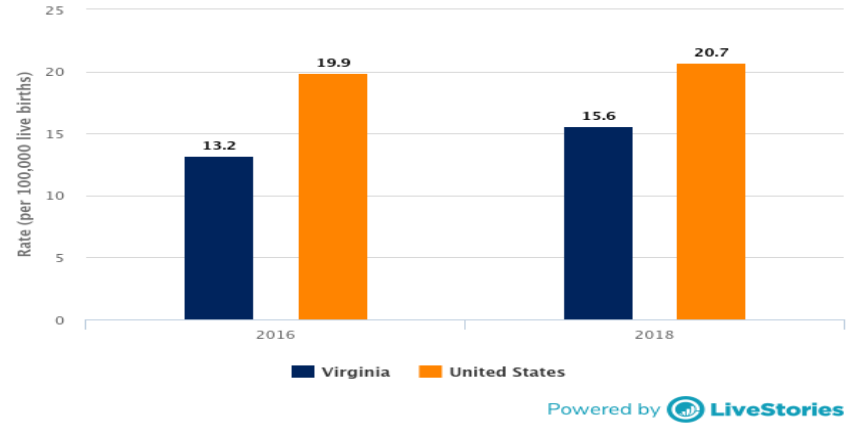
[37] Congresswoman Sewell introduced companion legislation in the House of Representatives. Kaine, Murkowski, Sewell, 2020.

[38] Kaine, Murkowski, Sewell, 2020. S.4269, Mothers and Newborns Success Act, introduced July 22, 2020. Most recent legislative action was two committee readings. Available at https://www.congress.gov/bill/116th-congress/senate-bill/4269

[39] A pregnancy-related death is "caused by a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy", Pregnancy-Related Mortality in the United States, 2011-2013. *Creanga AA, Syverson C, Seed K, Callaghan WM, Obstet Gynecol. 2017 Aug; 130(2):366-373.*

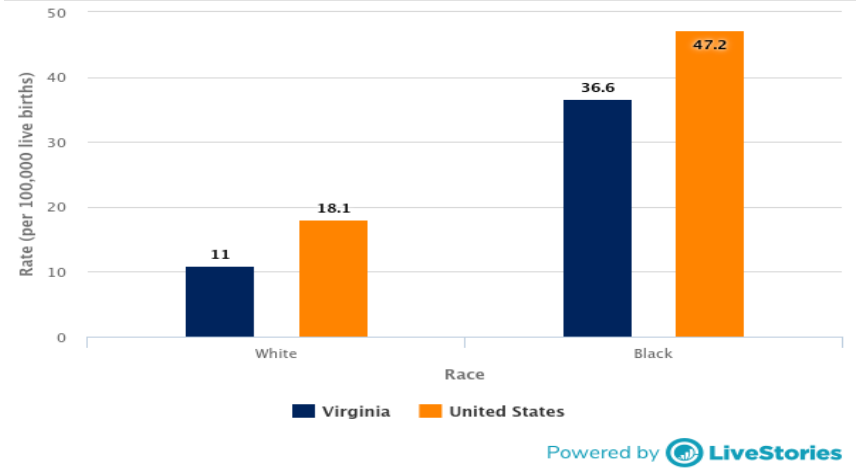
startling racial disparities. In Virginia, black women are three times as likely as non-Hispanic White women to lose their lives in the process of becoming a mother.[40]

Figure 33: Maternal Mortality Rate (per 100,000 live births), by Year
Source: CDC WONDER; retrieved from American Health Rankings 2016 and 2018



Further, the Commonwealth has not been able to ensure the safety of women of color either. The Virginia Department of Health's Office of the Chief Medical Examiner reported that the maternal mortality rate for Black women is over two times as high as White women.[41] Further, the Virginia Maternal Mortality Review Team shows that in the Commonwealth the majority of pregnancy-associated deaths occur more than 43 days after pregnancy.[42] For new mothers on a low-income, the threat of disparate impact is even greater as the FAMIS MOMs program in the Commonwealth only provides Medicaid coverage for women during pregnancy and 60 days postpartum[43].

Figure 34: Maternal Mortality Rate, by Race/Ethnicity
Source: CDC WONDER; retrieved from American Health Rankings 2018



[40] Virginia Maternal and Child Health, Maternal Mortality and Morbidity

[41] Yarmosky, A. (2019, June 5). Governor Northam Announces Goal to Eliminate Racial Disparity in Virginia Maternal Mortality Rate by 2025. Retrieved October 19, 2020, from https://www.governor.virginia.gov/newsroom/all-releases/2019/june/headline-840941-en.html

[42] Yarmosky, A. (2019, December 9). Governor Northam Announces Budget Proposals to Combat Maternal and Infant Mortality, Reduce Racial Disparity. Retrieved October 19, 2020, from https://www.governor.virginia.gov/newsroom/all-releases/2019/december/headline-849796-en.html

[43] Yarmosky, 2019, December 9.

In 2019, both the Legislature and the Governor recognized this issue and moved to action. In Spring 2019 two key pieces of legislative action were passed and supported by Governor Northam. House Bill 2546 was passed to establish a Maternal Death Review Team which is charged with developing and implementing procedures to ensure that maternal deaths occurring in the Commonwealth are analyzed systematically.[44] House Bill 2613 added information about prenatal anxiety to the information already provided to maternity patients and their families by nurses, midwives, and hospitals providing maternity care.[45]

Then in June 2019, Governor Northam announced his goal to eliminate the racial disparity in the maternal mortality rate in Virginia by 2025.[46] The Governor charged his administration, as well as the Commonwealth to engage in this goal. At that time, Governor Northam directed the Department of Medical Assistance Services (DMAS) and the Department of Social Services (DSS) to establish a process to expedite enrollment for expectant women who are eligible for Medicaid, as well as for all relevant state agencies to develop a framework for scaling home visiting. He additionally directed the Department of Health Professions and the Virginia Department of Health to find ways to increase implicit bias and cultural competency training for healthcare professionals, and further directed any executive branch agency to provide additional recommendations to improve maternal health. Govern Northam's administration partnered with the Virginia Hospital and Healthcare Association to form a collaboration between ten Virginia hospitals and their ambulatory provides to provide evidence-based, culturally sensitive training and education to their staff with the Virginia Department of Health's assistance to collect data on the process, as well as to provide coaching and technical assistance in this endeavor.[47]

In December 2019, Governor Ralph Northam continued his efforts to reduce maternal mortality by including approximately $22 million in his proposed budget earmarked to efforts that would combat maternal and infant mortality and reduce the racial disparity in the Commonwealth.[48] Funding would additionally work to expand Medicaid coverage for new mothers, increase financial support for home visiting services by $12.8 million, and investigate Medicaid reimbursement for Doula supports. Governor Northam also sought to increase the Temporary Assistance for Needy Families (TANIF) funding by $4 million to increase access to contraception through the Long-Acting Reversible Contraception (LARC) program[49].

[44] Legislative Information System (2019, April). HB 2546 Maternal Mortality Review Team; established, investigations. Retrieved October 19, 2020, from https://lis.virginia.gov/cgi-bin/legp604.exe?191+sum+HB2546

[45] Legislative Information System (2019, February). HB 2613 Maternity care patients; adds information about perinatal anxiety. Retrieved October 19, 2020, from https://lis.virginia.gov/cgi-bin/legp604.exe?191+sum+HB2613

[46] Yarmosky, 2019, June 5.

[47] Yarmosky, 2019, June 5.

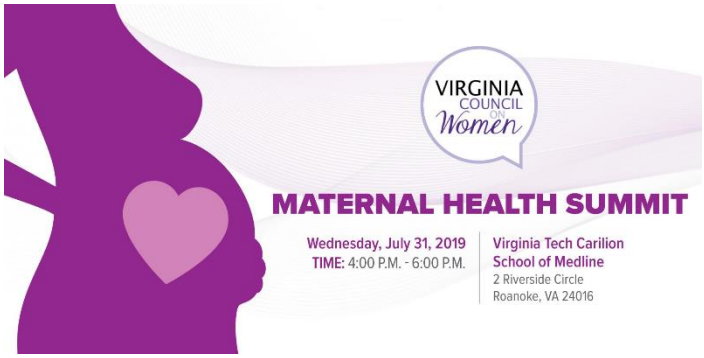
[48] Yarmosky, 2019, December 9.

[49] Yarmosky, 2019, December 9.

Health Committee Maternal Health Summit

The Virginia Council on Women's Healthcare subcommittee chose to focus on maternal health outcomes both holistically and with an emphasis on the nationwide health disparities experienced by African-American and Indigenous/Native women. This focus partnered well with Governor Northam's announcement of a goal to improve maternal health and eliminate the racial disparity in the maternal mortality rate in Virginia by 2025, as well as the Governor's budgetary focus on maternal health through a series of proposals that would have allocated $22 million to improve maternal health outcomes.[50]

The Council's Healthcare Committee, led by Mrs. Michelle Strucke as Chair, partnered with the Summit Subcommittee (now known as the Community Engagement Committee) which was led by Ms. Caryn Foster Durham to engage the women of the Commonwealth on this topic by hosting an event in Southwest Virginia. The event's goal was to bring to light real stories of women in the Commonwealth who have both positive and concerning maternal health experiences, partnered with an expert panel to continue the discussion as to why maternal outcomes are so poor in the United States for all women but specifically women of color.



On July 31, 2019, the Virginia Council on Women engaged the community through our *Maternal Health Summit* held in partnership with the Virginia Tech Carilion School of Medicine in Roanoke, Virginia on their campus. The event was the Council's attempt to bring awareness about maternal health outcomes to the community through a mix of presenting real-life stories from women in the Commonwealth about pregnancy, birth, and loss alongside a moderated expert panel. The event's keynote speaker was Ms. Gena Berger, Deputy Secretary of Health and Human Services Gena Burger. The Council membership engaged their communities to find stories that women were willing to share. Among those stories included one anonymously submitted story about miscarriage and pregnancy loss, a story read by Mrs. Larissa Grant about engaging in home births as a woman of color, a story by Mrs. Ashley Reynolds Marshall (read by Councilmember Mrs. Diana Gates) about African-American maternal mortality and its impacts on her decision to hold off on having children, a story by Mrs. Aisha Johnson (Council member) on her pregnancy experience, and a story by Dr. Katy Tyson (Council member) on her experiences with maternal mortality as an OB-GYN physician.

[50] Yarmosky, 2019, June 5.

An informational panel was moderated by Councilmember Dr. Katie Tyson, and the Council was honored to be joined by panelist Dr. Lee Learman, Dean of Virginia Tech Carilion School of Medicine and OB-GYN physician; Ms. Adenike Adenikinju, a 3rd-year medical student at the Virginia Tech Carilion School of Medicine who had researched race and obstetrics; Dr. Vanessa Walker-Harris, Director of the Office of Family Health Services at the Virginia Department of Health, and Ms. Stephanie Spencer, Executive Director of Urban Baby Beginnings (a Richmond, VA based nonprofit) and a Doula; RN.

The event format was powerful, allowing participants from a wide range of community organizations and students, faculty, and staff from the Virginia Tech Carilion School of Medicine the unique opportunity to hear perspectives from multiple touchpoints of maternal health on the same stage. Testimonies of women who had been recipients of maternal care, who had felt they were not heard in their care setting - a common problem reported by women, who chose to give birth outside of established health care systems through giving birth at home, and of a woman who - aware of the stark racial disparities in maternal health - had never been counseled by a medical professional on these increased risks, allowed audience members to witness experiences that too often go unheard in the common cultural narrative that motherhood is sacrosanct.[51] Then participants heard from providers themselves, including a powerful tribute to a woman who had tragically passed away in childbirth from an OB-GYN and member of the Council.

Panelists discussed their recommendations for how maternal health can be made more equitable in Virginia, and importantly talked about what is typically missing from conversations about maternal health. One key contribution by Ms. Adenikinju highlighted the often undiscussed role of black women in the racially unjust historic origins of gynecology, including that the 'father of modern gynecology' James Marion Sims experimented on black enslaved women's bodies,[52] and that black women were habitually left out of the narratives of medical ethics, such as how the horrific Tuskegee experiments in which black men were allowed to perish and suffer from untreated syphilis left out their black women partners who also suffered as a result. Other panelists made important points about the differential experience black women have within the healthcare system, the need to influence programming that health care providers provide to better recognize the racial bias and stressors black women experience to a higher degree than other women, and the important role other services such as home visiting can play, since only about 10% of a

[51] For a further discussion of the cultural tropes around motherhood and childbirth, see Lyz Lenz, Belabored: Vindication of the Rights of Pregnant Women, Bold Type Books, 2020.

[52] For greater discussion of this subject, see Dierdre Cooper Owens, (2017, November 15), Medical Bondage: Race, Gender, and the Origins of American Gynecology.

person's health is impacted by direct service delivery that they receive in the medical system.[53]

Following the Council on Women's *Maternal Health Summit*, the Virginia Office of the Secretary of Health and Human Resources held a series of Maternal Health Listening Sessions and Community Forums across the Commonwealth[54]. The roundtables used the event framework developed by the Council on Women and provided opportunities to bring the community, community organizations, local health care providers and hospital systems, elected officials, and leaders at state agencies to hear from individuals with lived experience and discuss strategies to improve maternal health and to help inform the development of a five-year strategic plan for achieving Governor Ralph Northam's goals to improve maternal health and eliminate the racial disparity in the maternal mortality rate by 2025.[55] The listening sessions were held during September and October 2019 in the following locations:

- Hampton, Virginia (in partnership with Delegate Jeion Ward and Senator Mamie Locke at Hampton University)
- Annandale, Virginia (in partnership with Delegate Charniele Herring at Northern Virginia Community College - Annandale Campus)
- Lynchburg, Virginia (in partnership with Motherhood Collective at the Community Access Network)
- Petersburg, Virginia (in partnership with Delegate Lashrecse Aird and Senator Rosalyn Dance at Virginia State University)
- Prince William, Virginia (in partnership with Delegates Elizabeth Guzeman, Jennifer Carol Foy, and Haila Ayala at Hylton Education Center - Sentara Northern Virginia)

[53] For more on the social determinants of health, see Sanne Magnan, (2017, October 9) "Social Determinants of Health 101 for Health Care: Five Plus Five", retrieved October 19, 2020 at https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/

[54] Yarmosky, A., &; Cunningham, L. (2019, September 25). Northam Administration to Host Maternal Health Listening Sessions. Retrieved October 19, 2020, from https://www.governor.virginia.gov/newsroom/all-releases/2019/september/headline-847582-en.html

[55] Yarmosky & Cunningham, 2019

- Portsmouth, Virginia (in partnership with Senator Louise Lucas at Lucas Lodge)
- Danville, Virginia (at the Mary B. Yancey House)
- Abington, Virginia (in partnership with United Way of Southwest Virginia at Southwest Virginia Higher Education Center)
- Richmond, Virginia (in partnership with Senator Jennifer McClellan at the Richmond Main Branch Library)
- Winchester, Virginia (at the Handley Regional Library)

These sessions provided critical grassroots information to help inform the development of the Governor's budget priorities around maternal health and have informed discussions around a proposed five-year strategic plan for achieving the Governor's goal to improve maternal health.

Based upon the Council's research on maternal health and health inequality, the Council on Women has created several recommendations for consideration by Governor Ralph Northam and his administration to continue to move the Commonwealth forward in reducing maternal mortality and decreasing instances of health inequity for not only expecting parents but for all marginalized women and girls.

Virginia Council on Women Recommendations

The VCW recommends the following actions that are under the purview of the Secretary of Health and Human Resources:

Maternal Healthcare Equity

- Provide a Medicaid benefit for home visiting and doula services. Build on the results of the study and of the home visiting pilot programs previously funded in the Commonwealth to develop and provide a Medicaid benefit for home visiting and doula services. This should include:
    - Oral health training for doulas.
    - Expanded access to home visiting by increasing coordinated referrals for home visiting services.
    - Direct resources for community organizations that are interested in offering home visiting services that don't currently have the capacity, particularly in areas that are likely to experience poor birth outcomes.
- Fully restore funds for the FAMIS MOMS' postpartum coverage benefits from 60 days to 1 year, in recognition of the fact that most deaths occur within one year of giving birth. This benefit would extend the length of time an uninsured expectant or new mother can be covered under the state's Medicaid program for uninsured mothers, known as FAMIS MOMS, which is critical to addressing some of the more common preventable causes of maternal deaths such as cardiac issues.
- Ensure that all women who have high blood pressure or develop it during pregnancy are issued a home blood pressure monitor free of charge and counseled on how to monitor their blood pressure at home.[56] This important step would help overcome barriers to care and increase access for women with high blood pressure by eliminating the need to schedule an appointment with a healthcare provider to monitor blood pressure. Preeclampsia is one of the most preventable major causes of maternal mortality.
- Initiate a two-year pilot program that provides a targeted, direct cash supplemental benefit to the lowest income pregnant women and mothers who are at most risk of experiencing the impacts of racial bias, modeled after San Francisco's Abundant Birth Project.[57] This monthly income benefit is a simple, innovative way to increase economic and reproductive power during pregnancy and in the months immediately following the birth of a child.
- Develop a partnership with major Virginia hospitals and birthing centers to develop, provide, and train staff on the use of a tool kit that includes everything needed to tackle emergency complications, based on the successful model developed in California that

[56] Harvard Health Blog, December 3, 2019, Can monitoring blood pressure at home cut maternal mortality? Retrieved October 8, 2020 from https://www.health.harvard.edu/blog/can-monitoring-blood-pressure-at-home-cut-maternal-mortality-2019120318455

[57] Mayor London Breed Announces Launch of Pilot Program to Provide Basic Income to Black and Pacific Islander Women During Pregnancy, retrieved October 8, 2020 from https://sfmayor.org/article/mayor-london-breed-announces-launch-pilot-program-provide-basic-income-black-and-pacific

helped the state cut maternal deaths in half.[58] The Commonwealth of Virginia should partner with a major research university, as well as key nonprofit organizations, to create a collaborative modeled after the California Maternal Quality Care Collaborative, which uses a multi-stakeholder approach to achieve gains in the reduction of maternal mortality.

- To follow up on the ten-stop maternal health listening tour and report back directly to populations who gave valuable feedback on racial disparities in maternal health and mortality, we recommend the Governor host a second maternal health informational session to talk about what is happening and what has happened since the events took place.

Diversity, Equity & Inclusion in Health

- The Council supports efforts in the Commonwealth[59] to declare racism as a public health crisis in the Commonwealth. As of June 15, 2020, Pew Trusts reports that more than 20 cities and counties, along with at least three states (Michigan, Ohio, and Wisconsin) have also declared racism a public health crisis.[60] The Council encourages considerations that would build on the work of the health equity task force within the COVID-19 unified command structure, the nation's first health equity structure in emergency response in a state. The Council implores the Commonwealth to develop an actionable, multi-sectoral strategic plan to tackle a range of health issues caused by racism in the Commonwealth of Virginia for her citizens.
- Improve, standardize, and make publicly available data on demographics as part of the plan that includes race, ethnicity, gender identity, and other information that is important to reducing disparities.
- Hold health institutions accountable, including by reporting on race/demographic data/c section rates in hospitals. C-section data was publicly available on the Virginia Department of Health website and is no longer published. While many hospitals have committed to lowering their c-section rates, women/womxn in Virginia are not able to make informed choices about which institutions to labor in without this important data.
- Create permanent health equity staff positions in relevant and critical State departments including but not limited to: the Virginia Department of Medical Assistance Services, the Virginia Department of Health, Department of Aging and Rehabilitative Services, Department of Behavioral Health and Developmental Services, Department of Social

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[58] NPR reports that "[f]rom 2006 to 2013, the maternal death rate in California fell 55 percent. These protocols — the checklists, carts, drills and teamwork — have not only saved women from dying, but they have also dramatically reduced the rate of women who nearly died. A study in the American Journal of Obstetrics and Gynecology found hospitals that signed up to implement the toolkits lowered the rate of severe maternal morbidity due to hemorrhage by nearly 21 percent. In hospitals not participating, that rate dropped by just over 1 percent. As of June 2018, 88 percent of California's birthing hospitals have joined, accounting for 95 percent of all the births in the state." Montagne, R. (2018, July 29). To Keep Women From Dying In Childbirth, Look To California. Retrieved October 23, 2020, from https://www.npr.org/2018/07/29/632702896/to-keep-women-from-dying-in-childbirth-look-to-california

[59] The Council supports the work of Delegate Lashrecse D. Arid who submitted House Resolution 570 and in the House of Delegates during the 2020 Summer special session to recognize systemic racism and a public-health crisis and to direct the state health department's health equity office to develop a policy to ensure fairness and preventive care to communities of color. Arid, L. D. (2020, August 25). House Resolution No. 570: Recognizing that racism is a public health crisis in Virginia. Retrieved October 23, 2020, from http://leg1.state.va.us/cgi-bin/legp504.exe?202+ful+HR570. The Council also supports the work of Delegate Hala S. Ayala who submitted House Resolution 582 that also recognizes racism as a public health crisis. Ayala, H. S. (2020, August 28). House Resolution 582: Recognizing that racism is a public health crisis in Virginia. Retrieved October 23, 2020, from http://leg1.state.va.us/cgi-bin/legp504.exe?202+ful+HR582

[60] Vestal, C. (2020, June 15). Racism Is a Public Health Crisis, Say Cities and Counties. Retrieved October 23, 2020, from https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2020/06/15/racism-is-a-public-health-crisis-say-cities-and-counties

Services, Office of Children's Services, Foundation for Healthy Youth, and the Virginia Board for People with Disabilities.

- Partner with medical and nursing schools/programs in the Commonwealth of Virginia to offer ongoing and in-depth implicit/explicit bias, anti-racism, cultural competency, and cultural humility training for students enrolled in programs focused on medicine, nursing, social work, and public health. The Council would suggest that this is a requirement for degree attainment. Further, the Council suggests working to provide similar continuing education for practicing midwives, nurses, OB-GYNs, and family physicians with funding support in place to assist in this endeavor.

Coordination & Multi-sectoral Approaches

- Institute universal, trauma-informed, and person-centered screening for pregnant and postpartum womxn to help create more comprehensive care. The Commonwealth of Virginia should focus on creating a seamless continuum of care - mindful that the systems need to talk to one another, and that they contain updated current information.
- Create workforce opportunities for more individuals to become certified peer specialists (drawing inspiration from behavioral-health and substance-use programs) and/or Community Health Workers to increase the opportunities for women in the Commonwealth to access health and wellness supports. The Council suggests a keen emphasis on advancing the pipeline for minority specialists and CHWs by partnering with all of Virginia's Colleges and Universities, including specific outreach and engagement with the Commonwealth's HBCUs and Community Colleges, to provide students increased opportunities to receive educational scholarships and direct links to workforce initiatives in not only urban localities but our rural communities.
- Provide more care coordination and system navigation support, particularly for vulnerable populations which include communities of color, communities with Limited English Proficiency, and our geographically-isolated communities. The Council suggests looking to nonprofit organizations that are engaged in this work such as United Way of Roanoke Valley's Healthy Roanoke Valley, Middle Border Forward, and The Health Collaborative who have both successfully piloted collective-impact based, social determinant of health-focused HUB programs in Southwest and Southside Virginia.

Childcare and Family Medical Needs

- Support paid maternity/paternity, and family medical leave for all Virginia families. Eight states and Washington, DC have successfully offered this benefit, which restores dignity and economic stability for families experiencing the birth or adoption of a child, or a family member's medical crisis. Virginians should not be left unattended in their greatest time of need due to the need for a paycheck. The Council also encourages the Commonwealth to ensure that any nonprofit organizations who are grantees be extended administrative allowances to build this into future grant requests to ensure individuals who work in the philanthropic sector (who oftentimes are women, and modest income women) are not left out.

- Support universal pre-K. The Commonwealth should view childcare as critical infrastructure. During the COVID-19 health crisis, one in four women nationwide is considering leaving the workforce.[61] This is largely attributed to a lack of childcare.

Reproductive Justice in Healthcare

- Expand access to assisted reproductive technologies. There are racial differences in access to care – black women are twice as likely to experience infertility but half as likely to access services. There are serious mental health ramifications that can result from not having access to reproduction-related services, particularly when access is limited based on finances. Currently, the Commonwealth of Virginia does not have any federal or state funding to address this challenge.

The VCW recommends the following actions that are under the purview of the Secretary of Education & Children's Cabinet:

Reproductive Justice in Education

- Investigate opportunities to engage youth in education that provides more than "abstinence-only" opportunities to learn more about their reproductive systems and the impacts of sexual activity which spans not only physical health and wellness but also mental and social wellness. The Council further recommends continued investment in education focused on healthy relationships as a part of during school-time education. These courses should include education on teen dating violence, domestic/intimate partner violence, bystander intervention for sexual harassment.

The VCW recommends the following actions that are under the purview of the Governor of the Commonwealth of Virginia:

Gender Equity

- Laws and policies that are on their face unrelated to health can have surprising impacts on marginalized populations and women. In recognition of the interconnectedness of these public policies, the Commonwealth of Virginia should develop a commission to undertake a gender equity review of laws and policies to make recommendations for key changes the legislature and Governor's administration can take to level the playing field. This could be modeled after the Governor's Commission to Examine Racial Inequity in Virginia Law[62], and examine laws and policies that appear gender-neutral, but have the impact of enabling inequities for women and womxn in Virginia.

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[61] Women in the Workplace study, 2020. Leanin.org & McKinsey & Company. Retrieved October 19. 2020 at https://womenintheworkplace.com/

[62] Governor Northam Commits to Repealing Racially Discriminatory Language in Virginia Law, Accessed October 19, 2020 from https://www.governor.virginia.gov/newsroom/all-releases/2019/december/headline-849698-en.html

- The Council on Women would further state that intersectionality, a term coined by Professor Kimberlee Crenshaw, is critical to the forward movement of women and girls in the Commonwealth who find themselves in multiple marginalized communities. The Council would recommend that an additional review of laws and policies be undertaken as a partnership between the commissions to review racial-equity and a commission to review gender-equity to ensure that the nuance required to fully support women and girls of all races, who are LGBTQIA, and who may be differently-abled are also supported fully.
- The Council on Women would further request that Governor Northam provide further tasks and charges for the Council on Women to focus on and approach our work in support and assistance to the Northam administration. This could include ways that the Administration could leverage the Council on Women within our focus on Women's Healthcare and issues of health inequality that impact the women and girls of the Commonwealth in addition to other key supports.