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Episode 2: Addressing root causes of reproductive and sexual health inequities, including racism, patriarchy and economic inequality

Dr. Mcdonald-Mosley:

Hello and welcome to a new podcast series focused on advancing equity and family planning. This podcast is a partnership through Power to Decide and Reproductive Health National Training Center. With funding from the Office of Population Affairs and the Office on Women's Health. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of OPA or HHS.

Throughout this series we will explore tactics, programs, frameworks, and ideals to increase reproductive and sexual health equity in health centers across the country. Through this podcast, we hope to give Title X clinics, providers and staffers practical, easy to access, action oriented training resources in order to advance health equity at family planning service sites.

My name is Doctor Raegan McDonald-Mosley and I'm the CEO of Power to Decide. The campaign to prevent unplanned pregnancy. I have over twenty years of experience in this field as a practicing OBGYN, with a dedication and commitment to reproductive health and justice.

Today, we have an amazing guest with us, Doctor Joia Crear-Perry. Dr.Crear-Perry is a physician, policy expert, thought-leader, and advocate for transformational justice and maternal justice. As the founder and president of the National Birth Equity Collaborative, she identifies and challenges racism as a root cause of health inequities. In this episode, we're going to address the root cause of reproductive and sexual health inequities. So let's dive in. Doctor Joia, I'm so excited to be here with you

Dr. Crear-Perry:

I'm excited to be here. Thank you for having me.

Dr. Mcdonald-Mosley:

Of course, yeah we're super siked to have you. So I'm just going to start with a little bit of statistics and then we can dive in.

Over the last few years, there has been heightened awareness of maternal mortality in the United States and the disproportionate rate of death among Black women. African American women die three to four times at the rate compared to White women. Black women are more likely to experience preventable maternal death compared to White women. And Black women's heightened risk of pregnancy related death spans income and educational levels.

Dr. Joia, as you know this issue of Black maternal mortality and its impact on families and communities, is not only a professional concern and passion for me, but also a personal one after having lost my dear friend, Dr.Shalon Irving four years ago after she had her first child.

Shalon was a Ph.D level researcher for the CDC and an advocate for health equity. So the sad irony of her death has garnered a lot of public attention. But I think it is really important to center the impact not just on society overall, but the impact for individual friends and family members including Shalons mother and her father. And to think of this issue magnified across the country for the countless preventable losses of Black mothers.

So the first question I have for you to reflect on. If we're going to create a more equitable healthcare system we must be willing to name the roots of this inequity. And you have been really outspoken on this issue to name racism, not race as the root cause here. How do you see racism playing out in the root causes of inequities in social and reproductive care in the United States today?

Dr. Crear-Perry:

Thank you so much. And thank you again for bringing Shalon and her family, Mrs. Irving, her mother and her daughter into this conversation because that helps us to humanize and remember why we are all here. Grounding us in the importance of the work, that it is not some foreign, far off thing.

Truthfully, as you and I both as we travel through medical school and residency, and your training and you learn that every statistic is higher in Black people. You hear “disparities” language constantly. I really feel like the gap between Black and White women, and when it comes to maternal death, the only reason it garnered so much attention is because it was a new number. We’re accustomed to saying “twice as likely”. So Black infant mortality is twice as high, obesity, premature birth, but somehow it captured their imagination of individuals when they heard that it was three to four times as high.

That increase is a mixture of both racism and patriarchy. So you get the fact that this country does not value women in general, so that root cause of White Supremacy also in addition to patriarchy gives you the outcomes that we have. So It is important for us to center the racism, the patriarchy, the white supremacy and not focus on individuals behaviors and their choices because it ignores the truth that we have a historical and current belief of a hierarchy of human value based upon skin color, based upon gender, based upon religion that is is killing all of us.

It’s believing that one group is more important or has different genes or biology that was taught to us in school. So for so long this biological basis for race or this cultural belief in a different evaluation of race shows up in how we receive care. You will see a person like Shalon, who is educated and who is working on these issues and who is still not seen as fully human. Her concerns are dismissed and she is not able to survive her pregnancy. And that happens over and over and over again.

Until we can be truthful about that. We are not going to have the outcomes that we need to have. So we need to stop blaming and shaming individual behavior and choices and really look at the root causes.

Dr. Mcdonald-Mosley:

Yeah, and I love that the way you're naming sort of the intersections of oppression and the hierarchy of our society. The sad reality right is that these are things we see in all aspects of our society. And so it's not surprising that we are seeing the impact of racism, misogyny, patriarchy, transphobia in the healthcare system and then in health outcomes that have real life impacts on people and how they experience the healthcare system, and how the ultimately live through the world and how they are able to lead healthy lives.

Can you speak to some of the ways the National Birth Equity Collaborative is seeking to dismantle these systems of oppression or address them or highlight them.

Dr.Crear-Perry:

One of the ways is things like this. We do a lot of speaking engagements because the way we talk about Black bodies, gender nonconforming bodies has to change. For so long we have talked about as if the people were the thing that was broken, like individual black bodies were the thing that was broken, people who weren't fitting into a binary of gender were broken. So this idea that it was, in fact it was so pathologized. It was diseased. If a black person who was enslaved wanted to be freed, they looked you in the eye, it was called drapetomania. This was in textbooks, a professor Dr. Cartwright at Tulane where I trained created that illness. So a lot of it is undoing this cultural belief and harm of this hierarchy that's important.

Next, we do a lot of research. We have research right now that we're doing along with American College of OBGYN and Johns Hopkins School of Public Health to create a framework for respectful maternity care. So we're excited about that. We have interviewed black birthing people around the United States to ask them what this standard would mean. It's a term that is used globally in the WHO and by others, White River Alliance has been working on respectful maternity care, but we have not operationalized that in any high-income country. We act as if having wealth makes you magically respectful. We show with our outcomes here in the United States that is just not a fact. We have the worst outcomes in an industrialized nation and we are not valuing and respecting women's bodies and their choices which is why we have the outcomes that we have.

We do trainings. We call them birth equity trainings, respectful maternity care trainings or we might call them implicit bias trainings. But really work with providers to ensure that they have the tools to unlearn a lot of the harmful things we were taught in school, including me.

Lastly, we do a lot of policy and advocacy work, working with local and federal officials to do things like improve access to doulas, or access to birth centers or midwifery. Really the tools people who are in the community are asking us for. We're working with them in their communities to get policies changed in order to do that.

Dr. Mcdonald-Mosley:

Wow, that's a lot. Thank you for all of the work you are doing with the National Birth Equity Collaborative.

One of the things that I find really challenging in talking about these issues and engaging providers specifically, is undoing this concept of race as a biological construct. We know race to be a social construct.

If I just look at the myriad of colors in my own family to see what that looks like. Right and sort of what that looks like. It's very obvious to me, but when I say to providers and healthcare administrations that race is a social construct I get a lot of push back often.

People sort of pivot to the things that they've learned in their training, which you mentioned earlier. What about sickle cell disease? What about hypertension or all of these things that we see that we sort of biologically ratify the concept of race. How do you talk to people about this in a way that is more accessible to them?

Dr.Crear-Perry:

I try to use myself as an example and my unlearning of this. Because people do not want to feel like you are. Providers, physicians, nurses we all feel that we know a lot. So it is challenging to challenge a core belief system. We were all taught these biological things.

The shortcut in medicine is to make race be the intermediary for a conversation. So I use myself as an example because I'm unlearning a lot of things I was taught and so I think it makes it easier for people to hear it and because I am also showing my own learnings. For example, I was taught that there were three pelvises: gynecoid for white women, android for Black women, and anthropoid for Asian women. When we start talking about the C-section calculator and undoing it, I can see where people don't want to let it go because even if they know it makes no biological sense that there could be no difference between the tie of my pelvis shape and the amount of melanin I produce. It makes no biological sense to have the size of your lungs or your kidneys tied to how much melanin you produce. So the underlying root of eugenics and White Supremacy that colonized medicine is so deep that it is hard for us to unlearn and let go of those belief systems.

The only thing that makes Black people different is you believing that they have a different pelvis cause they don't have a different pelvis. So how do you unlearn that area and modify your own behavior? So that's, I I hope that is useful. I've never done a training where someone has come up to me afterwards and said "but I just can't…". Black people and people from all around the world.

I do think the way we learn race in the United States is very specific. When I'm teaching to international audiences it can be a different push back as well, but we all have held these biological beliefs around how you can look at someone and just from their skin color you can tell if they have any diseases, if they are smart

or not. Think about that, there are so many things that we have tied to melanin production that don't make any biological sense.

Dr. Mcdonald-Mosley:

Yes. One thing that I find can be helpful around messaging around this is to contextualize this with an international setting. I am a light-skin Black woman. Here in the United States my cast or class is Black. If I were to have grown-up or have lived in South Africa my caste would have been categorized as “colored” and that would have given me access to different resources, housing, healthcare, etc.

If I was born and raised in Brazil, same person with the same DNA, I would have been categorized as mixed. That would have given me different access to resources. Because of how we cast people and because of our hierarchy access to resources, healthcare, education, etc. And that is what indicates health outcomes, not just their DNA or the fact that there is something biologically intrinsic to them.

Dr.Crear-Perry:

You know it’s funny. I do the same thing, but I also bring in New Orleans. So you can use international and then show how in the United States Creole people were codified to be able to go to school, get jobs. It was by law. We have a similar cast system right here. I’m also fascinated by the difference. My friends who are creole, whose parents were able to buy things, they run from that title right. They run from that title. They’re like “no I’m just Black” because they don't want to be seen as the harmful folks. But their parents and grandparents were able to go to school when people who were considered Black couldn't. They were able to buy property, own things. So you still see that lighter skin Black people in New Orleans had more wealth because of this history and legacy of racism and the codification of creole as a separate cast versus Black in the United States of America.

Dr. Mcdonald-Mosley:

That's a really important example. And I think you brought up a really good point with how we have been trained to think of different pelvises being associated with different races and this idea of the C-section calculator which incorporates a number of variables which include age and parity, race.

And this is an example of further ratifying the concept of race because if we think there is something different about people based on race that increases or decreases their risk of C-section and then make decisions based on that.

Then when we look back ten years from now we're gonna say “oh yeah Black women have much higher rates of C-section” without really identifying that's because we made those decisions assuming that they had a higher rate of C-section because of something about their anatomy or biology. When in fact the higher risk of C-section has nothing to do with who is intrinsically who they are or what their pelvis is or their capacity to give birth vaginally. It has everything to do with the healthcare system and the providers and the healthcare system doing rates of C-sections among Black women for other reasons.

Dr.Crear-Perry:

You know it's hard because we have been having this fight about this calculator for a few years now publicly. I think the people who created it, recently withdrew it and asked people to stop using it. They don't really have the capacity to make people stop using it because that's not how our healthcare system works. It's already been put out there.

Same thing with prostate cancer. All these things we have higher rates of. I was taught in medical school that we have higher rates of breast cancer in Black women. And they say it just like it's a fact. You start with the disparity as a fact you ignore the structural oppression that causes the disparity.

I don't use the word health disparity. I use health inequities because I have had so often people say "of course their disparities". Word disparity means different and there are always going to be differences. The problem is health disparities embed in and come from health inequities which were created by policies.

So yes, there's a difference between breast cancer rates in men and women because women have more breast tissue than men. So that is a disparity, but the inequity is that Black women die more frequently from breast cancer because we have less access to treatment, less access to screening, we are more likely to be off from work in order to get a screening or treatment. We don't contextualize inequities when we focus on the disparities or differences.

Dr. Mcdonald-Mosley:

That's powerful. That paradigm in really differentiating inequities vs disparities. So acknowledging how hard this is. We're pushing back on centuries of teaching and structural racism. How can institutions and health centers in your opinion address structural racism that is in their own work place, practice systems? And are there organizations you have encountered who are doing this evaluation well and who have been able to enact noticeable change because of their work?

Dr.Crear-Perry:

Well the first thing is it's hard and it's long. So I don't want any health system to think that I'm going to do a 90 minute webinar or podcast and now we've fixed everything and we can move onto the next issue. I usually start training with this graph that shows that 86% of the 400 years that Black people have been in the United States has been under legal, meaning explicit, by law racism. Structural inequities we can be owned, rapped murder, or lynched. We can't run from that truth, so it's going to take us a long time to undo and unlearn that. Give yourselves some grace for the act of trying. It's urgent, but it's going to be a long term strategy.

Secondly, we have to start with some truth telling. If you are at a center, what is the context of your community? The context of Baltimore is different from the context in Bogalusa, Louisiana. I love Bogalusa because it's a small town that I

know pretty well in Louisiana and I like the name. There are some activities and things. People know John Hopkins and they know the Lacks story. So they know the bigger things, but there is some local context in your community around health inequities that you may not know. If you are a health center you need to really spend the time to figure that out because that's the hot trauma that people are bringing into your centers. If you're saying “My, why won't they come?”, but you don't know that there are people in the community where a person died. There are a lot of things that have happened between communities and healthcare delivery. That a lot of the time healthcare delivery systems have no idea what the community actually believes about them and understands about them. takes to heart.

In New Orleans, there were hospitals Black patients knew not to go too, they knew that they were going to be treated poorly. If you don't know that as the ethos of what people believe about you, then you're not going to be able to take good care of them and so you need to undo that. Once you figure that out. Work on yourself, learn for yourself, have your individual providers, front desk staff, clerks. It's not just the people who are directly doing service provision. The front desk matters, who answers the phone matters. We have to unlearn a lot of things, behaviors around birthing people and people of color together.

Then you can work on collective action with the community, but first you have to unlearn things yourself, work with each other within your center, and then go out into the community and say “okay we’ve worked on ourselves, now we want to learn from you for how we should be better”. We start with usually as centers, going out into the community and saying “I want to work with you”, but you have not unlearned the harmful thing or learned more about them to do that well so start first with you. That's a long way to say that.

Dr. Mcdonald-Mosley:

I love it. I love it. So you spoke about the paradigms about differentiating between inequities and disparities . You know we have an audience of Title X providers out there. How can we encourage them or what would you recommend they do to think about dismantling inequities in their own institutions and health centers?

Dr.Crear-Perry:

So we have this whole body of work that we are working on and we honestly called it in the beginning Defund Family Planning. It freaked everybody out, but it got their attention in thinking why would we even be saying that. So what you can start with is why do we even call it family planning? What is the intention of family planning? Where is the history or legacy? When did it start? If you knew that it started under Nixon and that it was an anti-poverty strategy, did it work? Are people of color less poor because of family planning? The answer is no. People of color are less poor when they have access to jobs and education. We are trying to reframe the work. If you were inside of Title X and your goal is to create reproductive health equity. To work on reproductive and sexual well-being. How do you operationalize that? Reframing even your job.

So often we would do training with nurses who are doing family planning clinics to reimagine that their job is not to encourage people to plan a pregnancy, but

their job is to encourage people to have access to jobs, to access to their dreams, to work on whatever their needs are. They might never want to have a child or they might want to have ten. Your place is not to help them plan that. Your place is to support them along their decision making, to help them have the power they need to make those decisions. Changing that orientation in thinking about your role inside reproductive health and sexual well-being. Do you talk about sex and pleasure? Do you have an opportunity to know that sex is not just for reproduction.Do we talk about infertility?

People inside of Title X who want or desire pregnancies. Are we helping them with making the families however along the spectrum they wish. That would be an amazing opportunity for us to reframe how we think about reproductive and sexual wellbeing.

Dr. Mcdonald-Mosley:

I love that. Centering reproductive well-being and sexual health. And dismantling the paradigm of paternalistic providers in dictating what the patients do or what they need. Really thinking of us as a mechanism to help people live their best lives and access their dreams. That's beautiful.

A couple other action items I recommend. I've been working in Title X clinics providing direct patient care for the last twenty years now. Getting old. I recommend and something you have been outspoken on is measurements. Right.

You can't name the problem and create an action plan to address it if you're not looking at your outcomes. I would recommend that people really look at specifically their quality measures. Hopefully they are doing measures of their patients in terms of patient satisfaction and other quality measures. But look at that data and stratify it by race. If you see differences by race, assume that there is an element of racism involved and think about how you could address that through training and highlighting that for your staff. Making sure that you are centering equity and training about these important issues. These conversations are hard and it may take multiple times for people to be exposed to the concepts of race as a cultural construct versus a biological construct. We have to do the work to center that and prioritize it. I know that it is challenging and given all the Tile X requirements but this needs to be a priority for us in order to provide equitable services.

Dr.Crear-Perry:

I love that. The reason I honestly don't start with measurement is because if you don't know how you think about the patient or how you think about the work you're going to measure the wrong things. I'll give you a great example that Title X did for the last few years, well not Title X, reproductive health in general.

If you start with immediately measuring how we're going to keep people from getting pregnant versus whether people have access to what they want. Are they desiring a pregnancy and are we supporting them no matter if we think they shouldn't be getting pregnant or not. So I'm going to give you a concrete

example. When is it acceptable for a rural patient who is on Medicaid to say to you out loud that they are trying to get pregnant. It is socially not acceptable so therefore we are going to give them an IUD. When truthfully that person may be an amazing mother and they would do a great job. It is not our job or place to dictate that.

Thinking about when we are measuring for wellbeing and I know the Power to Decide has a great definition for reproductive wellbeing, make that be the frame for which you pick your measurements. Don't pick your measurements based on control or eugenics or population. That's my ask.

Dr. Mcdonald-Mosley:

I think that's exactly right. Centering reproductive well-being and making sure that we are measuring whether or not people are able to get the care that they want and have the care that aligns with their dreams and vision for what they see in the world. Anything else you want to share with our audience of Title X providers. This has been amazing.

Dr.Crear-Perry:

It has been amazing. We need yall. We need yall to have more money. So we're fighting for that. We recognize the full range. For example, if you were doing well-being you would get to do things like yoga in your Title X centers and it would be paid for and it should be because we know when people have high resources they get to take yoga and have more well-being. So let's do that together. Let's work on a world where Title X gets to invest in the things we know create wellness for all people. That's it.

Dr. Mcdonald-Mosley:

I love that. Thank you so much for your time and for joining us today. And for this informative discussion.

We hope you will all walk away with not only a better understanding on how to advance equity and family planning, but also actionable steps you can enact today.

To follow the work of Dr.Craer-Perry please follow her @doccrearperryand @birthequity on Twitter. To stay connected with me follow me @doctorregan on Twitter. Please follow Power to Decide @powertodecide on all platforms.

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