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

Dr. Raegan McDonald-Mosley (00:09):

Hello, and welcome to a new podcast series focused on advancing equity, and family planning. This podcast is a partnership between Power to Decide, and the 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 Dr. Reagan McDonald-Mosley, and I'm the CEO of Power to Decide, the campaign to prevent unplanned pregnancy. I have over 20 years experience in this field as a practicing OB-GYN, with a dedication and commitment to reproductive health, and justice.

Dr. Raegan McDonald-Mosley (01:10):

Today, we have an amazing guest with us, Dr. 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. Dr. Joia, I'm so excited to be here with you.

Dr. Joia Crear-Perry (01:40):

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

Dr. Raegan McDonald-Mosley (01:41):

Of course. Yeah, we're super psyched to have you. So I'm going to start with just a little bit of statistics, and then we can dive in. Over the last few years, there's been a 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. Raegan McDonald-Mosley (02:15):

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 PhD 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's really important, of course, to center the impact, not just on society overall, but the impact for individual friends and family members. Including Shalon's mother, and her daughter. And to think of this issue magnified across the country for the countless preventable losses of black mothers.

Dr. Raegan McDonald-Mosley (02:56):

So, the first question I have for you to reflect on. So 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 cause of inequities, and sexual and reproductive healthcare in the United States today?

Dr. Joia Crear-Perry (03:19):

Well, thank you so much. And thank you again for bringing Shalon, and her family, and Ms. Irving, her mother, and her daughter into this conversation because that helps us to humanize, and remember why we're all here. Grounding us in the importance of the work. That it's not some foreign, far-off thing. And truthfully, you and I both, as we travel through medical school. When in you're in residency, and medical school, and you're training, and you learn every statistic is higher in black people. And you hear this disparities language constantly. I really feel like the gap between black and white women when it comes to maternal death, the only reason it garnered so much attention is because it was a new number. We are accustomed to saying twice is likely. Black infant mortality is twice as high, obesity, premature birth, but somehow it captured the imagination of individuals when they heard that it was three to four times as high.

Dr. Joia Crear-Perry (04:11):

And 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's so important for us to center the racism, the patriarchy, the white supremacy, and not focus on individuals, and their behaviors, and their choices because it ignores the truth. That we have a historical, and a current belief of a hierarchy of human value based upon skin color, based upon gender, based upon religion. That is killing all of us. Believing that one group is more important, or has different genes, or different biology. That was taught to us in school.

Dr. Joia Crear-Perry (04:55):

And so, for so long this biological basis of race, or this cultural belief in a different evaluation of race shows up in how we receive care. So, you will see a person like Shalon who is educated, who is working on these issues, and who still is not seen as fully human, and her concerns are dismissed, and she is not able to survive her pregnancy. And that this happens over, and over, and over again. So until we can be truthful about that, we're not going to have the outcomes that we need to have. And so we have to stop blaming, and shaming individual behaviors, and choices, and really look at the root causes.

Dr. Raegan McDonald-Mosley (05:28):

Yeah, and I love the way you're naming the intersections of oppression, and the hierarchy of our society. And the sad reality is that these are things that we see in all aspects of our society. And so, it's not surprising that we're seeing the impacts 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 also, how they ultimately live through the world, and are able to lead healthy lives. Can you speak to some of the ways that the National Birth Equity Collaborative is seeking to dismantle these systems of oppression, or address them, or highlight them?

Dr. Joia Crear-Perry (06:08):

Yeah. Well, one of them is things like this. We do a lot of speaking, and engagements because the way we talk about black bodies, gender nonconforming bodies, has to change. So, for so long, we've talked as if the people were the things that are broken, individual black bodies were broken. People who weren't fitting into a binary of gender are broken. In fact, it was so pathologized, that it was disease. If a black person who was enslaved, wanted to be free, if they looked you in the eye it was called drapetomania. It 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 this harm of this hierarchy. So that's important.

Dr. Joia Crear-Perry (06:52):

Next, we do a lot of research. So we have research right now that we're doing, along with American College of OB-GYN, and Johns Hopkins School of Public Health to create a framework for respectful maternity care. So we're excited about that. And we have interviewed black working people around the United States to ask them what this standard would mean. It's a term that's used globally. The WHO, and others, White Ribbon Alliance, have been really 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, but we show with our outcomes in the United States, that that's just not a fact. We have the worst outcome, the industrialized nation, and we are not valuing and respecting women's bodies, their choices.

Dr. Joia Crear-Perry (07:33):

And so, that's why we have the outcomes that we have, and we do training. So either we call them birth equity trainings, respectful maternity care trainings, you might call them implicit bias trainings, but really working with providers to ensure that they have the tools to unlearn a lot of the harmful things we were taught in school, including me. And then lastly, we do a lot of policy and advocacy, working with state, local, and federal officials to do things like improve access to doulas, or access to birth centers, or midwifery. Really, the tools the people 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. Raegan McDonald-Mosley (08:09):

Wow, that's a lot. Thank you for all of the work that you're doing with the National Birth Equity Collaborative. One of the things that I find really challenging as I'm talking about these issues, and engaging providers specifically, is undoing this concept of race as a biological construct. And so, we know race to be a social construct. I think, if I just look at the myriad of colors in my own family, and what that looks like. It's very obvious to me, but when I say that to providers and to healthcare administrators, "Race is a social construct," I get a lot of pushback often. And people pivot to the things that they learned, that you referenced in their training. What about sickle cell disease? What about hypertension? What about all of these things that we see where we've biologically reified the concept of race? How do you talk to people about this in a way that you feel is more accessible to them?

Dr. Joia Crear-Perry (09:04):

Well, I try to use myself as an example in my unlearning of this because people don't want to feel like you are... Providers, physicians, nurses, we all feel like we know a lot, and so it's challenging to challenge a core belief system. So we were all taught these things, we were taught these biological things. So, if the shortcut in medicine is to make race be the intermediary for a conversation, I use myself as an example because I'm unlearning a lot of things that I was taught. And so, I think it makes it easier for people to hear it because I'm also showing my own learnings. So for example, I was taught that there was three pelvises, and Gynaecoid pelvis for white women, Android pelvis for black women, Anthropoid pelvis for Asian women, I think.

Dr. Joia Crear-Perry (09:51):

And so, 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 they still... Even if they know that makes no biological sense, that there could possibly be no difference, no tie between my pelvis shape, and the amount of melanin I produce. That 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, and that colonized medicine is so deep. That it's 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 must have a different pelvis because they don't have a different pelvis. So then how do you unlearn that yourself, and modify your own behaviors?

Dr. Joia Crear-Perry (10:35):

So that's, I hope what's useful. I hope It seems to... Every time I tell you, but I've never done a training where someone hasn't come up to me afterwards and said, "But I just can't..." I mean, they black people, people from all around the world. I do think the way we learn race in the United States is a very specific way. So when I'm talking, and teaching international audiences, it can be a different pushback as well. But we still have all held these biological beliefs around how you can look at someone and tell just from their skin color diseases, you can tell if they're smart, or not. Think about that. There's so many things that we've tied to melanin production that actually don't make any biological sense.

Dr. Raegan McDonald-Mosley (11:13):

Yes. Yeah. One thing that I find can be helpful, and the messaging around this, is to contextualize this with an international setting. Like, I am a light-skinned black woman. Here in the United States my class, or caste, is black. But if I were to have grown up, or lived in South Africa, I would've been categorized as colored, and that would've given me access to different resources, housing, health care, et cetera. If I was born and raised in Brazil, same person, same DNA. I would've been categorized as mixed, and again, that would've given me different access to resources. So because of how we caste people, and because of our hierarchy, people have differential access to resources, education, healthcare, et cetera. And that is what indicates their health outcomes, not just the fact of their DNA, that there's something biologically inherent, or intrinsic to them.

Dr. Joia Crear-Perry (12:05):

And you know what's funny, I do the same thing, but I also bring in New Orleans. So you can do 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 caste system right here. And I'm always fascinated by the difference because my friends who were Creole, whose parents were

able to buy things, they run from that title. So they're like, "No. I'm just black," because they don't want to be seen as the harmful folks. They don't want to be seen, but their parents and grandparents were able to go to school when the people who were considered black couldn't. They were able to buy property, own things. So you still see that lighter skinned black people in New Orleans have more wealth because of this history, and legacy of racism, and the codification of Creole as a separate caste versus black in the United States of America.

Dr. Raegan McDonald-Mosley (12:54):

That's a really important example. And I think you brought up a really good point, which is how we've been trained to think of different pelvises as being associated with different races. And this idea of the C-section calculator, which incorporates in terms of a number of variables, including age, and parody race. And this is an example of further reifying the concept of race because if we think that there's something different about people based on their race, that increases, or decreases their risk of C-section. And then, make decisions based on that.

Dr. Raegan McDonald-Mosley (13:29):

Then, when we look back 10 years from now, then we're going to see, "Oh, yeah. Black women have much higher rates of C-sections," 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 their biology. When, in fact, the higher risk of C-section has nothing to do with intrinsically, who they are, or what their pelvis is, or their capacity to give birth vaginally. But everything to do with the or system, and the providers, and the healthcare systems doing rates of C-sections among black women for other reasons, including their race.

Dr. Joia Crear-Perry (14:04):

It's hard too because we've been having this fight about this calculator for a few years now publicly, and I think if the people who created it recently withdrew it, and said to ask people to stop using it. They don't really have the good capacity to make people stop using it because that's not how our healthcare system works, and it's already been put out there, and same thing with prostate cancer. All these things we have higher rates of. I mean, I was taught in medical school that we had higher rates of breast cancer in black women, and then they say it like it's just a fact. So you start with the disparity as a fact, you ignore the structural oppressions that cause a disparity. So I don't even use the word health disparities.

Dr. Joia Crear-Perry (14:40):

I use health inequities because I have so often had many people say, "Of course they're disparities. The word disparity means different, and there are always going to be differences." But the problem is health disparities embed, 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 inequity is that black women die more frequently from breast cancer because we have less access us to treatment, less access to screening. We are more likely to not be able to be off from work in order to go and get a screening, and to get treatment. And so we don't contextualize the inequities when we focus on the disparities, or the differences.

Dr. Raegan McDonald-Mosley (15:23):

That's powerful, that paradigm, and really differentiating inequities versus disparities. So acknowledging how hard this is, just based on we're pushing back against, really, centuries of

teaching, and structural racism. But how can institution, and health centers, in your opinion, address structural racism embedded in their own workplace, practice, and systems? And are there organizations that you have encountered who are doing this evaluation well, and who have been able to enact noticeable change because of their work?

Dr. Joia Crear-Perry (15:57):

Well, the first thing is it's hard, and it's long. And so, I don't want any health system to think I'm going to do a 90 minute podcast, or webinar, and now we've fixed everything, and we can move on to the next issue. I usually start my trainings 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 could be owned, raped, murdered, lynched, and so we can't run from that truth. And so it's going to take us a long time to undo that, and unlearn that. So give yourselves some grace for the act of trying. So it's urgent, but it's going to be a long-term strategy. Secondly, you have to start with some truth telling. So if you are in a center, what is the context of your community? The context in Baltimore is different from the context in Bogalusa, Louisiana. I love San Bogalusa because it's a small town that I know pretty well in Louisiana, and I like the name. So there are some activities, and some things...

Dr. Joia Crear-Perry (16:58):

People know Johns Hopkins, and they know the [inaudible 00:17:01] story. So they know these bigger things, but there's actually some local context in your community that has happened around inequities that you might not know. If you're a center, you need to really spend the time to figure that out because that's the trauma that people are bringing into your centers. So if you're saying, "Ma why won't they come?" But you don't know that people in the community, a person died, or that someone believes... There's a lot of things that happen between communities, and healthcare delivery. That a lot of times, healthcare delivery systems have no idea what the community actually believes about them, understands about them, takes to heart. In New Orleans, there were hospitals that black patients knew not to go to. They knew that they were going to be treated poorly. If you don't know that that's what people believe about you, you're not going to be able to take good care of them, and you have to undo that. So finally, when you figure that out...

Dr. Joia Crear-Perry (17:48):

So 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 about behaviors around birthing people, and people of color together. Then, you can work on a collective action with the community, but you have to first unlearn things yourselves. Work with each other within your center, and then go out to the community, and say, "Okay, we work on ourselves. Now we want to learn from you. How should we be better?" We start with usually, as centers, going out to the community and saying, "I want to come and work with you." But you have not unlearned the harmful thing, to learn more about them, to do that well. So start first with you. That's a long way to say that.

Dr. Raegan McDonald-Mosley (18:36):

I love it. I love it. So you spoke about the paradigm of differentiating between inequities and disparities. 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. Joia Crear-Perry (18:57):

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

Dr. Joia Crear-Perry (19:45):

So, often we would do trainings with nurses who are doing family planning clinics, re-imagining that their job is not 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 not ever want to have a child, or they might want to have 10. Your place is not to help them plan that, your place is support them along their decision making. To help them have the power that they need in order to make those decisions, and changing that orientation to how you think about your role inside of reproductive health, and sexual wellbeing. Do you talk about sex, and pleasure? Do we have an opportunity to know that sex is not just for reproduction? Are we really allowing for the full [inaudible 00:20:29]? Do we talk about infertility? People inside of Title X also 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 really re-frame how we think about reproductive, and sexual wellbeing.

Dr. Raegan McDonald-Mosley (20:46):

I love that. I love that. Centering reproductive wellbeing, and sexual health, and dismantling the paradigm of the paternalistic provider who is dictating what the patient does, or what they need, and really thinking of us as a mechanism to help people live their best lives, and access their dreams. That's beautiful. A couple of other action items I would recommend, I've been working in Title X clinics providing direct patient care for the last 20 years no. I'm getting old. And something that you've been outspoken on is measurement.

Dr. Raegan McDonald-Mosley (21:21):

It's like you can't name the problem, and create an action plan to address it if you're not looking at your outcomes. And so, I would recommend that people really look specifically at their quality measures. Hopefully, they're doing some measures of their patients in terms of patient satisfaction, and other quality measures. But look at that data, and stratify it by race. And if you see differences by race, assume that there is an element of racism involved, and think of how you can address that through training, and through highlighting that for your staff. And then, making sure that you're 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, but we have to do the work. And we have to center that, and prioritize it. And I know that's challenging, given all of the Title X requirements, but this needs to be a priority for us to be able to provide equitable services.

Dr. Joia Crear-Perry (22:24):

And I love that. So the reason I honestly don't start with the measurement is because if you don't change how you think about the patients, or how you think about the work, you're going to measure the wrong things. And I'll give you a great example that Title X did for the last few years when we were talking about... Well, not Title X, reproductive health in general. So if we start with immediately measuring how we're going to keep people from getting pregnant, versus do people have access to what they want? Are they desiring pregnancy, and are we supporting them no matter if we think that they shouldn't be getting pregnant or not?

Dr. Joia Crear-Perry (22:57):

And so, I'm going to give you a concrete example. When is it going to be acceptable for a rural patient who is on Medicaid, as their payer for their insurance, to say to you out loud that they're trying to pregnant? So, it's socially not acceptable. And so then, therefore, we're going to give them an IUD. But truthfully, that person might be an amazing mother, and they'd do a great job, and it's not our place, and our job to dictate that for them. So just thinking about when we're measuring, that we're measuring for wellbeing. And I know the Power to Decide has a great definition for reproductive wellbeing, make that be the frame in which you pick your measurements. Not pick it based upon control, or eugenics, or population. That's my ask.

Dr. Raegan McDonald-Mosley (23:44):

Yep. I think that's exactly right. Centering reproductive wellbeing, and making sure that we're measuring the right things. Measuring whether or not people are able to get the care that they want, and have the care that aligns with their dreams, and their visions for what they see in the world.

Dr. Joia Crear-Perry (23:57):

Yep.

Dr. Raegan McDonald-Mosley (23:58):

That's right. Anything else you want to share with our audience of Title X providers? This has been amazing.

Dr. Joia Crear-Perry (24:05):

It has been amazing. Yeah. I mean, we need y'all. We need y'all to have more money, so we're fighting for that. We recognize that the full range... For example, if we were doing wellbeing, 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 resource, they get to take yoga, and they have more wellbeing. So let's do that together. Let's work on a world where Title X gets to really invest in the things that we know create wellness for all people. That's it.

Dr. Raegan McDonald-Mosley (24:38):

I love that. 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 of how to advance equity and family planning, but also actionable steps that you can enact today. To follow the work of Dr. Crear-Perry, please follow her at @doccrearperry. At D-O-C-C-R-E-A-R Perry, and @BirthEquity at Twitter. And to stay connect with me, follow me at @DrReagan on Twitter. And please follow Power to Decide at @powertodecide on all platforms. This podcast was produced as a partnership between Power to Decide, and the Reproductive Health National Training Center. Learn more at rhntc.org.