

A Historic Pursuit of Health Equity

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Last spring was a time to focus on health equity for ethnic and racial minorities nationwide. During Minority Health month in April, the fourth annual Black Maternal Health Week (April 11 to 17) was marked by a proclamation from the Biden administration to address pregnancy-related deaths in Black women (Health and Human Services, 2021). Why would there be a need to focus specifically on Black maternal health for an entire week? Because in 2017 the World Health Organization determined that the deaths of Black women from perinatal and postnatal complications were so significant that they raised the maternal mortality rate of all U.S. women to higher than that of other affluent countries (MacDorman & Declercq, 2018). Black women in the United States were dying of complications in childbirth at the same rate as women in underserved countries such as Mexico and Uzbekistan (Center for Health Journalism, 2017).

One such complication is peripartum cardiomyopathy, or congestive heart failure, that appears between the last month of pregnancy and 6 months after delivery. Symptoms include significant retention of water and sodium, which result in swelling and overworking of the heart due to increased blood volume (Yaméogo et al., 2018). There is no known cause for the condition, but cardiomyopathy represents the primary diagnosis contributing to the high rate of maternal mortality in Black mothers (Phan et al., 2020).

President Biden's proclamation calls for more effort toward data collection and analysis and more community involvement to identify and address factors contributing to disparities and inequity in the treatment of minority pregnancies and births (The White House, Office of the Press Secretary, 2021). The sentiment of President Biden's words mirrors what has been expressed by Office of Surgeon General and Department of Health and Human Services leadership for over four decades, during which Black women have continued to die at a rate three to four times higher than women of other races (Health and Human Services, 2021).

A review of historical data indicates these issues have persisted over time



with similar solutions outlined but very little movement made toward significant change in Black maternal mortality (Health and Human Services, 2021). Every state in the United States is eligible for federal funding to address maternal mortality in the form of a Maternal Mortality Review Committee (MMRC) and subsequent programming related to recommendations made by the committee. Maine, North Dakota, Nevada, Rhode Island, South Dakota, Vermont, and Wyoming have opted out the MMRC (Health and Human Services, 2021). The issue for Black women is the loose application of recommendations made by existing MMRCs. Without

the benefit of legislation to enforce recommendations and address contributing factors, MMRCs will become part of the system that maintains the deadly cycle previously described for Black mothers and children where recommendations are identified but no progress is made to reduce mortality numbers.

In the state of Kansas, these efforts are being led by Sharla Smith, Ph. D, MPH of the Kansas Birth Equity Network and Kansas MMRC, Sapphire Garcia-Lies of the Wichita Birth Justice Society, and former Representative Melody McCray-Miller in partnership with a coalition of House and Senate members including Oletha Faust-Goudeau,

Mary Ware, Elizabeth Bishop, and Gail Finney. They have proposed adding performance indicators exactly as they are identified by the Department of Health and Human Services (2021). As previously indicated, identifying solutions to address maternal mortality for Black women has historically resulted in very little movement toward success. However, when national indicators become the gold standard, the potential for change increases exponentially, because what gets measured, gets done (Parmenter, 2020).

Additional changes include the use of a social determinants of health review form, which includes a section on inequalities in health care, specifically racial discrimination and other factors related to racism. Unconscious bias can significantly affect the way physicians respond to patient complaints, resulting in unintended consequences such as a missed diagnosis, delayed response, or no treatment at all (Marcelin, et al., 2019). Without the benefit of a mechanism to collect these experiences, valuable data are being lost.

The voices of those most affected by the issue of maternal mortality deserve to be part of this critical conversation. For every 100,000 births in Kansas, 70 Black women die from complications, representing a disproportionate 60 percent of maternal deaths in Kansas (Kansas Department of Health and Environment, 2020). Consequently, an external community review committee has been suggested to provide the opportunity for individuals to review public data, clinical notes, and interviews related to maternal deaths and offer insight based on their own experiences.

The proposed changes are reasonably within the recommendations of the Kansas Maternal Mortality Review Committee, which indicated that 92.3 percent of the maternal deaths in Kansas are preventable (Kansas Department of Health and Environment, 2020). The Kansas Legislature overwhelmingly

disagreed, believing that enough is already being done. This legislative session, House Bill 2108 and its companion Senate Bill 42 have been referred to the Committee on Federal and State Affairs, where no action is expected be taken due to lack of support (Kansas Legislature, 2021). To those who believe enough is already being done, I pose this question: What should we tell this woman? During the last month of her third trimester, she experienced fluid retention in her ankles and was diagnosed with anemia. After delivering twins she continued to retain fluid, also known as edema, and required a blood transfusion. When she was discharged from the hospital four days later, she noticed shortness of breath. She contacted her doctor for a follow-up appointment and was told her body needed time to recover from having twins and to give it time for the symptoms to go away. So, she waited.

She was not new to motherhood. This was her seventh, and last, pregnancy. But caring for the twins seemed to take a lot out of her. Even with extra help she was overly tired. The shortness of breath would come and go. She was occasionally dizzy and nauseous. Sometimes she vomited. She mentioned these symptoms to her pediatrician during the follow-up appointment for the twins. Again, she was told, it takes time to recover from having twins. Give it time. And so, she waited.

The headaches became unbearable. She called her doctor again and asked for an appointment. He refused to see her until the following week. She was already used to waiting. A few days more would not hurt. The swelling in her hands was only painful if she tried to hold one of the twins. Maybe someone could lay the twins beside her while she rested. But that only helped a little because the shortness of breath returned, forcing her to get up and sit in a chair to rest. That made the swelling in her ankles and feet worse. She felt a sense of relief when her mother insisted that she go to the emergency room.

That sense of relief turned to panic because when she arrived at the emergency room her blood pressure was 200/130. Normal readings are indicated at 120/80. Anything higher than 180/120 represents a hypertensive crisis or a condition that can lead to a stroke (American Heart Association, n.d.). She immediately began treatment for the edema and a fever of 101. High internal body temperatures, known as hyperthermia, can result in brain damage if left unattended (Chin-Hong & Guglielmo, 2021). An electrocardiogram and a chest x-ray revealed changes to the function and size of her heart. Combined, these symptoms indicated cardiomyopathy or congestive heart failure (Prasodo et al., 2019). Neither were present prior to the pregnancy. Anemia was also not present prior to the pregnancy.

As she was being admitted, the woman suffered a grand mal seizure followed by respiratory arrest. Her systolic blood pressure increased from 220 to 250, requiring her to be placed on a ventilator with intravenous medication to treat her hypertension, edema, cardiomyopathy, and anemia. The symptoms persisted for two days, during which she was unresponsive. After regaining consciousness, she began physical therapy and worked to regain her strength until being discharged 22 days later. She had no recollection of anything that happened after she went to the emergency room. What would you tell her?

I would tell her, “Mom, I am sorry your story still has to be told. In a world that has seen its first Black president and now its first Black female vice president, your story is still as relevant today as it was 42 years ago. My hope is that sharing your story changes things for your granddaughters and great granddaughters. I hope it means no other woman has to live through this experience because bias has no place in how she is treated by providers. Her voice matters because her life matters. Maternal health is everyone’s responsibility because when mothers die, communities die.”

The role of social workers as advocates is more critical now than it has ever been in the history of the social work profession. We are presented with daily challenges to the basic freedoms guaranteed to everyone by the Constitution. The ability to access these freedoms should not be a partisan issue, nor should it be one on which the voices of social workers remain silent. We are charged to “enhance human well-being and help meet the basic human needs of all people with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty” (National Association of Social Workers, 2017).

Voting in elections is not the only way to let our voices be heard. As social workers we have an ethical and professional responsibility to be part of the solution by being informed about who our elected officials are and knowing what issues they are addressing long before critical votes are cast. We also have the right to contact elected officials and voice our concerns. Encourage others to do so as well by contacting their local state government office or visiting its website to identify their representative.

Tara D. Wallace is a licensed specialist clinical social worker in Topeka, Kansas. She is the creator of Lighthouse Therapeutic Community Outreach Foundation/Lighthouse TCO, a community-based mental health organization focused on addressing racialized trauma for minority communities. Tara believes poverty and limited access to resources should not be a hindrance to safe and healthy functioning for Kansas families. Her work with numerous community partners led to her becoming president of the Kansas African American Foster Care/Adoption Coalition. This organization works to provide culturally responsive education to foster families and engage community-based resources to support children and families in the child welfare system. Tara specializes in treating childhood trauma. She is also an adjunct professor for Central Texas College in Killeen, TX. When not providing therapy to children or teaching undergraduate students, Tara volunteers her time serving on the board of many agencies and organizations whose missions focus on improving the lives of children and families in Kansas. One of her most rewarding roles to date was the opportunity to serve on the Governor's Child Welfare System Task Force's Protective Services and Family Preservation work group

and provide testimony to the legislature on behalf of children and families. Tara holds an MSW from Washburn University and a BS in liberal arts (psychology focus) from Excelsior College. She is currently pursuing an EdD in community care and counseling: traumatology focus on Liberty University.

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