Advisory Neighborhood Commission 8C

RESOLUTION #ANC8C-03-22-2021
Bill 24-0026
Maternal Health Resources and Access Act of 2021

Adopted March 22, 2021

Maternal mortality impacts all women residents of the District of Columbia no matter the economic, racial, educational or social status. Any woman that is able to become pregnant, risks experiencing complications such as preterm labor, infections, gestational diabetes, and even death due to her pregnancy. Among the women who survive pregnancy and childbirth, approximately 50,000 women each year experience life-threatening pregnancy-related complications, known as severe maternal morbidity. Far too often the maternal health crisis in the District of Columbia, in particularly Ward 8, often excludes this condition that disproportionately affects women of color. African American women are twice as likely to experience severe maternal morbidity compared with non-Hispanic white women. Furthermore, African American mothers are twice as likely to have an infant who dies by their first birthday. Although other women of color also experience an elevated risk of poor outcomes notably in American Indian and Alaska Native and some Latin community's available data show that racial disparities between African Americans and non-Hispanic whites are the most critical. Pregnancy-related complications are closely tied to infant deaths as well.

Over 60 % of infant deaths occur during the first month after birth, often from congenital abnormalities and complications from preterm births. Preterm birth is a significant contributor to racial disparities in infant mortality. African Americans have the highest infant mortality rate of any racial or ethnic group in the District of Columbia, and higher rates of preterm births explain more than half of the difference, relative to non-Hispanic white

women. American Indian and Alaska Native and Puerto Rican women also have higher rates of infant mortality, and preterm births are a major driver for these groups as well.

Disparities in maternal and infant mortality are rooted in racism. Institutional racism in health care and social services, means that African American women often receive poorer quality care than white women. It means the denial of care when African American women seek help when enduring pain or that health care and social service providers fail to treat them with dignity and respect. These stressors and the cumulative experience of racism and sexism, especially during sensitive developmental periods, trigger a chain of biological processes, known as weathering, that undermine African American women's physical and mental health. The long-term psychological toll of racism puts African American women in the District of Columbia, Ward 8 specifically, at higher risk for a range of medical conditions that threaten their lives and their infants' lives, including preeclampsia (pregnancy-related high blood pressure), eclampsia (a complication of preeclampsia characterized by seizures), embolisms (blood vessel obstructions), and mental health conditions.

Although racism drives racial disparities in maternal and infant mortality, it bears mentioning that significant underinvestment in family support and health care programs contribute to the alarming trends in maternal and infant health. In the past decades, many programs that support families in need, such as Medicaid, Temporary Assistance for Needy Families (TANF), and nutrition assistance have experienced a steady erosion of funding, if not outright budget cuts. The fact that these cuts have a harmful impact on families of color, who are

overrepresented in these programs due to barriers to economic opportunity in this country, can be attributed to institutional racism.

Despite pervasive racial disparities in maternal and infant deaths, public attention has only recently focused on this issue as a public health crisis. The full extent of the crisis is not yet known due to incomplete data. Compared with data on infant mortality, data on maternal mortality are less reliable and complete. While the disparities in maternal mortality across race are clear within individual states, a reliable national estimate has not been possible because data have been inconsistent and incomplete across states. Behind these statistics are the stories of individuals and families. To bring the District of Columbia to the standard it needs to be, policymakers and health care providers must work together to eliminate these disparities. The residents of Advisory Neighborhood Commission 8C, see Bill 24-0026 - Maternal Health Resources and Access Act of 2021, as an opportunity to address these disparities.

Doulas are a major way to address these disparities. A doula is a professional trained in childbirth who provides emotional, physical, and educational support to a mother who is expecting, is experiencing labor, or has recently given birth. Their purpose is to help women and the entire family have a safe, memorable, and empowering birthing experience. The relationship with a doula can begin a few months before the baby is due. During this period, they develop a relationship in which the mother feels free to ask questions, express her fears and concerns, and take an active role in creating a birth plan. Doulas may provide

information about perineal massage and other techniques that can help to reduce stress and trauma often experienced during childbirth.

Doulas make themselves available in a variety of methods to address any concerns that might arise during the course of the pregnancy. They can help their clients gain a better understanding of the procedures and possible complications in late pregnancy or delivery. During delivery, doulas are in constant and close proximity to the mother. They have the ability to provide comfort with pain-relief techniques including breathing techniques, relaxation techniques, massage, and laboring positions. Doulas also encourage participation from the partner and offer reassurance.

A doula acts as an advocate for the mother, encouraging and helping her fulfill specific desires she might have for her birth. The goal of a doula is to help the mother experience a positive and safe birth, whether an unmedicated birth or a cesarean. After birth, many labor doulas will spend time helping mothers begin the breastfeeding process and encouraging bonding between the new baby and other family members.

Numerous studies have documented the benefits of having a doula present during labor. With their support, women were less likely to have pain-relief medications administered and less likely to have a cesarean birth. Women also reported having a more positive childbirth experience. Studies have shown that having a doula as a member of the birth team decreases the overall cesarean rate by 50%, the length of labor by 25%, and requests for an epidural by

60%.2 Doulas often use the power of touch and massage to reduce stress and anxiety during labor.

Therefore, Advisory Neighborhood Commission 8C recommends that Council of the District of Columbia pass the Bill 24-0026 Maternal Health Resources and Access Act of 2021 to improve the maternal health conditions for the residents of the District of Columbia.

Be it Resolved and adopted this day, March 22, 2021

FURTHER RESOLVED:

The Commission designates Commissioner Salim Adofo, ANC 8C07, to represent the Commission in all matters relating to this Resolution.

FURTHER RESOLVED:

That, in the event the designated representative Commissioner cannot carry out their representative duties for any reason, the Commission authorizes the Chair to designate another Commissioner to represent the Commission in all matters relating to this Resolution.

FURTHER RESOLVED:

That, consistent with DC Code § 1-309, only actions of the full Commission voting in a properly noticed public meeting have standing and carry great weight. The actions, positions, and opinions of individual commissioners, insofar as they may be contradictory to or otherwise inconsistent with the expressed position of the full Commission in a properly adopted resolution or letter, have no standing and cannot be considered as in any way associated with the Commission.

ADOPTED by roll call vote at a special public meeting, notice of which was properly given, and at which a quorum of four of seven members was present, on March 22, 2021, by a vote of 4 yes, 0 no, 0 abstentions.