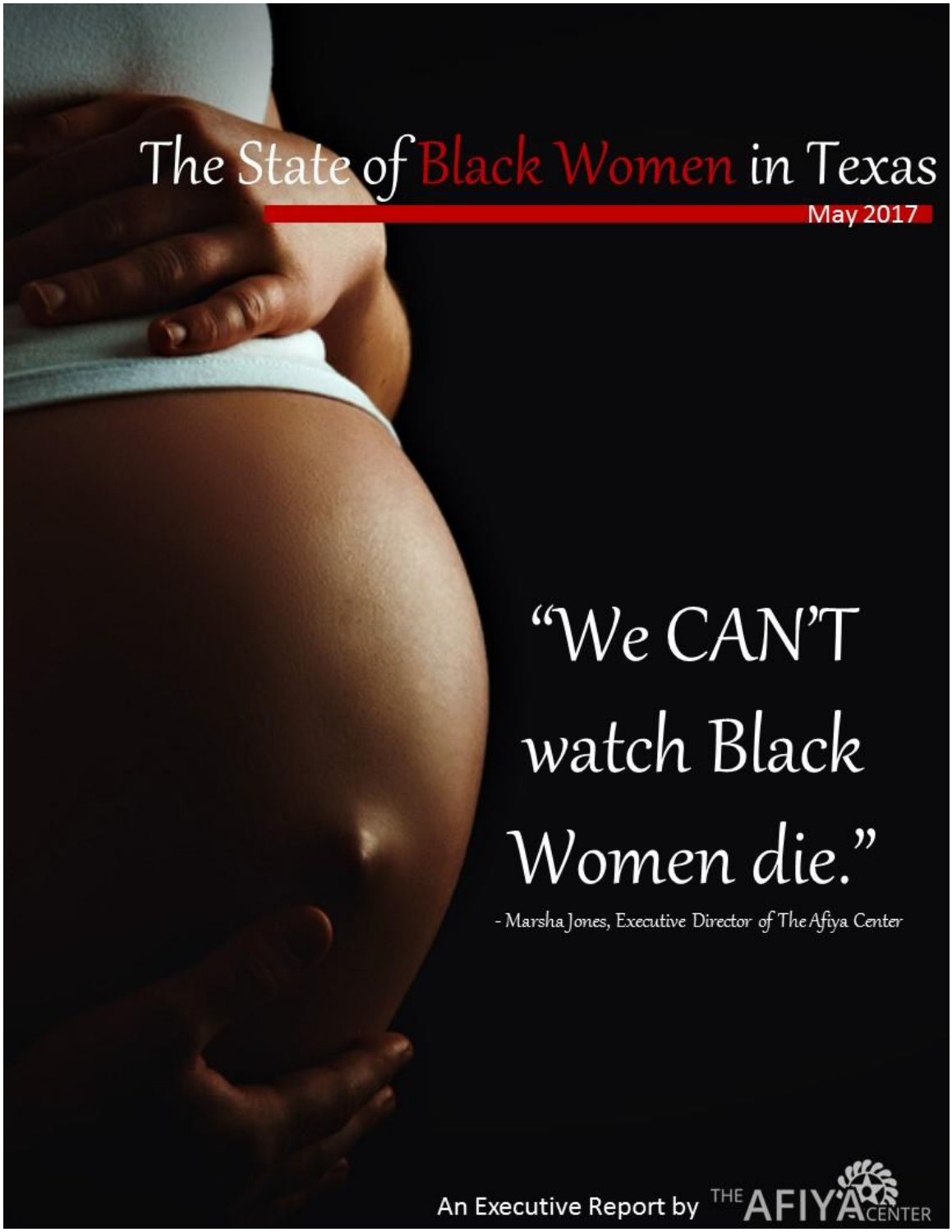

The State of Black Women in Texas
May 2017
"We CAN'T watch Black Women die."
- Marsha Jones, Executive Director of The Afiya Center
An Executive Report by THE AFIYA CENTER

EXECUTIVE REPORT

Background

The Afiya Center and its partners submit this Executive Summary on *The State of Black Women in Texas*. This intersectional report highlights our findings as it relates to health disparities with a focus on maternal mortality in Texas. This report also shows that while Black women have experienced systemic and institutional roadblocks, Black women continue to show progress; particularly in politics, education, and socio-economics. Lastly, this report shares recommendations on ways The Afiya Center and its partners can work collaboratively with community stakeholders and our elected officials to improve the lives of black women as it relates to maternal mortality in the state of Texas.

Overview

Over the past eight years, The Afiya Center has participated in four consecutive legislative sessions where Texas lawmakers have consistently presented and passed legislation that does not value the unique concerns of Black women in Texas. Situating the national climate in which Black women suffer overwhelmingly poor health outcomes and inequities, Dr. Avis Jones Weever stated the following in the 2016 Black Women's Report, "Black women continue to suffer, now facing a reality [in] which they are not only likely to find themselves on the wrong side of health statistics, but also at the mercy of state political actors…"[1] The same is true for Black women in the state of Texas. Currently the maternal mortality rate in Texas is higher than any other state. Governor Greg Abbott did not address Black women's health disparities during his 2017 State of the State address. Black women's health was not one of Lt. Governor Dan Patrick's legislative priorities and House Speaker Joe Straus did not mention Black women's health as a legislative focus during his acceptance speech. Although Black women's health disparities remain unacknowledged as a political priority for most in Texas, every legislator SHOULD know by now that more mothers are dying less than a year after giving birth.

We understand that maternal health care, like the rest of care, has no entitlement and therefore can only be obtained on the basis of ability to pay. Medicaid has historically covered poor women and most insurance plans cover maternal health. The Affordable Care Act made many who are not in either of those categories eligible for coverage that now is in jeopardy of being lost if it is overturned. This is especially true in Texas since there is no expansion of Medicaid. Even in the deliberations that ultimately led to the blockade of the Republican's initial health care bill (American Health Care Act), the question about whether insurance providers should be required to cover prenatal care was something that had not yet been asked.[2] Dr. Lisa Hollier, Director of the Maternal Mortality and Morbidity Task Force, says, "We need to work hard to make sure that the issue of maternal mortality is not forgotten. The problem has been here for a while, and I think sometimes when problems are chronic, they can be easier to ignore."[3]

The adverse data on maternal mortality is not only a challenge in the state of Texas but also the United States writ large. According to the Institute of Health Metrics and Evaluation, there were 28 maternal deaths for every 100,000 live births in the United States in 2013, up from 23 in 2005. The rate in 2013, the most recent year for which the Institute had detailed data from the United States[4] is more than three times higher than the rate in Canada and the U.K., which makes the United States the country with the highest death rate of all developed nations. Maternal Mortality has increased throughout the United States, with the exception of California, over the past decade. The trends in Texas, however, mirror national trends. Chronic diseases seem to be the source of blame; especially comorbid conditions that make pregnancy more complicated, such as Type II diabetes, obesity and hypertension.

There is also a large racial disparity in the world of maternal deaths. Historically, Black women have been four times more likely than white women to die from complications. In Texas, the state with the worst maternal mortality rate in the developed world, the situation is even more dire. Between 2011 and 2012 maternal mortality rates in Texas doubled, hitting a high of 33 per 100,000 live births in 2012, according to a study published last year by the journal of Obstetrics and Gynecology.

Figure 1. Percentage of Texas maternal deaths and births in 2011-2012 by mother's race/ethnicity.

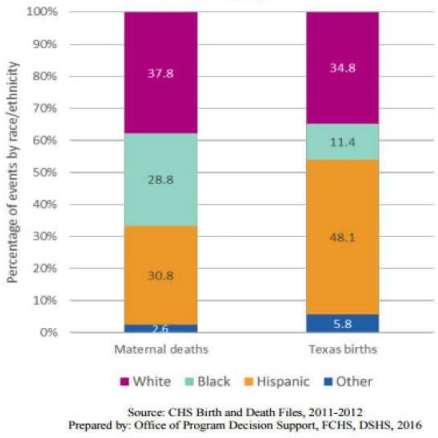
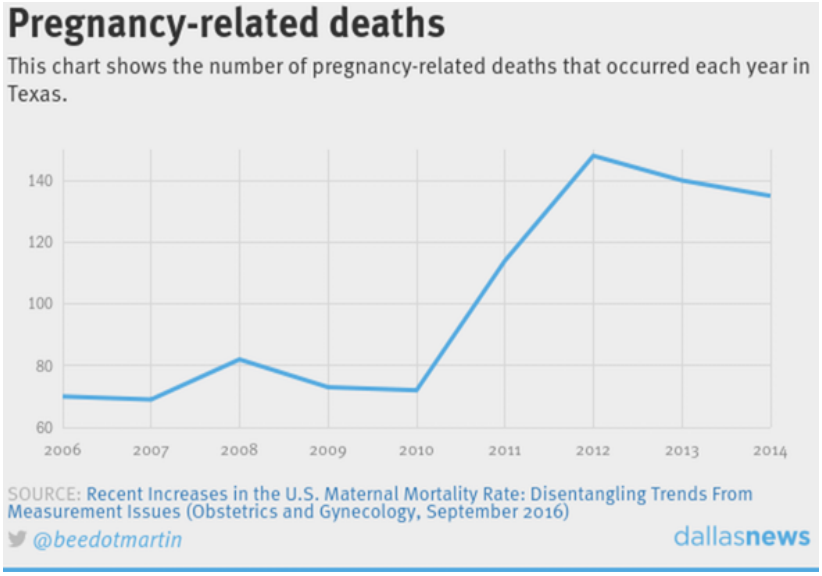


Photo: Maternal Mortality and Morbidity Task Force

State statistics demonstrated a steady climb in such deaths beginning in approximately 2003 according to the Joint Biennial Report produced by the Maternal Mortality and Morbidity Task Force and the Department of State Health Services.[5] Maternal deaths in Texas have been mentioned sparingly during the legislative session, overshadowed by issues such as child welfare, additional unnecessary abortion restrictions, the so-called 'bathroom bill' and sanctuary cities.



For many years, Texas maintained reasonable investments in family planning services. In 2007, Texas joined with other states in the U.S. in expanding Medicaid eligibility, specifically for contraceptive and related care, by creating the Women's Health Program for low-income adult women. ("Low income" is defined as income below 185% of poverty.)

The state took several major steps in 2011 to reverse course, motivated largely by the goal to put Planned Parenthood out of business in Texas. First, the state moved to ban Planned Parenthood health centers from participating in the Women's Health Program, based solely on the fact that these centers were associated with other sites where abortions were provided. Planned Parenthood Centers had been serving about four in 10 women in the program statewide, and some sites served as many as eight in 10 women within their service areas.[6] The Obama administration made clear that Texas' action violated federal law by discriminating against qualified providers. Governor Rick Perry remained insistent, which led to the state of Texas losing all federal support for the Women's Health Program - $9 for every dollar spent. As of January 2013, the program is an entirely state run effort with a more limited provider network and significantly fewer enrollees, and delivered thousands fewer contraceptive and related services during the first months of operation.[7]

Also in 2011, the legislature reallocated two-thirds of the budget for the state's family planning program (separate from the Women's Health Program) to other efforts, which resulted in an annual budget of approximately $19 million. In addition to this reallocation, Texas lawmakers tiered types of providers that could receive these remaining funds. Health departments have top priority, followed by community health centers. Specialized family planning centers are disadvantaged as they are only able to apply for any funds that remain. According to the Texas Department of State Health Services, in 2013, the state's family planning program served less than one fourth of the women it had served in 2011.[8]

According to researchers at the Texas Policy Evaluation Project, dozens of clinics closed in 2012, about half of them family planning – focused sites; dozens of the remaining open clinics have had to reduce their hours, patient loads and service delivery to accommodate their smaller budgets.[9] In addition to limiting family planning services, the cuts have also limited Texans' ability to obtain related services, including HIV/STI tests, Pap tests and other preventive care, from trusted providers who specialize in the administration of these sensitive and confidential services. There is no measure of a direct link between abortion clinic regulations and maternal mortality. Given that the definition of maternal mortality is the death of a woman due to conditions that are directly related to pregnancy, it can be reasonably inferred or at least correlated that limiting access to abortion forces women to remain at risk for maternal death from conditions that evolve as a pregnancy continues. Hence, there is likely a relationship with abortion access.[10]

In response to public outcry, in 2013, legislators attempted to restore some of the lost funding for the state's family planning program. Legislators also created a new program to deliver primary care to women aged 18-65. However, there is some skepticism about how much progress can be regained because of the extreme disruption lawmakers caused to the delivery of family planning care and because the resources have not been completely restored.

At the same time, the cycle for the Title X grant administered by the state came to an end in 2013, which required the state to reapply and created the opportunity for other entities to apply. The Title X grant is now administered by the Women's Health and Family Planning Association, which means the tiered provider requirement is no longer relevant. This change may be particularly beneficial in more remote, economically depressed communities such as the Rio Grande Valley, where after four Planned Parenthood health centers closed in the wake of budget cuts, one has been able to reopen with the restoration of Title X support.[11]

Government Duties to Ensure Safe and Respectful Maternal Health Care[25]

Respect: Governments must refrain from interfering, either directly or indirectly, with women's access to the health care services they need, or to the underlying determinants of health (safe communities, affordable housing, employment, social support, etc.…)

Protect: Governments must prevent third parties from interfering with the right to safe, respectful maternal health care and must investigate and sanction those who violate this right.

Fulfill: Governments must take positive steps (passing legislation, ensuring adequate funding for programs, training health care providers, etc.) toward the full restoration of the right to save and respectful maternal care.

"This confirms what we feared – that many of these deaths could be prevented," said state Rep. Armando Walle, D-Houston, the House author of the 2013 bill that created a Department of State Health Services Maternal Mortality Task Force and charged it with producing biennial reports and recommendations. "It's a travesty that this is happening."[12] The Maternal Mortality and Morbidity Task Force (MMMFT) discovered trends that were more alarming than the maternal death rates, particularly the severe maternal morbidity rates. The MMMFT indicated the complications were "so serious that more mothers might have died without major medical and technological intervention or sheer luck. Such cases were more common than deaths and far more common among African American women."[13] The reasons for the deaths and the severe maternal morbidity are complex. Researchers point to numerous contributing factors. For Texas, the main causes for the deaths have been cardiac problems followed by substance use and

mental health issues. For severe maternal morbidity, the main causes are hypertension, heart problems, obesity and drug overdoses.

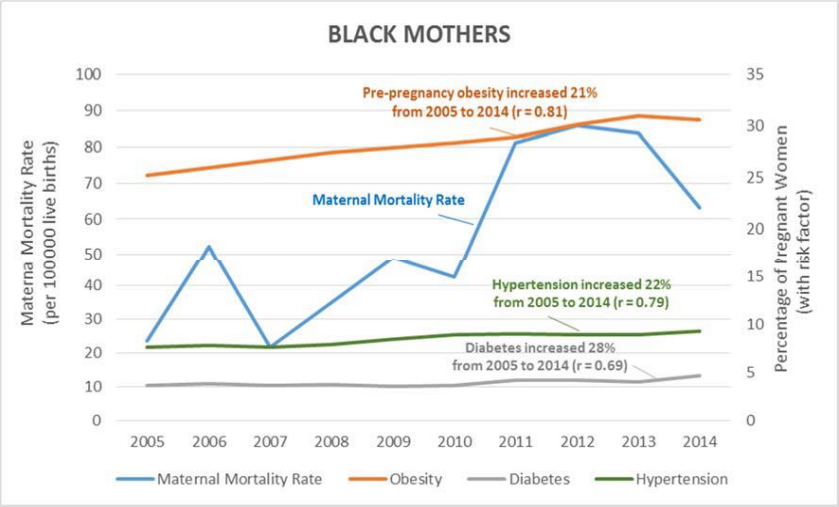


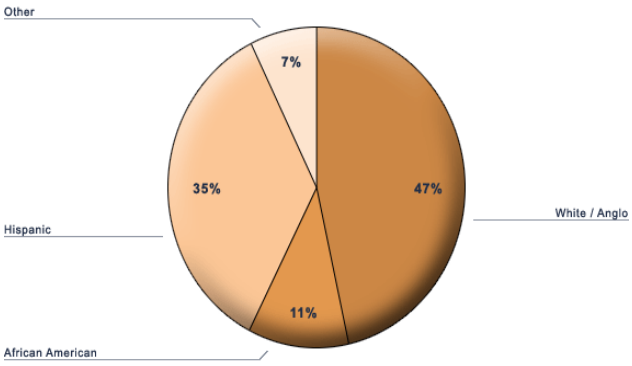
Photo: Maternal Mortality and Morbidity Task Force

Many women's health advocates point to the 2011 state cuts to Planned Parenthood and other family health clinics along with the lack of Medicaid expansion. Nationally, experts say multiple causes such as obesity, age and inequitable access to health care all play a role. But the overall maternal mortality rate and the actual number of maternal deaths remain uncertain, as does the underlying reason for the sudden jump in 2011 and 2012. Among the challenges encountered by task force members as they try to find answers are recent changes aimed at keeping better track of maternal deaths, such as checked boxes on death certificates noting that a woman was recently pregnant. These changes have led to confusion and more inaccuracies. "The short answer is, I don't know" what caused pregnancy-related deaths to rise sharply in that period, Hollier said. "The longer answer is I think it's unlike that there is a single explanation. The problem is complex and the increase is likely due to a multitude of factors."[14]

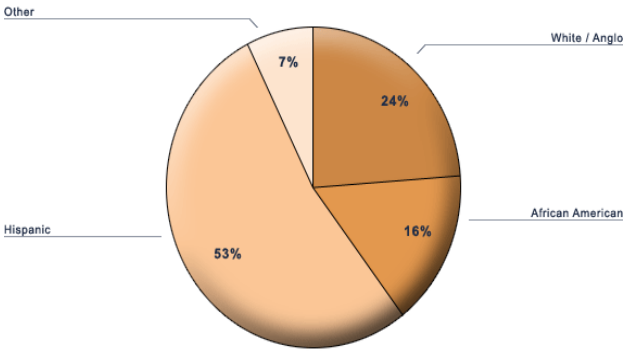
Maternal Mortality

No matter the cause, the issues associated with maternal mortality and severe maternal morbidity are of great concern. "Maternal Mortality is a human rights crisis in the United States. The 2014 *Trends in Maternal Mortality* report issued jointly by WHO, UNICF, UNFPA, the World Bank and the UN Population Division shows that the maternal mortality ratio (MMR) in the U.S. increased by 136% between 1990 and 2013, from 12 to 28 maternal deaths for every 100,000 live births."[15] The causes of maternal mortality are multiple and complex[16] but the problem must be understood in the context of pervasive racial and socioeconomic disparities.[17]

Socioeconomic factors and geography also drive disparities. Women of color comprise more than half the women in the U.S. women living in poverty[17] and the poverty rate for both Black women and Latinas is three times that of Whites.[18] In the state of Texas, Black women and other women of color represent 72.4% of those in poverty.



Texas Population by Race
Photo: Center for Public Policy Priorities



Poverty Breakdown by Race
Photo: Center for Public Policy Priorities

In addition, more than half of the female-headed households in Texas are living in poverty.[19]

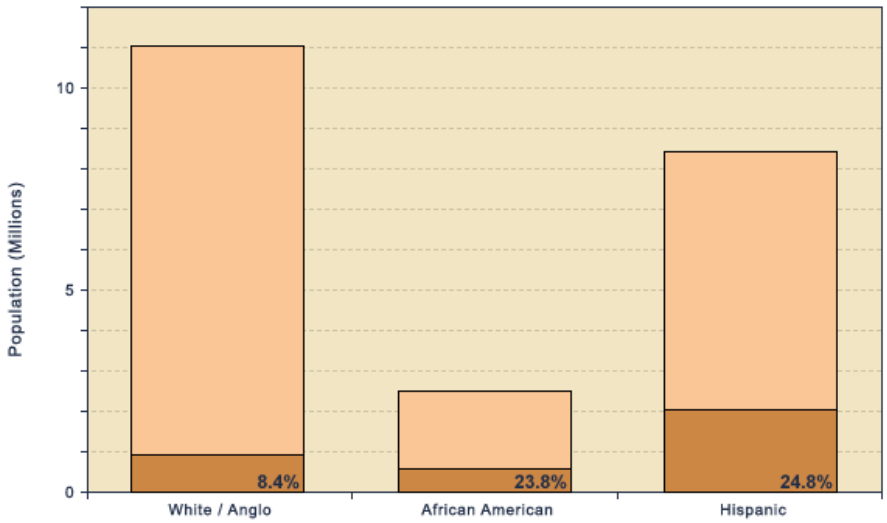


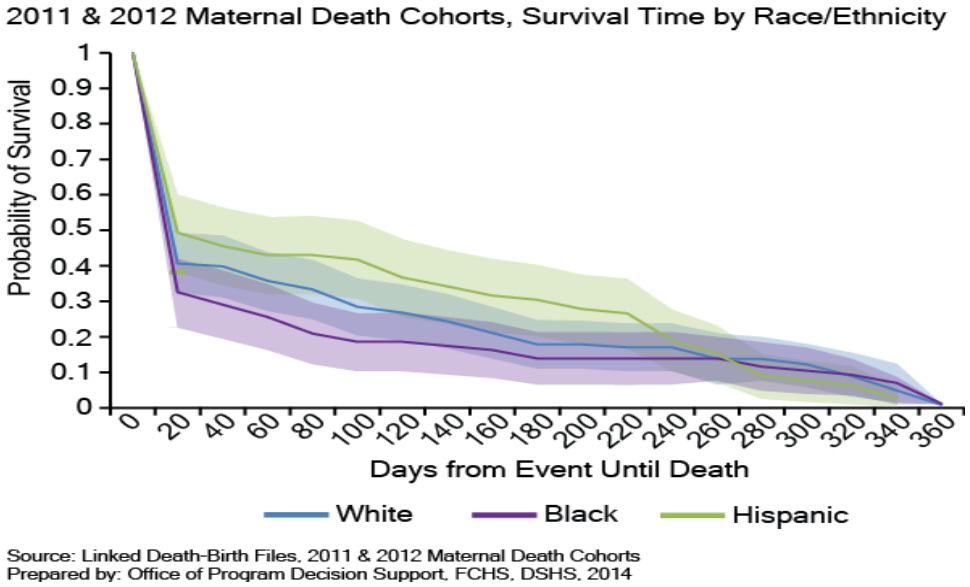
Photo: Center for Public Policy Priorities

Poverty has a very negative impact on maternal mortality. Mothers living in poverty are more likely to have low-birth weight babies, increasing babies' chances of developmental delays and disabilities. According to parent reports, children living in poverty have worse health than children not living in poverty. People living in poverty experience higher rates of chronic illness such as asthma, diabetes and heart disease. Children born into poverty are more likely to live in poverty and less likely to have consistent employment as adults.[20]

While women in the state of Texas have access to Medicaid during pregnancy, they lose access to coverage shortly after having their child. A lack of postnatal care is also a contributor to maternal morbidity. Some lawmakers are quick to point to the legislature funding of the Healthy Texas Women Program in July of 2016. The program focuses on helping women receive cancer screenings, post-partum depression screenings, family planning services, STD testing, contraceptives and more. Legislators also point out that low-income mothers are auto-enrolled in the program just as their Medicaid benefits

expire 60 days after giving birth, saving them from a lapse of coverage. Neither auto-enrollment nor the Healthy Texas Women Program has turned the tide in maternal mortality in Texas. Strengthening continuity of care from obstetric to primary care is critical to ensure risks continue to be assessed and managed so that women can enter pregnancy in optimal health, subsequently increasing likelihood of a positive pregnancy and birth outcomes. The task force found that nearly 60% of 2011-2012 maternal deaths occurred after 42 days postpartum to 52 weeks after delivery when, for many women, access to health care is limited.[21]

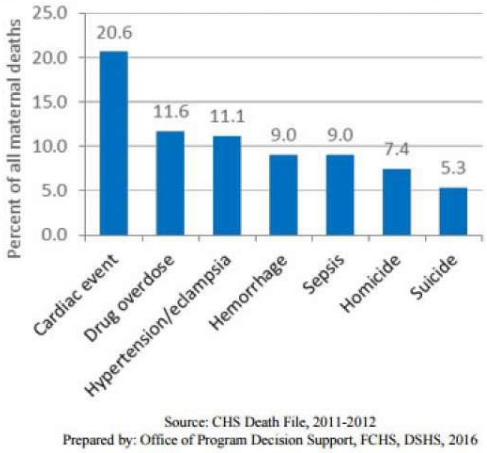
Texas State Rep. Jessica Farrar (D-District 148) said the Healthy Texas Women Program has not been easy for patients to access, and advertising on buses and billboards has not done enough to inform eligible women about the program and how to enroll. Farrar went on to say, "If I'm going to make such a big policy change I would make sure that there was something in place so that there was a seamless transition for Texas women to see another provider, and that was not the case."[22]



The 2012 Report of the Agency for Healthcare Quality and Research found that access to health care is decreasing, especially for people of color and low-income groups. As a result, low-income and uninsured Black women are already at high risk of maternal death by the time they become pregnant. Compared to white women, Black women and other women of color are more likely to struggle with diabetes, obesity, heart disease and hypertension. These conditions are exacerbated during pregnancy and are a driving force behind preventable maternal deaths.

Finding #2 — Overdose by licit or illicit prescription drugs emerged as a leading cause of maternal death

Figure 2. Top causes of maternal death in Texas in 2011-2012.



Source: CHS Death File, 2011-2012
Prepared by: Office of Program Decision Support, FCHS, DSHS, 2016

Photo: Maternal Mortality and Morbidity Task Force

Lastly, the economic burden is substantial to the state of Texas. Over half of all Texas births are paid by Medicaid, totaling over $2.2 billion per year in birth and delivery-related services for mothers and infants. The average amount spent in the first year of life for a preterm birth with major complications (excluding extreme prematurity) is $19,059, and $4,019 for a preterm birth without major complications compared to $410 for an uncomplicated term birth. Increasing access to care throughout the first postpartum year would improve interconception health while also reducing cost in the Medicaid program. This reduction in cost happens by decreasing the rate of unintended pregnancy, and by preventing, detecting and managing chronic conditions and other risks, such as obesity, hypertension, smoking, and mental and behavioral health issues. These various issues increase risk for maternal morbidity and mortality and lead to costly adverse pregnancy and birth outcomes including severe maternal morbidity, preterm birth, and low birth weight.

We have the opportunity to reduce the incidence of pregnancy-related deaths along with severe morbidity in the state of Texas by following the MMMTF's recommendations:

1. Increase access to health services during the year after delivery and throughout the interconception period to improve continuity of care, enable effective care transitions, promote safe birth spacing, reduce maternal morbidity and reduce the cost of care in the Medicaid program.
2. Increase provider and community awareness of health inequities and implement programs that increase the ability of women to self-advocate.
3. Increase screening for and referral to behavioral health services.
4. Increase staffing resources in support of the task force.
5. Promote best practices for improving the quality of maternal death reporting and investigation.
6. Improve the quality of death certificate data.

HIV/AIDS

Along with maternal mortality, Black women are significantly overrepresented among women who are living with HIV/AIDS. While Black women represent 12% of the population, they represent 57% of women diagnosed with HIV and 58% of women diagnosed with AIDS, according to the Texas HIV 3rd Quarterly Report representing January 1, 2016 – September 30, 2016. It is important to note that maternal mortality represents the beginning of one's life, and for many, an HIV or AIDS diagnosis represents the beginning of the end of life despite the current available medical interventions.

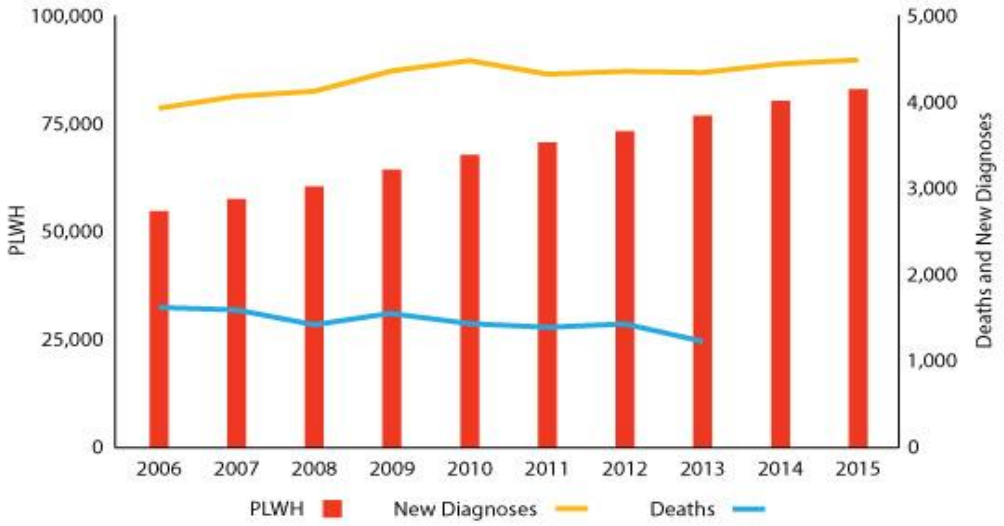


Photo: Texas Department of State Health Services

In Texas, the rate of Black women living with HIV is 7.8 times the rate of Hispanic women and 14 times the rate of White women living with HIV. The most common way that Black women are exposed to HIV is through unprotected sex with an HIV-infected

man (86.8%). Black women and other women of color are often diagnosed later in the disease process. Though they are often able to rebound due to current available medical interventions, the resulting internal damage leads to shorter life spans. According to the Texas Black Women's Initiative (TxBWI) report, 26% of Black women in Texas were diagnosed with HIV late in the progression of the disease. These same women received their HIV and AIDS diagnoses within one year. One in 168 Black women in Texas is living with HIV.

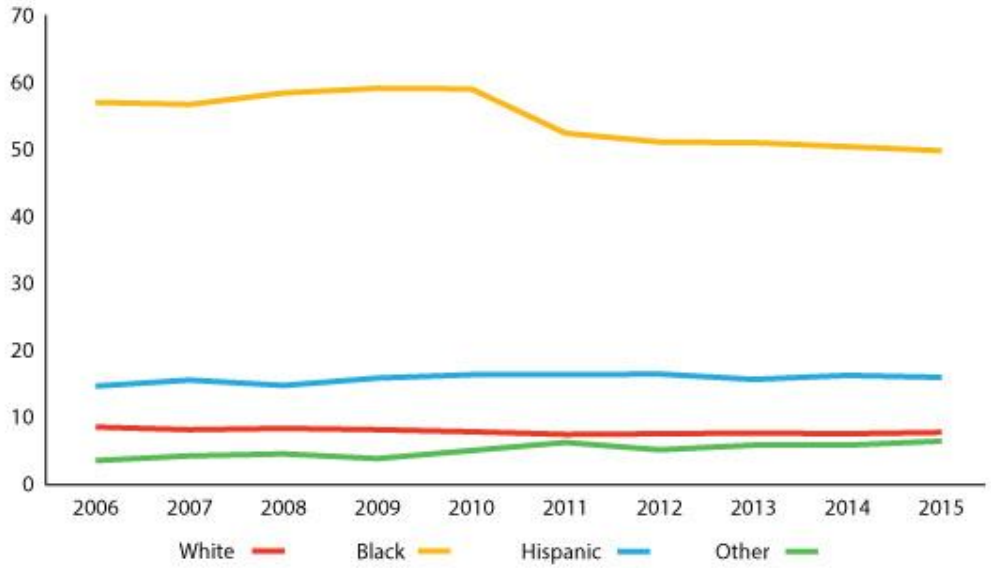


Photo: Texas Department of State Health Services

As stated earlier, advances in HIV-related care enable people living with HIV to remain healthy and survive longer. Due to lack of health insurance, HIV-related stigma and other comorbid conditions, every person does not get the opportunity to experience the advances in HIV-related care. Many do not seek care until they begin to show signs of illness. Blacks represent the highest number of individuals – 7,696 (25%) – who are not receiving medical care for HIV disease. In Texas, approximately one in five Black women were out of care in 2015. This represents 2,346 (23%) Black women not in care across the state.[23]

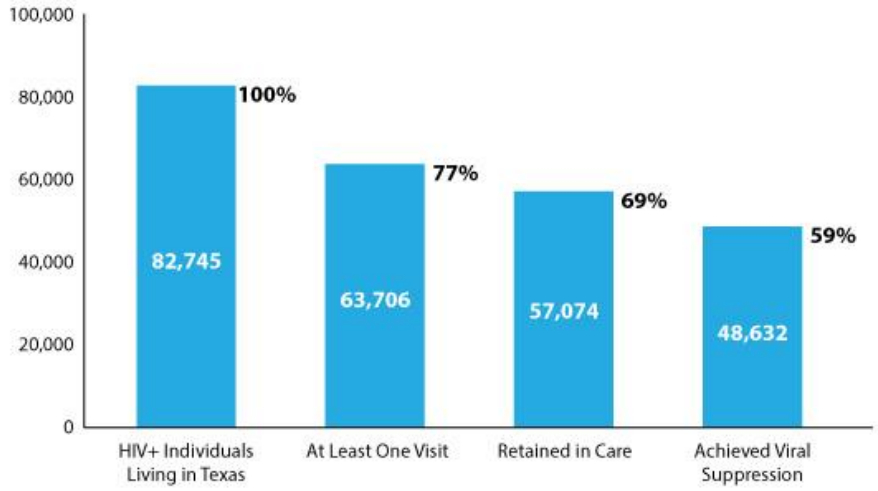


Photo: Texas Department of State Health Services

The social determinants of health, such as poverty, unemployment, stigma, trauma, relationship dynamics, biological vulnerabilities and lack of education, are factors that often contribute to HIV transmission among Black women.

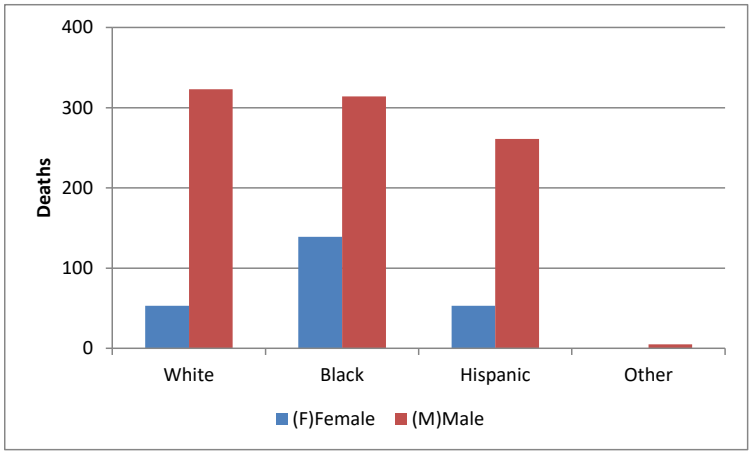
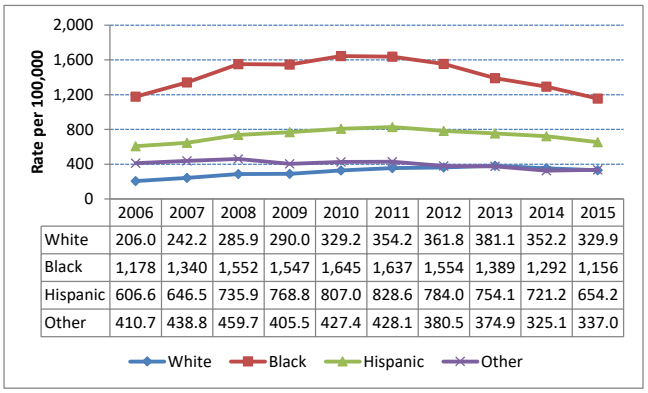


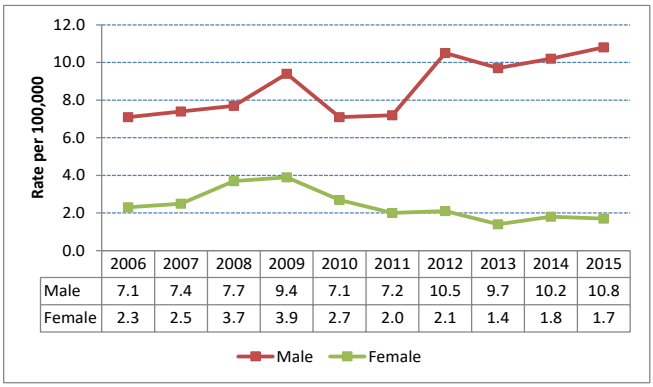
Photo: Texas Department of State Health Services

From 2013 to 2015, there were 434 new cases of HIV in women under the age of 25 in Texas. Over 63% of these were young Black women. The rate of new HIV diagnoses in Black women in Texas is 6.3 times the rate of new HIV diagnoses in Hispanic women and 13 times higher than the rate of new HIV diagnoses in White women. Black women have the highest case rates of Chlamydia, Gonorrhea and Primary and Secondary Syphilis in Texas.[24]



	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
White	206.0	242.2	285.9	290.0	329.2	354.2	361.8	381.1	352.2	329.9
Black	1,178	1,340	1,552	1,547	1,645	1,637	1,554	1,389	1,292	1,156
Hispanic	606.6	646.5	735.9	768.8	807.0	828.6	784.0	754.1	721.2	654.2
Other	410.7	438.8	459.7	405.5	427.4	428.1	380.5	374.9	325.1	337.0

Photo: Chlamydia by Gender – TXDSHS



	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Male	7.1	7.4	7.7	9.4	7.1	7.2	10.5	9.7	10.2	10.8
Female	2.3	2.5	3.7	3.9	2.7	2.0	2.1	1.4	1.8	1.7

Photo: Primary and Secondary Syphilis - TXDSHS

Facts to Consider:

- One in every 332 Texas has HIV
- One in 107 Black Texans has HIV
- One in 542 White Texans has HIV
- One in 411 Hispanic Texans has HIV

Resilience in the Face of Adversity

Despite the clear attack on Black women's bodies as it relates to health disparities, Black women have displayed resilience consistently throughout our history. There are many examples— from Harriet Tubman to Michelle Obama. For the purpose of this report, we will highlight education, politics and business in the local climate as well as at the national level.

Political Power

In both 2008 and 2012, Black women redefined voting history by becoming the largest demographic group to cast ballots in an election. In 2016, not only did Black women continue to vote at high levels, they also expanded their grasp on political power. Black women increased their numbers in Congress and for the first time in 18 years, a Black woman—Kamala Harris— was elected U.S. Senator. Ms. Harris is the first Black woman to serve in the upper chamber in nearly two decades after a string of historic achievements. Ms. Harris was also the first female district attorney general in 2011. According to *The Los Angeles Times*, her elementary school was the second one to bus children in the move toward integration in the 1970s.

During this same time period in the state of Texas, we maintained a consistent presence in both our local and state elections. We had more Black women participate in the political power by running for office.

In San Antonio, we elected the first Black Mayor, Ivy Taylor. We elected the first Black woman sheriff in the state of Texas, Zena Stephens, according to the National Sheriffs Association. When discussing her election win, Stephens said, "Growing up I never saw an African-American sheriff or police chiefs. I didn't think it was a possibility as a kid because I never saw anybody who looked like me in those positions."[26]

Mayor Ivy Taylor
Photo: Yahoo.com

Sheriff Zena Stephens
Photo: Fortune.com/2016/11/12/zena-stephens-texas-sheriff/

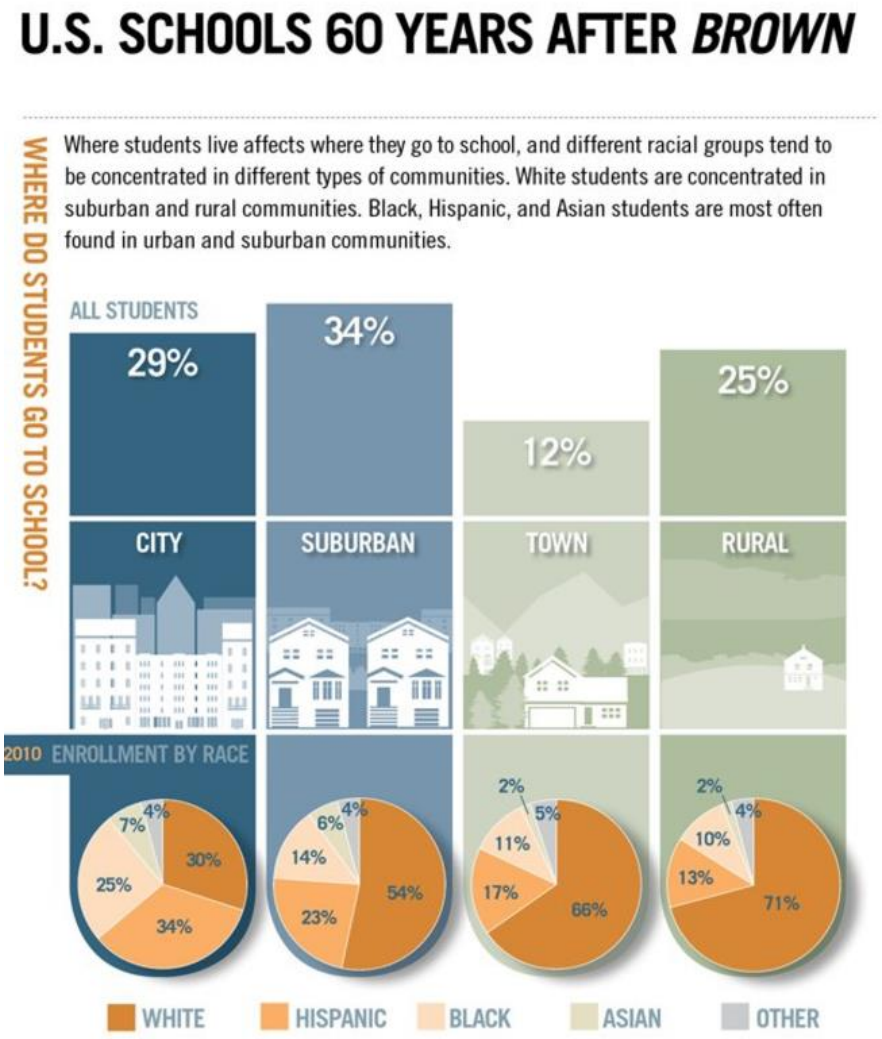
Education

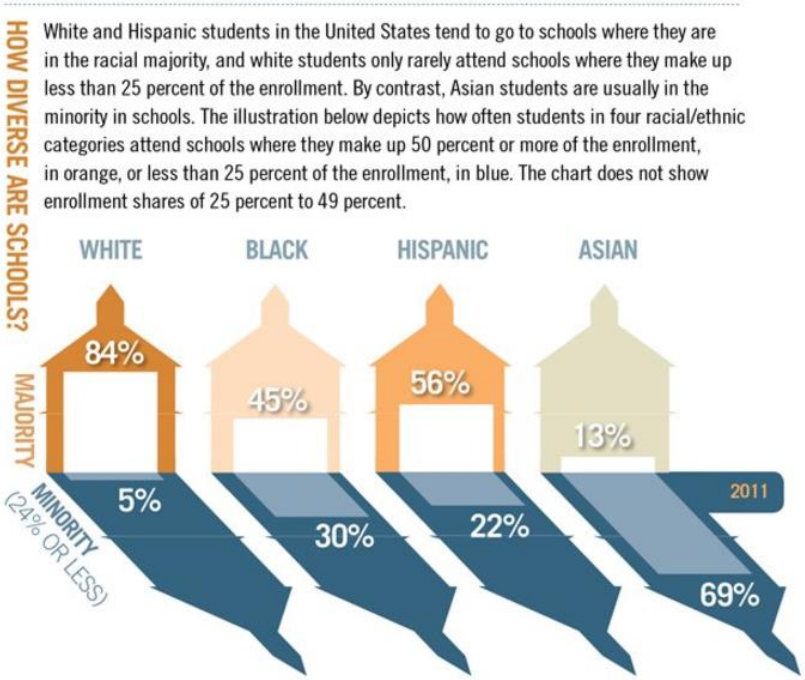
Education is a civil right. More students than ever are being taught to college and career-ready standards and dropout rates are at historic lows. The graduation rate is at 82%. And, since 2008, a million more Black and Hispanic students have enrolled in college. Black women earned 67% of Associate Degrees and 65% of Bachelor Degrees earned among Blacks. Black women outpace their male peers by more than any other group by completing higher education. Despite these accomplishments, Black women continue to lag behind when it comes to those enrolled in a major vertical of the STEM fields (10.6% Black women vs. 19.3% Black men respectively). In the state of Texas, the public school system ranks the 4th worst in the nation.

Today, African-American and low-income students stand far behind their peers in almost every indicator of school achievement. And today, the more affluent students are still six times more likely to complete college than students with the lowest family income. When given the chance, Black women and girls excel in education. However, challenges still remain and inequities and stereotypes continue to plague the ability of Black women and girls to fully progress in our current educational system.

Within the schools, a larger number of Black students attend schools with higher concentrations of poverty and a higher number of inexperienced teachers compared to their White peers. In addition, almost 40% of Black students attend a highly-segregated school (90-100% minority). Schools with predominantly Black students lack quality resources and have less rigorous course offerings. This lack of course offerings results in

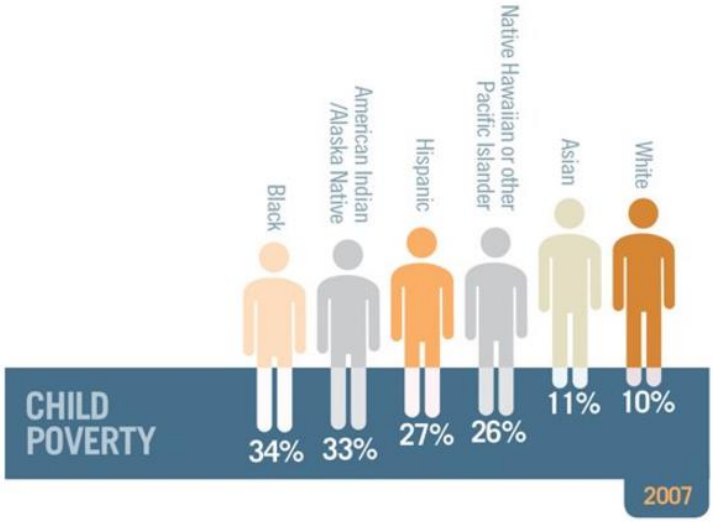
Black girls having limited opportunities to enroll in Science, Technology, Engineering and Math (STEM) courses.




HOW DIVERSE ARE SCHOOLS?
White and Hispanic students in the United States tend to go to schools where they are in the racial majority, and white students only rarely attend schools where they make up less than 25 percent of the enrollment. By contrast, Asian students are usually in the minority in schools. The illustration below depicts how often students in four racial/ethnic categories attend schools where they make up 50 percent or more of the enrollment, in orange, or less than 25 percent of the enrollment, in blue. The chart does not show enrollment shares of 25 percent to 49 percent.
WHITE
BLACK
HISPANIC
ASIAN
MAJORITY
MINORITY (24% OR LESS)
84%
45%
56%
13%
5%
30%
22%
69%
2011

HOW DO RACE AND POVERTY INTERSECT?

Higher percentages of minority children than white children are poor. (The Education Department separated Asian from Pacific Islander children in this category.)



Higher percentages of black and Hispanic children attend school with peers from low-income households. White and Asian students are more likely than others to attend "low poverty" schools, which are defined as those "in which 10 percent or less of students are eligible for free or reduced-price lunch."

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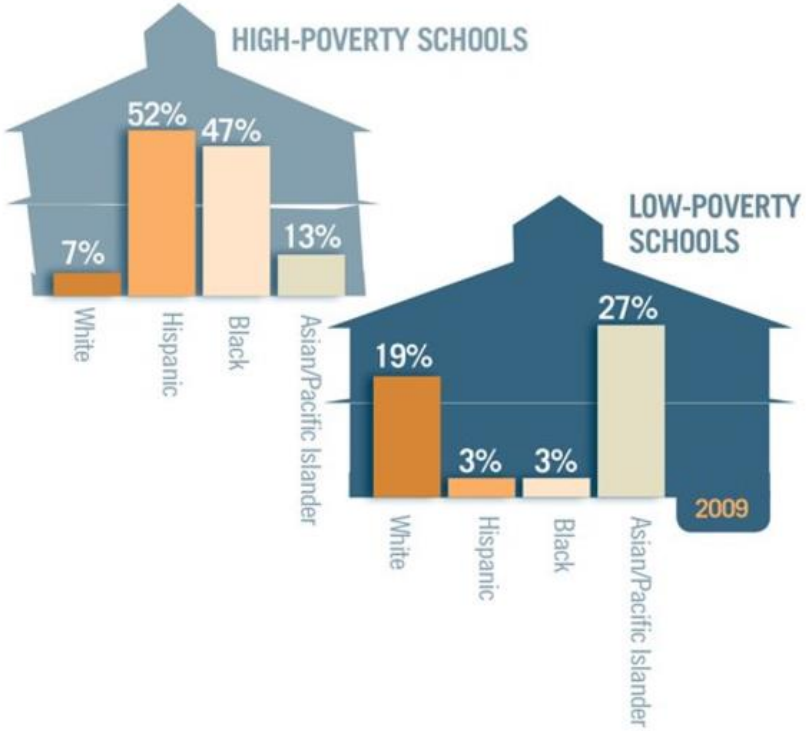

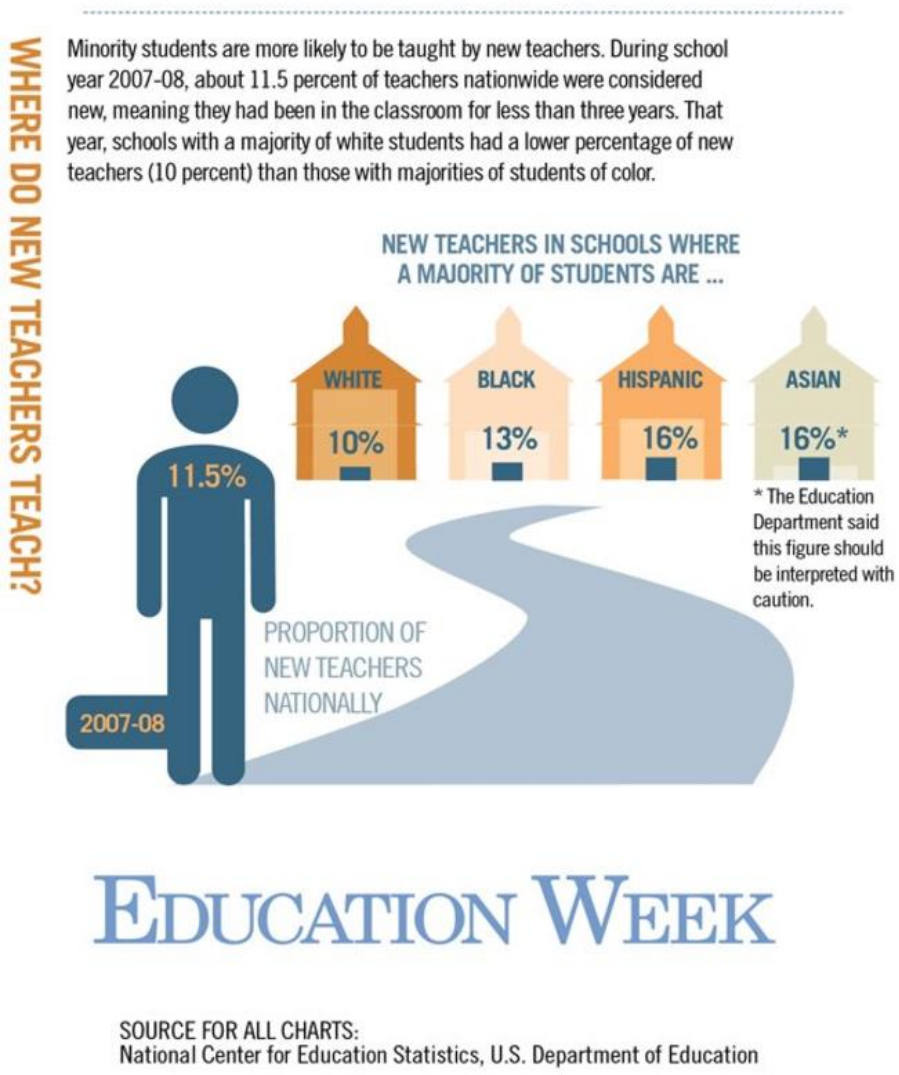

As mentioned earlier, the good news is that despite the odds, Black women still graduate with degrees in higher education at a higher rate than all of their counterparts, including White women.

As we are facing challenges from a new administration that seem hostile toward public education, the Black community must continue to demand accountability from the state, federal and local governments that are responsible for ensuring quality and equitable public educational opportunities for our children.

Socio-Economics

As access to education has increased, Black women have increased their resources. According to the 2017 State of Black America report released by the National Urban League, Black America has seen a modest increase in its economic positoin. The modest increase of Black America at a national level was matched by the state of Texas. Blacks in Texas showed a 4.1% increase in overall income. While we acknowledge the increase for Blacks compared to their white counterparts, the income increase is less than modest. Looking at the Texas cities examined in the report, there is an approximate $30,000 difference in wages for Blacks compared to Whites.

Even with the increase in overall income, we remain behind our White counterparts. To put a dent in the health disparities that plague black women, we need a more equitable piece of the current economic reality in Texas. We do not want it as an entitlement. We want the chance to participate in equitable pay.

EQUALITY INDEX OF BLACK AMERICA, 2016–2017

	REVISED 2016	2017
EQUALITY INDEX	72.2%	72.3%
Economics	56.2%	56.5%
Health	79.4%	80.0%
Education	77.4%	78.2%
Social Justice	60.9%	57.4%
Civic Engagement	100.6%	100.6%

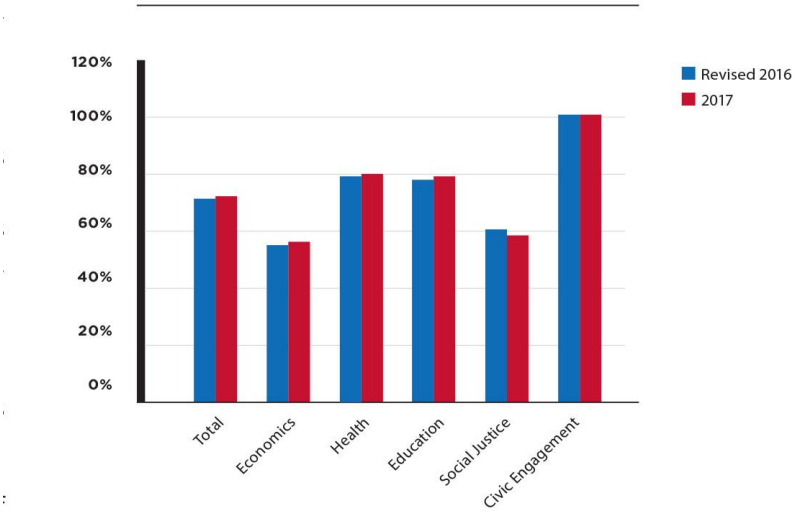

Photo: State of Black America 2017, soba.iamempowered.com/2017-report

Summary

We believe every woman deserves the right to health care. Taking a human rights-approach is one way the legislature, constituents, and community stakeholders in Texas can work together to address the health disparities noted in this report.

A human rights-based approach to maternal health is especially critical to ensuring equality and non-discrimination. Its purpose is not limited to avoiding isolated clinical pathologies, like morbidity and mortality. Instead, this approach empowers all women to claim their full set of human rights in order to live the healthiest lives possible.[27]

A human rights-based approach recognizes that discrimination plays a role in undermining women and girls' access to reproductive health care. It also requires attention to groups that are experiencing disparities.

A human rights-based approach to maternal health in the U.S. therefore requires the government to directly confront racial discrimination in the context of maternal health,

and to specifically address the harm and inequalities experienced by Black women during pregnancy and childbirth.[28]

A Human Rights Based Approach to Improving Maternal Health[29]

Accountability: Governments must create mechanisms of accountability to enforce the right to safe and respectful maternal health care, including monitoring and evaluating policies and programs, taking corrective action when violations are found, and implementing remedies for women and families.

Transparency: People should have access to information that enables them to make decisions about their health care choices, or helps them to understand how decisions affecting their health are made. This includes transparency in budgeting and funding allocation.

Participation: All people have a right to participate in decision-making processes that affect their right to safe and respectful maternal care, including decisions about government policies and distribution of health resources.

Empowerment: Women and girls must be valued and engaged as agents and rights-holders when it comes to decisions or actions that affect their sexual and reproductive lives.

Non-Discrimination: The right to safe and respectful care should be ensured without discrimination of any kind, regardless of whether the discrimination is committed purposefully or results from seemingly neutral policies and practices that have a discriminatory effect on Black women.

Equity: Health care resources, goods, and services must be distributed and accessed based on a model of equity, which is based on need and remedying historical injustice.

Universality: Health care goods and services must be available to everyone, without exception or distinction based on any discriminatory grounds.

All women need the resources, opportunities and support that will enable them to protect their human right to health and life and to make the best decisions for themselves and their families.

These needs are important as a woman chooses to become a parent and remain important throughout her life and the life of her child. At a minimum, protecting her rights requires she have access to comprehensive reproductive health services and information, freedom from discrimination and bias, and living conditions that support health rather than risk.

Finally, we must establish public health practices that improve maternal health and use measures that empower women.[30] We believe implementing a framework that values the human rights of women can be done through administrative measures, legislation, allocation of resources and comprehensive policies and programs that support women and their maternal health.

A human rights-based approach to maternal health and other health disparities incorporates principles and methodologies into government policy and practice. By integrating mechanisms that promote accountability, transparency, participation, empowerment, non-discrimination, universality, and equity, governments can ensure the health policies they create are meeting people's core needs and respecting their human dignity.

As a community partner and community stakeholder, we are willing to work with our elected officials to identify policies in need of reform, propose policy solutions rooted in human rights and hold our government accountable to human rights standards. Understanding that our priorities will vary based on the current needs of the state of Texas, we believe we should give effect to the right to health through the measures listed below:

Improve Health Care Access & Quality

- Remove existing barriers to care during and after pregnancy and throughout the lifespan of a child
- Develop a more diverse health care workforce that is trained in human rights standards and engaged in generating solutions to maternal health problems
- Ensure that every woman receives quality care, regardless of the site or setting of care
- Facilitate greater availability of obstetric care and family planning services

Address Underlying Determinants of Health

- Prioritize social support for Black women and Black communities
- Address nutrition and food security for pregnant women
- Ensure adequate, safe housing and safe communities
- Facilitate healthy occupational and environmental conditions

Eliminate Discrimination in Law and Practice

- Reform discriminatory laws and policies that impact Black women's health and well-being
- Take proactive measures to address discrimination in practice, particularly for groups that have faced historical discrimination or injustice
- Address racial bias, stereotypes, stigma, discrimination, and disrespect in health care encounters, specifically
- Eliminate disparities in maternal health safety and survival outcomes for Black women

Ensure Accountability

- Collect and disseminate adequate, disaggregated data on maternal mortality and morbidity
- Set targeted goals and benchmarks for improved maternal health outcomes
- Design state plans to improve maternal health that consider the specific needs of vulnerable populations, especially Black women and girls

- Develop policy solutions aimed at the conditions that make it likely for maternal health violations to reoccur
- Provide remedies for violations of the right to access safe and respectful maternal health care

Include and Empower

- Encourage human rights education and outreach to Black women regarding their sexual and reproductive health and rights
- Involve Black women, especially at the community level, in maternal health policy design, budgeting, monitoring and review processes
- Build partnerships between government, civil society, and other key stakeholders to assess maternal health needs and devise solutions[31]

Improving health outcomes alone does not solve the persistent health disparities of Black women. We cannot take for granted that constituents understand access. The health of Black women and their families is impacted by all the social determinants associated with health. With these strategic interventions, we believe we can work together to ensure that no Black woman is disposable and that the state of Texas is a place where Black women and their families are able to thrive without the impact of systemic violence.

Endnotes

[1.] Jones-De Weever et al., Black Women's Roundtable, *Black Women in the US 2017: Moving Our Agenda Forward in a Post-Obama Era, 2017*, 4th Annual Report.

[2] Parker, Willie, Personal Interview, May2017.

[3] Rewire, *Texas Legislators 'Ignore Spiking Black Maternal Mortality Rates*, March 14, 2017, 5:22, Teddy Wilson, rewire.news/article/2017/03/14/texas-legislators-ignore-spiking-black-maternal-mortality-rates/.

[4] New York Times, *Maternal Mortality Rate in US, Defying Global Trend Study Finds*, Sabrina Tavernise, https://nytim..ms/2cShjiS.

[5] *Maternal Mortality and Morbidity Task Force and Department of State Health Services (MMMTF), Joint Biennial Report*, July 2016, www.dshs.texas.gov/mch/maternal_mortality_and_morbidity.shtm.

[6] Ku LC et al., *Deteriorating access to women's health services in Texas: potential effects of the Women's Health Program affiliate rule*, Policy Research Brief, No. 31, Washington, DC: George Washington University, 2012, http://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1000&context=sphhs_policy_ggrchn.

[7] Janek K et al., *Presentation to Senate Committee on Health and Human Services: Texas women's health and family planning programs*, 2014, <http://www.hhsc.state.tx.us/news/presentations/2014/022014-2014.

[8] Texas Department of State Health Services, Council agenda memo for State Health Services Council, 2013, http://www.dshs.state.tx.us/council/agendas/Nov2013/4c-Family-Planning.pdf

[9] White K et al., *Cutting family planning in Texas, New England Journal of Medicine*, 2012, 367 (13):1179-1181.

[10] Parker, Willie, Personal Interview, May2017.

[11] Guttmacher Institute, *The State of Sexual and Reproductive Health and Rights In the State of Texas: A Cautionary Tale, March2014*, https://www.guttmacher.org/gpr/2014/03/state-sexual-and-reproductive-health-and-rights-state-texas-cautionary-tale.

[12] Houston Chronicle, Todd Ackerman, August 22 2016, Updated: August 23, 2016, 12:19pm, Report: *Black Women in Texas Face the Greatest Risk from Pregnancy Related Death*, www.houstonchronicle.com/news/health/article/Report-Black-women-in-Texas-face-the-greatest-9178447.php.

[13] Mother Jones, *Maternal Mortality in Texas is a "National Embarrassment"*, Nina Martin, ProPublica, August 24,2016, 1:35pm EDT, http://www.motherjones.com/pring/312331.

[14] Mother Jones, supra note13

[15] World Health Organization (WHO), et al., Trends in Maternal Mortality: 1990 to 2013, 43(2014), http://apps.who.int/iris/bitstream/10665//112682/2/9789241507226_eng.pdf?ua=1(hereinafter WHO Trends in Mortality). See also Nicholas Kassebaum et al., *Global, Regional, and National Levels and Causes of Maternal Mortality During 1990-2013: A Systemic Analysis for the Global Burden of Disease Study 2013*, The Lancet (May 2, 2014), http://dx.dol.org/10.1016/S0140-6736(14)60696-6.

[16] Gaskin, Ina May, *Maternal Death in the United States: A Problem Solved or a Problem Ignored?*, 17 J. Perinatal Edu., 9-13, (2008), http://www.ncbi.nim.nih.gov/prnc/articles/PMC2409165/pdf/JPE170009/pdf; Francine Coeytaux et al., *Maternal Mortality in the United States: A Human Rights Failure*, 83

Contraception 189-93 (2011), http://www.arhp.org/UploadDocs/journalededitorialmar2011.pdf; Berg Cynthia et al., *Pregnancy-Related Mortality in the United States, 1998 to 2005*, 116(6) Obstetrics & Gynecology 1302-09 (2010), http://www.cdph.ca.gov/data/statistics/Documents/MO-CAPAMR-PregnancyRelatedMortality-Berg2010-1998-2005.pdf.

[17] Nat'l Women's Law Ctr., Poverty Rates by State, 2012 (Sept. 2013), http://www.nwlc.org/sites/default/files/pdfs/final_compiled_state_poverty_table_2012.pdf.

[18] Farah Ahmad & Sarah Iverson, *The State of Women of Color in the United States, Ctr for Am. Progress*, 12(Oct. 2013), http://www.americanprogress.org/wp-content/uploads/2013/10/StateofWomenColor-1.pdf.

[19] Center for Public Policy Priorities, http://www.forabettertexas.org/images/EO_2014_ACSPovertyIncome_Charts.pdf, US Census Community Survey Data.

[20] MMMTF, supra note 5, 16.

[21] MMMTF, supra note 20.

[22] The Texas Tribune, *Rise in Texas maternal deaths absent from legislative agenda*, Marissa Evans, Feb. 28. 2017, 12:01 am, https://www.texastribune.org/2017/02/28/texas-maternal-deaths-absent-legislative-agenda/.

[23] Texas Department of State Health Services (TXDSHS), *Black women and HIV in Texas*.pdf.

[24] TXDSHS, supra note 23.

[25] Adapted from Hu*man Rights Council*, Rep. of the Office of the United Nations High Commissioner for Human Rights on Preventable Maternal Mortality and Human Rights (14th Sess., 2010), para. 12, U.N. Doc. A/HRC/14/39 (2010).

[26] Texas County Elects Black Woman Sheriff and Votes for Trump, The Associated Press, Nov12, 2016, forture.com/2016/11/12/zena-stephens-texas-sheriff/

[27]Universal Declaration of Human Rights, adopted Dec. 10, 1984, art. 3, G.A. Res. 217A (III), U.N. Doc. A/810 at 71 (1948); International Covenant on Civil and Political Rights, adopted Dec. 16, 1966, art. 6, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171(entered in force Mar. 23, 1976); Convention on the Rights of the Child, adopted Nov. 20, 1989, art. 6. G.A. Res. 44/25 Annex. U.N. GAOR, 44th Sess., Supp. No. 49, U.N. Doc. A/44/49 (1989) (entered in force Sept. 2, 1990): Convention on the Rights of Persons with Disabilities, adopted Dec. 13, 2006, art. 10, G.A. Res. A/RES/61/106, U.N. GAOR, 61st Sess., U.N. Doc. A/61/611 (entered into force May 3, 2008).

[28] Center for Reproductive Rights, Advancing Maternal Health As A Human Rights Issue, Black Mamas Matter: A Toolkit for Advancing the Human Right to Safe and Respectful Maternal Health Care.

[29] Adapted from the following sources: National Economic and Social Rights Initiative (NESRI), *What are the Basic Principles of the Human Rights Framework?*, http://www.nesri.org/programs/what-are-the-basic-principles-of-the-human-rights-framework; Human Rights Council, Technical Guidance, supra note 26, Center for Health and Gender Equity (CHANGE), *The Right to Safe Motherhood: Opportunities and Challenges for Advancing Global Maternal Health in U.S. Foreign Assistance*,10-13 (2015), http://www.genderhealth.org/files/uploads/change/publications/The_Right_to_Safe_Motherhood_.pdf.

[30] *Human Rights Council*, Technical Guidance, supra note 26
[31] Center for Reproductive Rights, Advancing Maternal Health As A Human Rights Issue, Black Mamas Matter: A Toolkit for Advancing the Human Right to Safe and Respectful Maternal Health Care, supra note 27.