Maternal Health
Learning & Innovation Center™

MHLIC Health Equity Statement

Editorial Note: The below statement draws from the "Joint Organizational Commitment to Anti-Racism and Racial Equity" signed by four national maternal and child health organizations in May 2021. It is intended to be a "living document" and updated over time.

This version was completed in April 2022 by an internal working group and with input from the full MHLIC team on two occasions during the development of the statement.

Background
The mission of the Maternal Health Learning and Innovation Center (MHLIC) is to foster collaboration and learning among diverse stakeholders to accelerate evidence-informed interventions advancing equitable maternal health outcomes through engagement, innovation, and policy.

Equitable maternal health outcomes cannot be realized unless we eliminate the racial disparities that exist in our communities by acknowledging racism as a public health crisis and identifying bold strategies to address it. Racism, and its influence on our systems, has a detrimental impact on our society and on health outcomes. The impacts of racism are irrefutable, when looking at the disparities in maternal and infant morbidity and mortality rates among Black/African American and Indigenous populations compared to their white counterparts. Although our nation has made progress in improving maternal and infant health outcomes, success has not been experienced equitably across racial and ethnic groups and the pace of improvement has not progressed with the urgency this crisis demands.

For decades, the World Health Organization and other members of the international public health community have encouraged more of a focus on the social determinants of health -- the conditions in which we live, work, learn and play -- to enhance our understanding of factors that impact health outcomes. Simultaneously, the maternal and child health community has focused on the life course approach to health, which indicates that a mother's birth outcomes are impacted by her entire lifetime of experiences as well as the experiences of ancestral generations preceding her. While understanding these approaches has helped, we have politely tiptoed around the impact of racism. Structural, institutional, inter-personal and internalized racism directly impacts the environments in which people exist and critically shapes the experiences of African American, Latino, and Indigenous families throughout the course of their lives. Racism is the social determinant most responsible for the racial disparities that exist in our country. Failing to boldly acknowledge racism as the root cause of inequitable health outcomes results in merely addressing the symptoms of the problem rather than the cause. For example, if one has an infection, taking Tylenol may relieve the symptom of a fever caused by the infection, but leaves the cause of the infection to wreak havoc on the patient. Just as the underlying cause of an infection must be treated to truly cure the patient, racism must be dismantled.

The terms racial equity and health equity have often been used interchangeably. Although there may be overlap, we believe that health equity cannot be achieved without first achieving racial equity.

According to Dr. Nancy Krieger, “Social inequality kills. It deprives individuals and communities of a healthy start in life, increases their burden of disability and disease, and brings early death. Poverty and discrimination, inadequate medical care, and the violation of human rights all act as powerful social determinants of who lives and who dies, at what age, and with what degree of suffering.” For that reason, we believe striving for racial equity is essential to achieving health equity.

Racial inequities are compounded in underserved rural areas where there are lower numbers of health care providers per capita. Geographic disparities in maternal health highlight the need for improving maternal health care services for women residing in rural counties. Pregnant people in rural counties are more likely to die from pregnancy-related complications than those living in more populated areas. Recent trends indicate declining access to obstetric services in rural areas. For example, many rural counties lack hospital obstetric services, including trained staff and necessary equipment to manage perinatal care or emergencies. This is in part due to difficulties recruiting and retaining maternal health providers in rural areas, as well as closures of rural hospitals and obstetric units. Therefore, pregnant women who live in rural and underserved areas have limited access to obstetrician-gynecologists, specialists, and licensed midwives and as a result, may have had less frequent prenatal and maternal care prior to delivery, particularly if the long travel distances to obtain care are prohibitive or costly. Black women and Indigenous women in rural counties suffer the worst maternal outcomes due to the intersectionality of race and geography.

Commitment
MHLIC is committed to centering equity in our work to improve maternal health, which we recognize as the mental, emotional, and physical wellbeing of individuals during pregnancy, childbirth, and the year following pregnancy. To improve outcomes for all, we commit to particularly focusing on efforts to support those who have been historically marginalized and are consequently made most at risk for maternal mortality and morbidity: people who have experienced racism and those living in rural and frontier regions of the United States.

Area of Focus
Achieving maternal health equity is predicated on achieving racial equity and health equity. While recognizing that public health challenges result from a complex network of social, political, and economic factors, MHLIC focuses our resource creation, curation and dissemination efforts on initiatives most closely related to maternal mortality and morbidity, particularly as they are exacerbated by racism and/or geographic access.

Examples of Equity in Practice
MHLIC exists to be a resource hub and learning center. True learning is reciprocal and based on mutual respect and trust. We strive to share power by being forthcoming and clear with objectives, and positioning lived experience as authoritative. We recognize that the University of North Carolina at Chapel Hill, the lead funded agency of MHLIC, is a white-centered institution. As one mechanism for addressing this imbalance, MHLIC is intentional in partnering with organizations that are led by and serve people of color. MHLIC seeks to be a part of solutions. As such, the following are some examples of how we are operationalizing equity in our internal practices, collaborations with partners, and services we provide to customers.

Internal Equity Examples

- Participating as individuals and a cohort in the Intercultural Development Inventory (IDI) assessment, followed by action planning and coaching led by RACE for Equity
- Hosting monthly opportunities for racial equity caucusing through which team members can discuss issues of race and racism, particularly as they relate to maternal health
- Developing, adopting, and continuing to refine an inclusive language guide to inform how we speak about, appreciate, and advance support for diverse birthing people

External Equity Examples

- Training and technical assistance
  - Developing webinars, Learning Institutes, and technical assistance opportunities through which partners and a national audience can engage in conversations and shared learning about best practices to embed and promote equity in their work
  - Sharing strategies to address and eventually eliminate racist behaviors and practices at interpersonal and institutional levels in maternal health programs and organizations
  - Providing resources about the use of telehealth to overcome geographic and economic health access barriers

- Embedding Equity
  - Sharing our definitions of equity and health equity and our commitment to centering equity publicly
  - Welcoming feedback and criticism with an eye toward continued learning, growth and improvement

- Modeling Diversity and Inclusion
  - Modeling diversity and inclusion by meaningfully integrating organizations with experience engaging and focusing on equity into all aspects of MHLIC, including Reaching Our Sisters Everywhere (ROSE), a community-based Black breastfeeding support group, and R.A.C.E. for Equity, a capacity-building organization supporting development of results-based strategies to advance health equity
  - Ensuring visual representation of diverse populations in MHLIC communications, website, and training materials

Appendix

Numerous definitions exist for concepts related to equity. Two that MHLIC found useful during our internal discussions include:

1. HRSA, based on White House Executive Order 13985 (1/20/21):
   "Equity is the consistent and systemic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities that have been denied such treatment, such as Black, Latino, Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons

with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality."

2. Robert Wood Johnson Foundation (2017):
   “Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.”