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3 U.S. Department of Health and Human Services
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7 Virtual Meeting
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10 Day 2
11 Wednesday, March 16, 2022
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1 P R O C E E D I N G S

2 REVIEW OF DAY 1

3 ED EHLINGER: It looks like we've got most of the
4 people coming on and welcome back to the second day of our
5 March SACIM meeting, our virtual meeting, here on March
6 16th, the eve of St. Patrick's Day. And knowing that
7 competition is always a thing, you know, here in Minnesota
8 the Finns have to create a saint because they didn't want
9 the Irish to have all of the visibility on this week, so
10 they created something called St. Urho, totally fictional
11 because they just needed some competition, so happy St.
12 Erhose Day on the eve of St. Patrick's Day.
13 And welcome back to our meeting. Yesterday was,
14 I think, a great meeting and we'll reflect on that a
15 little bit. But I want to start out first with
16 highlighting the fact that today is the birthday of James
17 Madison, who was the fourth President of the United
18 States, and I bring him up not only because he really was
19 foundational in creating our Constitution, he's considered
20 the Father of our Constitution, and drafted the Bill of
21 Rights, which is very important, very relevant in this day
22 and age when we're really talking about threats to our

1 Constitution.
2 But he also made a statement that I think is
3 relevant to what we talked about yesterday when we were
4 talking about Indigenous health, and the lack of data on
5 Indigenous people that really keeps us from really doing
6 good things. And James Madison had a quotation that I
7 think highlights the importance of getting that
8 information, and he talks about a popular government. And
9 when he talks about popular government, it's not about
10 being liked. It's popular meaning it's made up of people,
11 and it's a government of people. And he says a popular
12 government without popular information or the means of
13 acquiring it is but a prologue to a farce, or a tragedy or
14 both.
15 I think that really reflects the fact that we
16 have to find ways to get the data about the people who
17 live in our society, in our communities, in our nation,
18 because we can't develop good policies without knowing
19 about those individuals, their needs, and their desires
20 and the issues that they're facing and the then the
21 resources they've got.
22 So, as Madison said, a popular government

1 without popular information, or the means of acquiring it
2 is but a prologue to a farce, or a tragedy, or both. So,
3 with that, there's a challenge to us.
4 Also, I reflect on yesterday. I thought I was
5 really impressed with the meeting. I really liked the
6 interactions that we had with the people, you know, the
7 members who have been on for a while and the new members.
8 And I really appreciated the presence of HRSA
9 Administrator, Carol Johnson. I really think we have an
10 ally in her. I mean, she seems -- I mean, I'm making a
11 judgment on a very small period of time, but she seems
12 open and willing to engage with us. And I know that --
13 same as yesterday, she met with the ASTHO folks, the
14 Association of State and Territorial Health Officials.
15 So, I think she's reaching out and trying to develop those
16 relationships. So, I think we need to take advantage of
17 that.
18 I was also impressed with the list of the things
19 that Dr. Warren, Dr. Michael Warren, listed in terms of
20 what MCHB is doing. It's obvious that they're paying
21 attention to what SACIM talks about and what they put
22 forward and puts those into practice in terms of

1 developing their programs and their initiatives. So, that
2 also gave me, you know, comfort that our work is not in
3 vain, it actually has -- it’s heard by things and actually
4 put into practice.
5 And I love the stories. I loved the stories of
6 hearing what the new members bring to the table, what’s in
7 their heart and what’s in their passion. I really think
8 that is good. And I also like the interaction on the
9 discussion on of race concordant care, and all of the
10 issues that were brought up. I love that kind of
11 discussion.
12 I’m just curious if there are other reflections
13 that other have about yesterday before we get into the
14 main part of our agenda. Any big takeaways from yesterday
15 that you’d like to just highlight? Magda, you have your
16 hand up. You have to unmute yourself, Magda.
17 MAGDA PECK: Thank you, I’m calling in twice
18 again, so I’m on my -- working with my hearing capacity.
19 Thank you. I just want to acknowledge yesterday the voice
20 of -- and all out the voice of Dr. Janelle Palacios, whose
21 eloquence and push is a prelude to both what is in the way
22 and what is possible as we directly address the health of

1 Indigenous mothers and babies, and families and fathers.
2 And the reminder that it is our job to push. It
3 is our responsibility to turn up the heat. We can do that
4 in ways that folks within Government cannot. And so both
5 on the specific as well as the strategy, I was – it was a
6 wonderful, passionate, purposeful, power reminder of the
7 influence we can have now. So, thanks for the comment.
8 ED EHLINGER: Thank you, Magda. And I reflect
9 on the fact that, you know, a lot of people want to avoid
10 tension. Actually, I learned from my parents that tension
11 is actually where things get done. You need tension in
12 order to move. That's what creates the energy, creates
13 the friction sometimes that creates the heat to move
14 things forward. So, we shouldn't be afraid of creating
15 some tension. It's creative tension, and so -- and I
16 think Janelle did a little bit of that yesterday, so thank
17 you for that.
18 Any other reflections? Particularly interested,
19 any of the new members, sort of the feel for the meeting,
20 is this something that -- was this what you were
21 bargaining for?
22 MARIE-ELIZABETH RAMAS: Yeah, I appreciated the

1 meeting very much so yesterday. I can easily tell that
2 this is going to be one of those meetings that I look
3 forward to that work gets done and that it is effective
4 and purposeful. So, I'm very much excited to dig in with
5 the work that's already been done and to continue to
6 innovate.
7 I think if I could sum up in one word my
8 thoughts from yesterday, my impression from yesterday, it
9 would be possibilities. That we have a unique position as
10 leaders here to present possibilities of how to create
11 movement within the inevitable bureaucracy that we're
12 working within, but also to provide salient and actionable
13 steps for the Secretary. So, I appreciated very much so
14 yesterday and looking forward for the rest of our working
15 together.
16 ED EHLINGER: It reminds me of a quotation of
17 William Butler Yates, the poet, he said in dreams begins
18 possibilities and responsibilities. So, I think you bring
19 your dreams here, but you, like he mentioned, it creates
20 the possibilities that we can move things forward.
21 Thanks.
22 I also see that you have a sick child, so it

1 seems like that's several members are in the same boat, so
2 we recognize being a parent is an important piece of what
3 you do, and you've got to set your priorities straight, so
4 thanks.
5 CHARLENE COLLIER: Again, I would echo those
6 sentiments and I also reflected upon the building and
7 rebuilding. There's a lot of history and precedent and
8 generations of projects, and programs, and policies that
9 we're working with, but also brand-new things we're trying
10 to forge forward and the need to kind of reflect on what's
11 been done and existed and what needs to be redesigned,
12 recreated as well as bringing on things that just were
13 non-existent or new in some ways. And so, I think that's
14 an interesting balance of kind of working on, which is a
15 longstanding history of addressing maternal and infant
16 health but clearly needing to do things in new and
17 different ways that haven't been done before and that
18 being really necessary for change.
19 So, I appreciate all of the comments yesterday
20 and I've tried to take some of those things and act upon
21 them, give myself actual to-do lists for right here in
22 Mississippi as we're just reflecting on them for the

1 recommendations to the Secretary. So again, thank you and
2 it's really been an honor and I look forward to today.
3 KATHRYN MENARD: And I can't say anything more
4 eloquently than Dr. Collier has already, but I am really
5 challenged and energized. I think we're -- the group that
6 we have is we're going to challenge one another, and then
7 collectively, we're going to challenge others, which is
8 very exciting.
9 ED EHLINGER: I agree. All right, well, thank
10 you for those comments and reflections. And again, at the
11 end of the day we will have some additional reflections,
12 I'm sure.
13 **INTRODUCTION OF ACIMM MEMBERS**
14 ED EHLINGER: But yesterday we heard about the
15 stories of our new members for the Committee. So today
16 the new members and us, you know, existing current members
17 who have been on for the last few years also get to hear
18 some stories. So, we're going to hear the stories of the
19 members who have been on for the last three or four years.
20 And again, I'm asking them in about two-and-a-half minutes
21 to share your personal story of what stimulated or
22 encouraged you to pursue the work that you are doing in

1 your current setting or what made you want to be a member
2 of SACIM.
3 And I'll do the same thing we did yesterday by
4 going in reverse alphabetical order. So, Belinda, with
5 your P name, you get to start. Tell us your story.
6 BELINDA PETTIFORD: Well, good morning or
7 afternoon to everyone, depending on where you are. So, I
8 have worked in public health for 30 plus years, and much
9 of that time has been in MCH -- actually, all of it may
10 have been in MCH.
11 And really what pushed me and to be excited
12 about MCH, it's been twofold. One has been the
13 opportunity to actually be in the delivery room with my
14 great niece when she had her first child and to go with
15 her through that entire process because she was scared to
16 death. I mean, she was 23 years old, scared to death, and
17 she had a really great support system, but I was one of
18 the people and she said I want you there. And so that was
19 just wonderful, just to have that special experience.
20 But also, loosely to my mother's history. So,
21 my mother is 88 years old. I am blessed to have her. She
22 lives with me. But I also know her history, as they say,

1 her maternal health history. In 1954 she had a daughter
2 prematurely. Unfortunately, at that time her first
3 husband had walked out on her while she was pregnant, so
4 it added that extra stress to it, and so she had a
5 premature daughter, my big sister. And for the first six
6 weeks of her life, she couldn't see her. She was born
7 prematurely. She was in a hospital, but in rural North
8 Carolina, at the time they didn't think my sister was
9 going to make it. So that whole bonding time for the
10 first six weeks did not exist because they kept thinking
11 my sister was going to die, and she didn't. But you know,
12 my mother had to deal with the stress of that, of being a
13 mom, and at that point, a mom whose husband had walked out
14 on her.
15 And so fortunately, she had a network of her
16 parents and her brothers and sisters, but you know it put
17 her in a difficult situation. And I was saying that, you
18 know, listening to that and watching when I actually
19 watched, but listening to my mother tell that story,
20 knowing the history of that really touched me along the
21 way and it really moved me into the MCH world. And I knew
22 it could be better. I didn't know what it could be when I

1 heard the story, but I knew it could be better. And then
2 just my experience over the years.
3 And then later on in life, after my mother
4 married my father, she had a miscarriage. And in watching
5 her go through that. So, just the trauma of a pregnancy
6 that I have watched just with my own mother and not just
7 mentioning other family members have really motivated me
8 and made me want to remain part of the MCH world, and you
9 know, I have done that the very vast majority of my
10 career.
11 So, that's kind of my story that keeps me
12 centered and keeps me grounded.
13 ED EHLINGER: Thank you, Belinda. Just
14 interesting. I've worked with you now for four years and
15 I have not heard that story before. I mean, that's -- and
16 it's so powerful. Thank you. Thank you for sharing that.
17 It raises -- you know, as Dr. Collier said, it raises the
18 possibilities, you know, what is possible. Thank you.
19 Thank you for sharing that. Next, Dr. Peck. Unmute,
20 unmute.
21 MAGDA PECK: Thank you so much. I want to thank
22 you for inviting our stories. It's our lived experience,

1 it's our data, it's our currency. And so, here's one of
2 mine about professional development, slightly different
3 take than the stories that have been told.
4 So, I was in my first semester at the Harvard
5 School of Public Health, and I was in one of those
6 windowless conference rooms with about ten other graduate
7 students learning the basics of maternal and child health.
8 I was maybe 26. I was the youngest student and the first
9 physician's assistant to be accepted into the School of
10 Public Health, and I could not afford that unearthly
11 tuition.
12 And of course, the MCH training grant, then and
13 now, would not support PA's, so I took out loans, 25 years
14 to pay them off, and worked as a research assistant with
15 faculty. And my first assignment was tallying by hand and
16 a calculator infant mortality rates and trends for Boston.
17 And I just couldn't believe the data. So, I went into
18 that seminar room with the speaker, and the speaker that
19 morning happened to be someone named Dr. Julius Richmond.
20 I don't know if any of you know -- remember, but
21 we should, because he's one of the greats. He was a child
22 health policy expert, former surgeon general. He's the

1 one why we have cigarette pack warnings from the surgeon
2 general, that one, founder of Head Start, and he was
3 mentor over time. But it was the first time I met him,
4 first semester, and I was so eager to raise my hand, as
5 you know, I am still, and I just said why, like why is the
6 infant mortality rate for Boston's black babies three
7 times higher than it is for white babies. You live in
8 this city, Dr. Richmond. Tell me why. And if we have so
9 much data and research, tell me why it's not getting
10 better.
11 And that's when I heard about the three things,
12 the three things that still motivates me to be with you
13 today, almost 40 years later. Dr. Richmond told me about
14 the secret sauce of how social policy is made in this
15 droll voice. He said you need three things. I remember
16 it like it was yesterday. He said you need a strong
17 knowledge base. He said, you know, you need to have the
18 data and research, but that's never enough. And he said
19 you need a social strategy, and I didn't know what that
20 meant, but it had to do with policies and programs based
21 on evidence. That, I got.
22 But then he said something I had never heard

1 before at 26. Without political will, nothing happens.
2 And I had never heard that expression before. What did
3 politics or power have to do with public health research
4 and policy? I thought data, research, programs, impact.
5 He was so patient. He was so pragmatic. It was
6 so powerful. And that tripartite framework has guided my
7 work for four decades, because when I ask questions, I'm
8 trying to figure out will it serve data or program and
9 policy, or is it to build political will? And I came to
10 the Magdaism out there that I was remined by a friend over
11 coffee yesterday when she said you told me this one, she
12 who asks the questions has the most power, not she who has
13 the data.
14 So, when I agreed to serve on SACIM, it was so
15 that I could encourage powerful questions and ask a few of
16 my own so that we can bring the data the program, the
17 policy together to influence the political will and make
18 justice happen.
19 It's been an honor to serve and a blessed
20 memory. I will still remember that moment when I first
21 met Dr. Richmond and he changed the way my brain thinks,
22 and I hope to bring some of that brainwork still on the

1 remaining time I have with you. Thanks for the invitation
2 for the story.
3 ED EHLINGER: Thank you, Magda. I appreciate
4 that story. It also reminds me that each of the members
5 of SACIM can be that Julius Richmond to somebody. You
6 guys are leaders in the field, and you have lots of ideas.
7 You can mentor, you know, graduate students or others,
8 undergraduate students, to -- so 30 years later they can
9 be on SACIM saying I remember when so and so from SACIM,
10 you know, talked to me about infant and maternal
11 mortality.
12 All right, Janelle, you’re next.
13 JANELLE PALACIOS: All right, thank you. This is
14 -- I was caught a little bit by surprise. I wasn’t
15 expecting to share this and I’m trying to -- we also do a
16 little bit of self-editing as well, and I’m trying to
17 gauge what I'm going to share. So, it will be off the
18 cuff. And what a better public place to do this then, I
19 guess, right?
20 So, I am happy to be here and thank you for
21 inviting us to share these stories and for all the stories
22 shared yesterday, because we’re finding connection through

1 the stories that each of us tell, and we're finding how we
2 each are more human than the moment before.
3 So, my mother was a teen mother like her mother
4 and living on a reservation. And I grew up quickly into
5 an adult with responsibilities before age 10. Before age
6 10 I had lived in six different places on the reservation.
7 I had been homeless and underhoused according to our
8 definitions today. And I started drinking heavily before
9 age 11 to deal with all the things that were going on in
10 my life and to escape.
11 So, my story is not really special. It's very
12 typical for people with my similar background, and very
13 typical for people in my family and my friends. One of my
14 best friends was not lucky and she became pregnant by
15 rape. And I was with her through most of her pregnancy,
16 and I was with her through attending Indian Health Service
17 visits. I was with her when she chose to travel 120 miles
18 roundtrip to go deliver her first baby, and I was with her
19 when she underwent a lot of violence with her relationship
20 with her partner.
21 My friend's experience is very much close to
22 home of what I experienced in my own family. And knowing

1 that there is something that is pressuring us to act this
2 way, to behave this way, to find ways to escape, knowing
3 that it's not because I'm Native American. I's not
4 because I'm Indian or I have a special last name on a
5 reservation. And it's not because I'm stupid. It's not
6 because I'm lazy. It's not because I'm a drunken Indian.
7 There are other things going on. And I didn't know how to
8 express that at a young age. And I didn't know how to
9 explain that to my non-white family members. My father's
10 family is not Indian,
11 But I had a lot of support through some family
12 members and some friends, and I was able to go on to the
13 INMED Program at the University of North Dakota which was
14 for high school students. So, imagine a hundred Native
15 crazy kids in North Dakota of all places for six weeks.
16 And that program was one of the pipeline programs trying
17 to get Native students interested into health sciences.
18 And it stuck with me, and it came at a time that
19 was really important. It came when I was in sixth grade,
20 when I had friends who already had, you know -- I'm
21 forgetting, I'm blanking on the name, but like Nexplanon,
22 the precursor to Nexplanon in the hand, in the arm.

1 So I was able to go to school, become a nurse,
2 and I carried with me the hope that I'd become a midwife.
3 And as I was in midwifery school, I also became co-
4 president of the Native Research Network, and I began
5 giving lots of my presentations about how the significant
6 history of Native American history is to understand in a
7 health context.
8 And it was at one of these presentations that I
9 was giving that a representative from Indian Health
10 Service actually asked me if we could talk. And when we
11 talked to each other, she asked me at the end if I'd be
12 interested in being nominated to be on SACIM. And I had
13 no idea what SACIM was. I did not know what kind of
14 privilege this was at all. And I said sure. And that is
15 how, years later, I was able to join this board as the
16 most junior person getting to learn through all of the
17 wisdom and the mentorship through everyone here.
18 ED EHLINGER: Thank you, Janelle. You're not
19 junior in any way, shape, or form. You are a master. So,
20 I really appreciate that. The next was going to be
21 Colleen Malloy, but I know she -- I don't think she's on.
22 She's got some other assignments that are pending, so she

1 may come later. So, Tara Sandra Lee.
2 TARA SANDRA LEE: Hi. Thank you, Janelle, for
3 sharing your personal experience. I know that's not an
4 easy thing to do. And I also want to express my thanks
5 for everybody since I was dealing also with a sick child
6 at home yesterday. So, I was definitely listening, I just
7 had to keep a very close eye on the couch for my son, who
8 is fortunately back at school today, so that's good.
9 Okay, so you know, we all have so many
10 experiences, and so I'm going to focus in on just the ones
11 that I think were most relevant to what brought me here
12 today.
13 You know, for as long as I can remember, I
14 believe that I have been called to be a scientist and to
15 understand what causes disease, and I've been blessed to
16 have some amazing jobs. I've worked in a children's
17 hospital setting both for my education and my experience.
18 To work hand in hand closely with colleagues, to have a
19 better understanding about why some children are not born
20 with certain diseases, and why they unfortunately do not
21 survive.
22 So, I've worked hand in hand in both pediatric

1 surgery and pediatric pathology and seen firsthand how
2 surgeons can do amazing things to help these babies, but
3 that also there are several, unfortunately, that do not
4 survive. And so, I saw firsthand the pathology and heard
5 the discussions about how so many of these infants were
6 not surviving.
7 So, so much of my research and academic
8 experience has been focused on really trying to understand
9 what causes childhood disease and why some of these
10 infants, unfortunately, do not make it. And so that has
11 just been a passion of mine. So much of my research was
12 focused on congenital heart disease where I would actually
13 stand and wait in the OR for these babies that were
14 undergoing unbelievable surgeries, and I would then take
15 their ex-planted heart back to the lab and try to
16 understand why did they develop that congenital heart
17 disease inside the womb.
18 And for babies that didn't make it, we would
19 also collect, unfortunately, the discarded tissue that,
20 unfortunately from the diseased children so that we could
21 understand why they had disease.
22 So, this has been a really passion for me and

1 knowing that the leading cause of infant death, as we've
2 heard before from the CDC, you know, that the leading
3 cause of infant death, you know, that birth defects are
4 one of the leading causes of infant deaths. And so, I
5 feel very passionate to then continue to work on this
6 committee and have the opportunity in conjunction with the
7 job that I currently am doing to really -- and the job
8 that I currently do is all science and statistics and
9 research to help people have a better, deeper
10 understanding of what are some of the issues affecting
11 women's health, especially during pregnancy, prenatal
12 diagnosis, treatment for the unborn.
13 You know, a lot of what I do is helping to
14 educate and advance ethical advancements in healthcare
15 that are going to really help these moms and their babies,
16 you know, just as we know, you know, I participated in the
17 forum last meeting where we brought in Dr. Moldenhauer
18 from CHOP to help people understand just how much medical
19 advancements are saving babies, fetal interventions. I
20 mean, the first fetal intervention was in 1981, and now
21 they've celebrated their 2000th lifesaving surgery there
22 and we know that viability is getting younger. We know

1 that now with advanced healthcare, we can save babies as
2 early as 21 weeks gestation.
3 We know that like diagnostics has advanced
4 significantly, and so it's really -- I mean, I don't know
5 if you guys saw the New York Times piece, but with these
6 advancements in healthcare, it's so important that we have
7 accurate information. So, we know the New York Times said
8 that like we know that with these rare conditions, women
9 that are facing the prenatal like screening, that a large
10 percent of the time that diagnosis is wrong. And so, I
11 really advocate for accurate timely information that's
12 going to help these moms and their babies so that women
13 have all the information they need to make the best
14 decision possible for their child.
15 And you know, we all have our personal
16 experiences that are weaved into all of, you know, our
17 career experiences that brought us to this point and I
18 will just tell you that in my own experience I had a
19 complicated pregnancy that resulted in an emergency C-
20 section and they were worried that my child was not going
21 to make it as his heart rate was dropping during delivery.
22 My mother grew up poor on a farm in Iowa. She

1 had -- and I won't use the exact terms that she used, but
2 she basically didn't even have a pot to pee in. And so
3 grew up very poor. Part of her story, she faced an
4 unplanned teenage pregnancy with no support from her
5 family. They basically kicked her out of the house. She
6 had very difficult decisions to make. She ended up
7 adopting out the child.
8 And then it's also interesting that I have a
9 brother who's adopted out, but I also have a brother who's
10 adopted in, because he also -- his birthmother faced an
11 unplanned pregnancy, decided to keep the child, but then
12 adopted him out. And so, I feel like I -- you know, just
13 a lot of personal experiences. COVID has hit our family
14 hard. Lost a sister-in-law in her 40's to COVID just
15 within the last few months. My brother is now facing
16 raising two boys without a mother.
17 And so, you know, these are really real things
18 that everybody is facing and weaved into our lives. And I
19 think we are all connected. We need to remember we are
20 all connected and share the same interest in really
21 helping these moms and their babies at the very best that
22 we can.

1 So, thank you for listening. I hope I didn't
2 take too much time.
3 ED EHLINGER: Thank you, Tara. I just love the
4 diversity of the stories and the complexity of the
5 stories. It's all a mosaic that's really important to
6 really get a picture of the group that we have here, but
7 also the issues that are facing moms and babies throughout
8 the country.
9 Next, it's my turn. I was born and raised in
10 Green Bay, Wisconsin. And when I was eight years old, I
11 went to my first Green Bay Packer game with my dad, and
12 there I got to see -- back in those days, the NFL, the
13 kids could walk on the field, and we were -- you know,
14 there was not the high pressure that there is now with the
15 NFL. I got to walk behind the Packer bench, and I got to
16 see Bobby Mann. Bobby Mann was from Detroit. He was the
17 first African/American I ever saw, and he was the only
18 African/American on the team.
19 And on the way home from the game, I asked my
20 dad, who is this guy, tell me about him. I said, I don't
21 see him around. He says well, he can only come into Green
22 Bay during the football season, and he has to leave after

1 the season is over.
2 And I said, but I don't even see him downtown.
3 You know, Green Bay was a small town at that point. And
4 he said well, because he has to live on the outskirts of
5 town, he can't live in the town. And I said well, that
6 doesn't seem fair, and my dad says no, it isn't. And my
7 mom piped in, and she said, and that's also why you don't
8 see your American Indian cousins in town, because they
9 don't feel welcome here.
10 And our expectations, my mom and my dad said
11 your generation needs to do something about that, and
12 that's our hope for you. You've been given some
13 privilege, and they actually used the privilege, you know,
14 a good education to actually do something.
15 So, I took that to heart. Ten years later I'm
16 in high school, a senior in high school playing football,
17 and our football coach was a Packer Hall of Famer. And I
18 said boy, the Packers have really changed a lot from ten
19 years, now half of the team is African/American, and he
20 said that's a lot of progress. He was a white guy, and he
21 says not enough progress has been made. You know, just
22 because half the team is Black, that doesn't mean the

1 things in the community are any better than they were ten
2 years ago. You guys need to do something. And by the
3 way, here's a book that you need to read.
4 And so, my football coach asked me to read
5 Michael Herrington's The Other America. And I didn't know
6 it at the time, but The Other America actually was the
7 book that stimulated JFK, John F. Kennedy and Lyndon
8 Baines Johnson to implement the war on poverty.
9 It was also a book that made me think I need to
10 go into medicine, and particularly primary care to deal
11 with the other America. And so, when I got into college
12 and medical school, this was also the time when a lot of
13 technology was coming on board. Respirators were just
14 starting for infants, and newborn intensive care units and
15 CT scans and MRIs were just coming on board. So, the
16 technology was just blossoming, and we were looking at all
17 the wonders of technology.
18 But at the same time the war on poverty was
19 putting together community health centers and was looking
20 at environmental issues and was looking at women's rights
21 issues and was looking at all sorts of things, and I
22 realized that there were these two paths that actually

1 impacted health. And so, I decided that I would try to
2 merge both medicine and public health or those community
3 activities. But then when I am, I continue to try to do
4 that and when I finally got into, you know, actually
5 working for the City Health Department in Minneapolis,
6 recognized that it was those social issues that were much
7 more important than the medical issues, and technology
8 issues that were there for advancing the health of moms
9 and babies.
10 So, that's where I started to focus more and
11 more on the public health, the social aspects, the
12 community development aspects that got me into this
13 balance of medical care and public health that articulated
14 the social issues, community issues and building power in
15 communities to create their own healthy futures. And so
16 that's what got me engaged in this. All right, Jeanne
17 Conry.
18 JEANNY CONRY: Well, everybody's got incredible
19 stories. Mine is probably much simpler. I am certainly a
20 child of the 60's and 70's and I got my bachelor's degree
21 in science and decided I wanted to get my PhD, so I went
22 to the University of Colorado and got a PhD in biology

1 doing environmental research at 13,000-foot elevation,
2 community ecology and then began teaching at the
3 University of Colorado.
4 While I was teaching there, I decided I wanted
5 to change careers and go into medicine. So, my husband
6 and I, while I was pregnant, decided this is the time to
7 do it. We kept putting off having children because it
8 always made sense, and then we finally realized, just get
9 over that, there's never a good time, go for it.
10 So, while I was applying to medical school, I
11 had my first child and then my daughter was born in my
12 second year of medical school, and they were probably the
13 greatest gifts because it just opened my eyes towards
14 parenting, being a mom. And I promised my family I would
15 not be in OB/GYN, I'd be a pediatrician, because who
16 wanted OB/GYN hours. And I did my first rotation as an OB
17 because you do the one, you're sure you're not going into,
18 and darn if I didn't love it and realized I liked
19 everything about obstetrics and gynecology and surgery and
20 went into OB/GYN.
21 I can remember being at the checkout board on
22 labor and delivery and somebody saying okay, we need a

1 person to represent UC Davis at ACOG, Jeanne, you're going
2 to do it. And I had no idea what ACOG was or what they
3 did, and as a second-year resident, became involved in
4 ACOG, and my interest in that aspect of medicine has never
5 stopped. I went on to join Kaiser Permanente and found I
6 was this lone voice of talking about not fee for service
7 medicine, not private practice medicine, but a different
8 way of practicing, and I've been committed to that type of
9 practice very since, a very collaborative practice that
10 puts primary prevention as a focus, and I've spent my
11 whole life doing that.
12 I became very interested in preconception health
13 and then finally stepped back and said we're missing the
14 boat here, 50 percent of pregnancies aren't – you know,
15 are surprises. So, if we don't focus on how to improve
16 the health and wellbeing of women at all times, we're
17 never going to succeed with anything about preconception
18 health.
19 So, I changed what I was doing and started
20 focusing on well women healthcare, and that's really taken
21 me where I am.
22 I would say the other thing that happened while

1 I was chair out in California, ACOG, I got a phone call
2 from one of the state legislators saying what is ACOG's
3 policy about lead lipstick? And we all went oh, okay. Led
4 is bad, we know that, and I realized, well, lipstick, it's
5 got to be fine. And we realized that ACOG had absolutely
6 zero guidance about anything to do with the environment,
7 and we went to Dr. Hal Lawrence then and he said well, if
8 you put together a team and a task force, we'll start
9 looking at it.
10 So, that was back in 2008. We met with SMFM and
11 Society for Reproductive Medicine and put environmental
12 issues on a path for ACOG and I decided to keep that work
13 going. And when I retired from Kaiser Permanente, I
14 became president of FECO to keep the two things that I'm
15 most passionate about going, environment and how it
16 influences health, from climate change to endocrine
17 disruptors and everything else and well women healthcare.
18 So, that's why I'm kind of in Europe half the
19 time and in California half the time.
20 ED EHLINGER: Great.
21 JEANNE CONRY: So, I say it's the accidental
22 tourist because it was never a series of -- it was

1 decisions that kind of led me where I am.

2 ED EHLINGER: Well, I'm glad it led you to

3 SACIM, I really appreciate --

4 JEANNE CONRY: Thank you.

5 ED EHLINGER: -- good contributor. And finally,

6 Steve Calvin.

7 STEVE CALVIN: Great. Well, thanks, Ed, for

8 having us do this. I mean, I have gotten to know, you

9 know, my colleagues already, but this was really, really

10 helpful.

11 My story is kind of my professional career

12 story. I'm a person who went to a medical school who

13 actively discouraged family medicine. It happened to be

14 Wash U in St. Louis. But anyway, there were a few of us

15 that wanted to do family medicine, and I really respect my

16 family medicine colleagues. I discovered pretty quickly,

17 however, that crying children drove me crazy, and that's

18 sort of an odd thing to say for someone who has a bunch of

19 grandchildren now, but crying children led me to

20 obstetrics.

21 During medical school, I received a National

22 Health Service Corp scholarship. That's kind of pertinent

1 to the HRSA, sort of place where we reside as a committee.
2 So, I had a National Health Service Corp scholarship
3 payback that I completed after a residency. I did that
4 scholarship payback for three years as a Health Service
5 Corp physician down at the El Rio Neighborhood Health
6 Center in Tucson, and that was a wonderful experience
7 working with almost exclusively Spanish speaking patients,
8 and then some used to be called the Papago Tribe but now
9 Tohono O'odham, were our patients.
10 Subsequently then I did a maternal fetal
11 medicine fellowship down in Tucson, and then spent 20
12 years -- I don't know how foolish it is to move back from
13 Arizona to Minnesota, but I did. I'm originally from
14 Minnesota. We can come back here like the swallows to
15 Capistrano.
16 So, I ended up in Minnesota for 20 years doing
17 high risk OB with a group that grew from five to 16
18 members, but we were working really hard. So, it was
19 basically an intensive care internal fetal medicine. And
20 at the same time, teaching at the University of Minnesota,
21 and then trying to fit in some basic science research on
22 fetal membranes and biomechanics of those sorts of things.

1 After about 20 years of that, knowing every bad
2 thing that could possibly happen to a pregnant woman and
3 to her baby or babies sometimes, I concluded that I was
4 not going to live very long if I continued to be up ever
5 fifth night 24 hours, and also, I had gained a real
6 appreciation over the course of time of physiologic birth
7 and the role that midwives play. So, I've been accused at
8 times of having the midwife gene, and I consider that an
9 honor. I'm not anywhere as good as midwives, but about 12
10 years ago, I decided that the only way that I was going to
11 have any impact in how care was provided to the vast
12 majority of pregnant women was to launch out from the –
13 just the role as an MFM doctor.
14 So, working with midwife colleagues, we
15 developed the Minnesota Birth Center Practice that does
16 about 400 births per year, most of those intended as out
17 of hospital births in accredited birth centers integrated
18 with our hospital partners. So, that has been quite an
19 experience. And over the course of that time 3,300
20 births, and we have a great database. Those that are
21 familiar with the American Association of Birth Centers
22 maybe know about the perinatal data registry, which is a

1 really robust database with, I think almost 200 data
2 items. So, we really follow what we do, and it's gaining
3 traction.
4 The thing that I've also learned about, 20 years
5 of practice, you just sort of say well, I want to do what
6 is the appropriate care for the patient, and I really am
7 not going to get too into the weeds about payment. So, I
8 really appreciated Jeanne's comment, too, I have come to
9 the conclusion and totally agree that the fee for service
10 world, despite -- there are some, I guess, motivational
11 benefits, but there are some huge downsides. So, I'm a
12 big fan of payment reform. And in that regard, and that's
13 part of being part of this Committee, is that there is a
14 lot of -- there are almost half of moms in the United
15 States are supported with public programs, mostly
16 Medicaid. In our state in Minnesota, it's almost 45
17 percent, some states higher, some states lower.
18 But there is spending that is going on that as I
19 followed the money, I realized that that spending is
20 actually not going to high value care. And the Affordable
21 Care Act had the research study, Strong Start, that was
22 done, completed a number of years ago showing that there's

1 some really great benefits of midwife led care. Not all
2 moms are eligible for out of hospital birth, but half of
3 American women give birth in hospitals that don't have in-
4 house anesthesia or OB. So, if we're going to argue for,
5 you know, has to be a hospital with an in-house
6 anesthesia, we're going to have to do major changes.
7 However, I have just become much more aware that
8 there are models of care that work. I've basically put my
9 money and my time where my mouth is. I've been grateful
10 to be on this Committee. I'm really pleased that we have
11 representatives from the communities, a community in
12 particular, but I think we have one new member, and we're
13 grateful that she's part of this.
14 Part of the reason I'm doing this, too, is that
15 my children have been -- our children have been very
16 productive with grandchildren. So, between ages of 15 and
17 two we have 11 grandchildren. Seven of them are girls.
18 And so I'm doing it for them, but I'm also doing it for
19 the mothers in North Minneapolis. Our birth center in
20 Minneapolis is one mile from where George Floyd was
21 murdered. And so, the experience during the summer of
22 2020 was bracing for everyone. But I've been aware,

1 having been in the Twin Cities for more than 30 years in
2 practice, that we have significant disparities that have
3 to be addressed, and most of those, especially the Black
4 mothers in North Minneapolis can get better care. So, I’m
5 deeply committed to that as both a life affirming reason
6 and just the fact that these are our fellow citizens, and
7 they deserve better.
8 So, I’m excited to be on the Committee with the
9 new people, too. People bring so many different
10 perspectives, and I’m grateful for the chance to be with
11 you all.
12 ED EHLINGER: Thank you, Steve. Another great
13 story, another great perspective to bring to the table.
14 So, I’m so pleased that we have this group, and I wish
15 this group could, you know, stay together for a lot longer
16 than just two meetings, but we will take advantage of
17 every opportunity we have, and I know that the current
18 members are going to hand it off in our next meeting to
19 the new members and it’s going to be a good hand off and
20 the work is going to continue. So, thank you very much, I
21 appreciate those stories.
22 **IMPACT OF VIOLENCE ON INFANT AND MATERNAL MORTALITY**

1 ED EHLINGER: And so now, we're going to
2 transition to an issue, a new issue that we have not
3 addressed before. That's the impact of violence on infant
4 and maternal mortality. And I think Janelle's story
5 highlighted some of the violence that's there. And it's
6 interesting that most people don't think about violence
7 when they think about maternal mortality. You know, I
8 just Googled causes of infant mortality, and certainly
9 what comes up are cardiovascular conditions, non-
10 cardiovascular conditions, infection, obstetric
11 hemorrhage, amniotic fluid embolism, thrombotic,
12 hypertension. And then I'm known in other issues, they
13 never really focus on violence. And so I -- but yet,
14 violence is one of the leading causes of maternal
15 mortality.
16 So, we have a session today -- and I've been
17 able because we didn't have the HIS person yesterday, give
18 a little bit more time to this topic today. We're going
19 to talk about the impact of violence on infant and
20 maternal mortality. And because we have a little bit of
21 time, that four presenters that have agreed to be with us
22 that I think will really give us some good perspective.

1 And then at the end I'm going to ask Jeanne
2 Conry to actually talk about war as another related to
3 violence and infant mortality at the end of this session
4 so that we can have that perspective also.
5 So, we have four presenters, and I'm going to
6 have them, you know, give their -- and we're going to take
7 about five minutes after each one of the presenters for
8 some conversation questions. And then we'll have time at
9 the end.
10 So, we're going to start with Jacquelyn
11 Campbell. Dr. Campbell is professor and the Anna D. Wolf
12 Chair at the Johns Hopkins University School of Nursing.
13 And I know Jackie was with us yesterday, and actually, I
14 found out she was one of the authors on one of the
15 articles related to American Indian Health that we put in
16 our briefing book. So, Jacquelyn, Dr. Campbell, I turn it
17 over to you. And unmute yourself and --
18 JACQUELYN CAMPBELL: All right. First of all,
19 I'm honored to be here. And I was able to listen to your
20 proceedings yesterday, and it's an impressive Committee
21 and an impressive work that you are doing.
22 And supposedly, I can advance these slides, but

1 I don't -- it doesn't seem to be happening.
2 EMMA KELLY: One second, I'll give you
3 permission to advance them yourself.
4 JACQUELYN CAMPBELL: Thank you. All right here
5 we go. First of all, I wanted to acknowledge the original
6 owners of the land where I am, and Piscataway Tribes are
7 the most still here. And of course, the tribes that were
8 here have been subjected to the historical trauma of
9 disease and forcing roles I the boarding schools as all of
10 the east coast was subjected to.
11 And also, I think, that that is incredibly
12 important, and I want to acknowledge Janelle's incredibly
13 important remarks yesterday, and state in terms of the
14 missing and murdered Indigenous Women's Project. And
15 three of those women in the original report were pregnant
16 when they were murdered. And how many of the ones that
17 are missing, and where the murderer is unknown, we don't
18 know, and that's the problem with not having data there.
19 So, when we think about social determinates of
20 health during pregnancy, I want to emphasize that for
21 Indigenous women, the historical trauma, but also the
22 structural and individual experiences of racism, the many

1 structures that have and still do deny access to wealth,
2 which is incredibly important in terms of health. Also,
3 the ACE's and gender-based violence.
4 And for Black women, also, the historical
5 trauma. Sotero has a wonderful model in terms of
6 historical trauma for African/American populations in an
7 urban context, and also the structural and individual
8 experiences of racism, the structures that have and still
9 do deny access to wealth, also ACE's and gender-based
10 violence.
11 And when we think about pregnancy associated
12 deaths, those are deaths during pregnancy, the post-
13 partum, from causes unrelated to the pregnancy. And I
14 would like to challenge that in terms of the pregnancy
15 associated deaths from homicide, and also suicide, and
16 probably also drug overdose.
17 I was asked to help put together a scoping
18 review in terms of maternal mortality for Indigenous
19 women, American Indian/Alaska Native women, and I helped
20 put together this team. They did all the work. Half of
21 the authors are Indigenous themselves; the other half are
22 healthcare professionals who work closely with Indigenous

1 populations.

2 And some of their results, there was only eight

3 studies that could be found that explored American

4 Indian/Alaska Naïve maternal deaths by homicide. All of

5 the other ones used the other category because they said

6 there were too few cases to discuss. And those homicide

7 rates for quote, unquote, other women, ranged from zero

8 percent to 3.8 percent. And these are during pregnancy or

9 after pregnancy, and that percentage seems incredibly low,

10 especially given the known disproportionately high rates

11 of intimate partner violence amongst Indigenous women in

12 the CDC NISVS survey.

13 And is this in part because of the missing and

14 murdered Indigenous women, those many Indigenous women

15 that are missing from our data, or if there's a homicide,

16 that it's never been the perpetrator of the homicide, the

17 homicide has never been solved.

18 Some of the same issues with maternal deaths by

19 suicide. Most often people use the other race ethnicity

20 category, and a study that I'm involved with, and I'll

21 tell you more about it in a minute, but the Palladino,

22 2011 did look specifically at American Indian/Alaska

1 Native women and did find a disproportionate rate of
2 suicide during pregnancy or post-partum for those women.
3 And despite the suicide deaths disproportionately
4 affecting Indigenous peoples generally, we don't see that
5 well highlighted in most of our research.
6 So, homicide, the studies vary tremendously in
7 data used, and this is from the review that I led with a
8 wonderful group of authors who did most of the work. But
9 for homicide, the studies vary tremendously in data used.
10 And in studies of homicide overall, approximately five
11 percent of women who are murdered by intimate partners are
12 pregnant when they're murdered.
13 And if you look at it the other way, eight to 25
14 percent of women who died during pregnancy, or the post-
15 partum die from homicide. So, this is major, and this is
16 something that all of us need to think about carefully in
17 terms of our recommendations.
18 Among women who are murdered when they're
19 pregnant, approximately 50 percent are murdered by
20 intimate partners. Black women are disproportionately
21 affected according to the research. I also believe that
22 Indigenous women are disproportionately affected. They're

1 just missing from the data.

2 Part of the issue here is the consistent issue

3 of failure to use the pregnancy check box on death

4 certificates, especially in deaths by homicide, suicide

5 and substance abuse disorder.

6 One of the studies that looked at this, and this

7 is fairly old now, was published in the American Journal

8 of Public Health, and even there, homicide was the second

9 leading cause of maternal mortality when you compare it

10 to the other actual causes of maternal mortality, when

11 pregnancy does cause the death, and this is after

12 automobile accidents, firearms, the most common mechanism,

13 and disproportionately affecting African/American women.

14 One of the more in-depth studies that was done

15 was done in the State of Maryland, my state. And there,

16 again, when Diana Chang and Isabelle Horon compared

17 homicide with other causes of maternal mortality, they

18 found that that was the leading cause of maternal

19 mortality in those years in the State of Maryland.

20 Most prevalent for African/American women, we,

21 of course, have a very low proportion of Indigenous women

22 in our state, so that’s why they’re totally missing from

1 this. Firearms, most common method, and importantly, 56
2 percent of these homicides were done -- were perpetrated
3 by an intimate partner. And if you take away the
4 proportion that were never solved, 65 percent of the
5 solved homicides were intimate partner homicides. Nearly
6 half of them occurred during pregnancy, and all of these
7 women received prenatal care. So, they were in our
8 prenatal care settings. And apparently, we never found
9 out about prior abuse.
10 Sometimes the cases were directly linked to the
11 pregnancy. So, when we say well, pregnancy associated
12 deaths are not because of the pregnancy, like one of the
13 cases, the man who murdered his partner, it was a partner
14 that he had on the side of his marriage. He wanted her to
15 have an abortion and she refused, and he murdered her.
16 So, one of the things that Illinois has done
17 that I think is a promising approach, is they are
18 mandating that state maternal mortality review panels also
19 review the cases of homicide, that they don’t omit them
20 from their reviews because it’s a pregnancy associated
21 death.
22 Going back to that other review in terms of the

1 review of homicide, suicide and drug overdose pregnancy
2 associated deaths, in terms of suicide, one of the things
3 that we need to remember is that intimate partner violence
4 is a significant risk factor for suicide attempts
5 globally. It's the number one risk factor for suicide
6 attempts that have been looked at carefully in the WHO
7 Multi-Country Study.
8 In the United States, Nadine Kaslow found that
9 it was also the number one risk factor for suicide amongst
10 Black women. And in a 2005 article, suicides were
11 estimated to account for up to 20 percent of post-partum
12 deaths. And we find in our review, we found that intimate
13 partner violence was significantly associated with the
14 suicide and suicidality for pregnant women and for post-
15 partum women. And yet, in our most recent post-partum
16 depression, the recommendations for addressing post-partum
17 depression, we do not have in the review anything about --
18 in those protocols, we don't have anything about intimate
19 partner violence anymore. And it's like this link has
20 been forgotten.
21 The fewest number of studies were about
22 substance abuse disorder deaths, and there was also,

1 unfortunately, an increase in pregnancy associated
2 mortality from substance abuse disorder deaths and
3 involving opioids, and over time more than twice the rate.
4 So, this is also increasingly important, and we also find
5 significant associations with intimate partner violence
6 and substance abuse disorder.
7 This is the Palladino article that we looked at
8 the NVDRS data from 2003 to 2007. I'm really pleased the
9 CDC is associated with this Committee. This is one of the
10 things that the NDVRS has been difficult to code and re-
11 code. It is now easier. We need to do more analyses like
12 this. But what we found, and again, my other co-authors
13 did more of the work than I did, but we found, as you can
14 see there, that homicide and suicide, there were higher
15 deaths per 100,000 live births than there was for
16 hemorrhage and for eclampsia.
17 So, it's very important that we consider these
18 homicides and suicides as very important causes of death
19 for women. 45.3 percent of the homicides were what we
20 call IPV related. There was some notation of intimate
21 partner violence. That's lower than the rate in Maryland,
22 but there's -- it depends on what data you look at, and

1 the NDVRS at that point did not have all 50 states.
2 The 42 percent of partner or former partner was
3 killed. Black women were disproportionately affected.
4 Unfortunately, and this is my own writing, when I went
5 back and looked at this, I was like yuck, too few Native
6 Americans to compare kind of thing. We were able to
7 actually look at Native Americans in terms of suicide.
8 More than half of those suicides were IPV related, and
9 Native Americans were disproportionately affected there.
10 So, and we're going to hear from Dr. Wallace
11 shortly, but this is an earlier study in terms of
12 pregnancy associated homicides and suicides, and this was
13 in the 37 states in 2016. This was published, and as you
14 can see, that for pregnant women, the homicides were
15 slightly more for pregnant women than non-pregnant women,
16 and less in terms of suicide. But still, the homicide,
17 the third leading cause of death after quote, unquote,
18 natural causes and injury.
19 And so, since IPV is such a significant risk
20 factor for homicide, suicide, and substance abuse disorder
21 pregnancy associated deaths, what do we know about
22 intimate partner violence around the time of pregnancy?

1 And this is very early work from Linda Saltzman, but it's
2 -- and she was at CDC, and she was one of my mentors, and
3 unfortunately, she has passed. But Linda was the one that
4 pointed out to us that there are different periods of
5 abuse – different periods of pregnancy when intimate
6 partner violence occurs. So, we have abuse during
7 pregnancy, and that's where most of our prevalence is
8 calculated. But we also have abuse before pregnancy, and
9 that's the 12 months prior to the pregnancy. Abuse around
10 the time of pregnancy includes women abused before and
11 during and/or both. Then there's the year of the
12 pregnancy, the 12-month period during which a pregnancy
13 occurred, and abuse after pregnancy. Abuse in the post-
14 partum period.
15 The reason that that's important, and this is
16 from PRAMS data, from 2016 through 2019, and as you can
17 see, there are higher prevalence of abuse before pregnancy
18 than during pregnancy. And oftentimes when we think about
19 abuse during pregnancy, we only measure the abuse that
20 happens during the pregnancy. And what's important here,
21 and this is, again, from Linda Saltzman's work, is that
22 oftentimes the pattern of abuse is that it happens, and

1 this is physical and/or sexual assault. It happens before
2 pregnancy and then not as much during pregnancy, and then
3 picks up again after pregnancy.
4 And so, this is what we fail to recognize around
5 this pattern, that although the abuse during pregnancy may
6 become less and pregnant women are often very much hopeful
7 that the abuse has ended. It may become only
8 psychological abuse during pregnancy when it was physical
9 abuse before that, that she and all women want the father
10 of their baby to be non-abusive. And this gives her hope
11 that the pregnancy, he wanted the baby, that the pregnancy
12 is a time when she is not being abused, or at least not
13 being abused physically, so she thinks well, things are
14 getting better, things are going to be okay. And
15 unfortunately, oftentimes the abuse starts up again after
16 pregnancy.
17 Why is this important? Because when we, as
18 healthcare providers, ask about abuse during pregnancy,
19 oftentimes if we only concentrate on that pregnancy
20 period, she is not willing to disclose. She’s afraid
21 we’re going to tell people. She’s afraid that it’s going
22 to be reported somewhere, that it’s going to affect her

1 actually keeping her baby. And so, she may oftentimes say
2 no, even though it happened before pregnancy and may start
3 up again after pregnancy.
4 So, one of the things I think is important is
5 this overlap between physical, sexual and emotional abuse.
6 Many women are only psychologically abused. And even
7 though that's harmful, it's harmful to her health, but it
8 gives her a different picture of what's happening in terms
9 of this relationship.
10 Other women are only physically abused. Most
11 commonly women are both physically and emotionally abused
12 and sometimes also sexually abused, and as one can
13 imagine, the physical health affects our worse, depending
14 on how many types of abuse she is experiencing.
15 And Coker did this framework, it's a very busy
16 slide, it violates all of the slide construction precepts
17 that we're supposed to follow. But it shows you, and
18 these are all evidence-based connections of intimate
19 partner violence and health outcomes. It's exacerbated if
20 the woman has experiences ACE's, Adverse Childhood Events.
21 All of these physical health problems are even more so,
22 and it's what we talk about in terms of cumulative trauma

1 or cumulative violence. The more types of violence you
2 experience, the more difficult your pregnancy and health
3 will suffer from it.
4 Importantly, here, we're not only talking about
5 physical health problems, we're also talking about actual
6 death of both infants and women as the most severe
7 outcome. But that doesn't happen very often. We more
8 likely see women abused, not killed, thank goodness.
9 And one of the PRAMS databases that examines
10 some of these health outcomes is the one that was done by
11 Jay Silverman and Michelle Decker using PRAMS data, again,
12 the same sorts of associations with both physical problems
13 during pregnancy and for the infant, but also the
14 psychological issues.
15 And so take home, we need to be asking women
16 about abuse, not only during the pregnancy but whether or
17 not there was abuse before the pregnancy. We have good
18 screening tools. There's been a lot of work done in terms
19 of this. This is why screening is recommended by all of
20 our organizations. It's in the Affordable Healthcare Act
21 that there needs to be routine screening. The reason that
22 routine is important is that because otherwise, we will

1 decide -- we will, as providers, often time think that we
2 would know whether or not this woman in front of us was
3 being abused. There would be other indicators that would
4 suggest to us that they might be abused.
5 I've interviewed more than 3,000 women myself.
6 How would we know that she's abused? Oftentimes, if
7 there's any actual bruises, women just won't keep that
8 prenatal care visit. So, we need to ask at each trimester
9 during pregnancy and importantly, we need to ask in a way
10 that she is willing to respond. And that's part of the
11 issue. You need to first give her a little bit of
12 context, something like because domestic violence happens
13 to so many women, because it affects babies before they
14 are born as well as after they are born, women are very
15 concerned about their infant's health, their unborn
16 child's health. We say we're asking you not because we
17 think you might be abused but because it happens to many
18 women.
19 We also ask people about -- we need to ask women
20 in a way that they can respond in a helpful way, not in
21 order to report it. So, especially like for adolescents,
22 to assure them that this will be confidential, that their

1 response is confidential. This is also particularly
2 important, I think, for Indigenous women and Black women
3 because of the fear that the violence is going to be
4 reported to CPS for some reason.
5 So, that's important to assure people of. So,
6 you give them a little context ahead of time. It's also
7 like saying to her, and now you're going to be asked about
8 abuse. Oftentimes we find immigrant women are afraid that
9 it's going to make for deportation.
10 The other thing is, we have to make eye contact.
11 We can't be looking at a screen when we're asking someone
12 about abuse as if it's a checklist. We have to modulate
13 our voice. We have to look at her straight on and we also
14 have to be careful that the partner is not in the room.
15 Oftentimes abusers, unfortunately, will go to prenatal
16 care with her, and we call them the hoverer. Our voice
17 tone is incredibly important, all of t hose things make a
18 big difference in whether or not she feels like she can
19 disclose.
20 Futures Without Violence, I'm on the board, full
21 disclosure. Has wonderful materials in terms of how to do
22 a little bit of education. How to have these

1 conversations with women and it's very useful for
2 providing training for providers. And they have found
3 that the women who talk to their healthcare provider about
4 the abuse were four times more likely to use at
5 intervention, and three times more likely to exit the
6 abuse of relationship. But we have to remember, she may
7 not want to leave. And if we think that's the only
8 solution for her, that is not a helpful approach. We need
9 to help her stay and help her stay safely and help both
10 her and the baby be safe.
11 Now, there are really good interventions, the
12 Dove Intervention, you're a Committee member. Dr. Sharps
13 developed this. It's brochure driven. It can be a
14 digital brochure or a paper brochure. The brochures for
15 the provider, not for the woman to take home. We have to
16 remember that if she is not safe at home, papers that she
17 takes home that are about abuse or going to be a problem.
18 It can be modified for various audiences. It
19 contains the danger assessment which is my instrument that
20 helps identify the abusers that are very dangerous. And
21 the Dove Intervention has been tested with a pragmatic
22 trial and a home visitation setting, but it also can be

1 used in prenatal care and indeed, Dr. Sharps and her team
2 found that there was significantly less intimate partner
3 violence after 24 months for the intervention group, and
4 that was more so than for the control group.
5 But just getting – and everybody got discussion
6 about abuse and referrals for abuse. So that's an
7 important piece, too.
8 The other evidence-based intervention that I
9 think people should consider is My Plan app. It's for any
10 woman, not just a pregnant woman, but it also connects up
11 people with resources, women with resources, and in a way
12 that's digitally friendly and also has the danger
13 assessment in there. And it's also brilliantly programmed
14 by Dr. Glass and her team to reflect women's priorities.
15 So, it's individually based, and it has, you know, safe
16 access, et cetera.
17 So, in closing, just a couple of quotes from
18 women I have interviewed, but I think we also have to
19 think about fathering. How do we develop better -- and
20 they're called offender intervention programs, but better
21 fathering programs that include how to have a healthy
22 relationship, taking advantage of all of the new brain

1 science about what trauma does to brains. Helping abusers
2 become non-violent. And there are ways to do that that
3 don't include necessarily an arrest for domestic violence,
4 which is a way a lot of our intervention programs include.
5 Many Indigenous communities are working on justice,
6 community justice sorts of interventions. But everybody
7 needs to rethink those and have a new paradigm that is
8 around helping abusers not use violence and abuse against
9 partners. Thank you much. Sorry if I went on.
10 ED EHLINGER: All right. Well, we've got – we
11 have time at the end for some questions, but I know we had
12 Dr. Ramas, you had a question. We'll give you time for one
13 question.
14 MARIE-ELIZABETH RAMAS: Great. Thank you so
15 much for this presentation and very much needed,
16 particularly in the midst of the isolation we've
17 experienced in COVID. For sake of time, I'd like to just
18 ask two questions. One, are the resources that you have
19 discussed translated in different languages?
20 JACQUELYN CAMPBELL: Yes. But to Spanish. At
21 least that far. Most of them have not been translated to
22 other languages.

1 MARIE-ELIZABETH RAMAS: Excellent. And then the
2 other question I alluded to in the chat was for our
3 nonbinary patients that are parenting and how has that
4 been discussed or approached, because, you know, I've seen
5 statistics showing that the intimate partner violence
6 death and abuse are much higher in our nonbinary,
7 particularly our trans population.
8 JACQUELYN CAMPBELL? We're not as far as we need
9 to be for trans populations. There definitely has been
10 work and like My Plan has a pathway for women who are in a
11 relationship with another woman. We've got people working
12 on a My Plan for trans populations, but you know, we're
13 not as far as we need to be there.
14 MARIE-ELIZABETH RAMAS: Thank you for that. I
15 know that my family physician colleagues are - they're
16 eager to understand and develop better acumen when taking
17 care of our nonbinary patients, lactating or those who are
18 providing human milk, for instance, you know, just trying
19 to be as inclusive as possible, so we're really looking
20 forward to those improvements.
21 ED EHLINGER: All right. Janelle, hang onto
22 your question because we're going to move on to our next

1 presentation so we can get everybody in. Next, we've got
2 Maeve Wallace, Dr. Wallace, Assistant Professor,
3 Department of Social Behavior and Population Sciences,
4 Associate Director of the Mary Amelia Center for Women's
5 Health Equity Research at Tulane University School of
6 Public Health and Tropical Medicine. Dr. Wallace, welcome
7 and thank you for being here.
8 MAEVE WALLACE: Thank you so much for having me.
9 I think I can share my screen. Let me do that now. Does
10 that look okay, can everyone see my screen?
11 ED EHLINGER: All right. Janelle, hang onto
12 your question because we're going to move on to our next
13 presentation so we can get everybody in. Next, we've got
14 Maeve Wallace, Dr. Wallace, Assistant Professor,
15 Department of Social Behavior and Population Sciences,
16 Associate Director of the Mary Amelia Center for Women's
17 Health Equity Research at Tulane University School of
18 Public Health and Tropical Medicine. Dr. Wallace, welcome
19 and thank you for being here.
20 MAEVE WALLACE: Thank you so much for having me.
21 I think I can share my screen. Let me do that now. Does
22 that look okay, can everyone see my screen?

1 ED EHLINGER: Good.
2 MAEVE WALLACE: Okay, great. Thank you all so
3 much for having me here, it's such a privilege to join
4 each day for conversation, and thank you, Dr. Campbell,
5 for that overview, which many of the points of which I'm
6 going to just echo with some of our most recent work in
7 this area.
8 So, I've organized my presentation today to two
9 points that I hope you can take away from this, and a lot
10 of these, again, echoing what Dr. Campbell has shown.
11 So first, that homicide is a leading cause of
12 death during pregnancy and the post pregnancy in the
13 United States.
14 So, this figure is a chart of cause-specific
15 mortality rates mirroring the charts that Dr. Campbell
16 shoed. This was our analysis of 2018 and 2019 data.
17 Again, you see homicide there on the left and a mortality
18 rate that, you know, vastly, I'd say twofold increased
19 risk relative to some of the leading causes of what the
20 CDC counts as maternal mortality. So, those are causes of
21 death.
22 And this is 2018-2019 data, which was actually

1 the first years of data that was nationally available.
2 So, the check box for pregnancy status was implemented
3 across every state finally, and then in 2018. So from
4 2018 going forward, we have that information from every
5 single state. You know, the point the doctor raised --
6 Dr. Campbell raised about the underutilization or perhaps
7 misclassification of women using that check box is an
8 issue, but it’s there and you can transfer files on using
9 it and making sure that we’re really classifying these
10 woman who are pregnant or pos-partum at the time of their
11 death.
12 So, why does it matter? Well, it matters
13 because, you know, despite national data only recently
14 becoming available, what we saw from all of the work that
15 Dr. Campbell shared previously, going back decades, we
16 know this has been true for decades. And also, the fact
17 that it remains true today begs the question about why, if
18 we’ve about it for so long, it’s been true for so long.
19 It's at what level and at what point were the level of
20 concern that we have around this issue raised to the level
21 of intervention.
22 It matters because, like I just mentioned, now

1 we have nationally available data. And so, as the CDC is
2 putting out maternal mortality estimates annually now for
3 the United States beginning in 2018, we can do so looking
4 at other causes of death as well. So, keeping in mind
5 that you know, maternal mortality does not just include
6 those obstetric causes of death, but if we look at
7 homicide as data to monitor our improvements to evaluate
8 our efforts to reduce these deaths and to continue
9 surveillance, in the effort of prevention, ultimately.
10 So, just to this point about maternal mortality
11 definition used by the CDC includes all of those
12 pregnancy-related causes of death, so obstetric causes of
13 death. And it doesn't count these external causes, which
14 is violence and suicide, homicide, suicide, et cetera.
15 So, when we focus exclusively on maternal
16 mortality data, to me that's a failure to sort of see the
17 totality of preventable death occurring in pregnant and
18 post-partum people. So, I just – I want to make the very
19 important point that it's never my intention to obscure
20 the imperative for prevention of maternal mortality or
21 obstetric causes of death, but rather it's my hope that we
22 can broaden our prospective around maternal death and

1 maternal mortality and efforts to prevent it to include
2 all causes of death, including homicide and suicide.
3 As I mentioned in a few slides from now, both
4 pregnancy related mortality and violent maternal share
5 some of the most deeply rooted causes. So if we move far
6 enough upstream, I think we can see prevention on both
7 fronts.
8 The second key point that I wanted to discuss
9 today is that pregnancy, itself, increases a person's risk
10 for homicide and risk for homicide is kind of a strange
11 epidemiologic way to say that, so sometimes I say it in
12 another way, women who are pregnant or have recently given
13 birth are more likely to be killed than other women of
14 reproductive age.
15 And again, this fact has been shown by a growing
16 number of studies from various jurisdictions. Across the
17 studies the added risk conferred by pregnancy varies, sort
18 of depending on how much geography you're looking at, age
19 group and race, but consistently what we see is that there
20 is an especially heightened risk among adolescents and
21 among Black women where we have much higher pregnancy
22 associated homicide rates than the homicide rates among

1 non-pregnant and non-post-partum adolescents or Black
2 persons.
3 So, here's sharing some findings from our 2018-
4 2019 analysis that are among all women of reproductive
5 age, homicide is 16 percent higher among those who are
6 pregnant or post-partum. Within racial groups we see that
7 there was no difference based on pregnancy status among
8 white woman, but for Black women there was reporting nine
9 percent increase in risk associated with pregnancy and
10 post-partum. And then stratifying there by age we see
11 this huge sixfold increase in homicides among adolescents
12 who were pregnant or post-partum compared to adolescents
13 who are not.
14 And then we looked again even more closely at
15 the intersection of both race and age, and so we see that
16 substantially elevated risk in adolescents is true for
17 both white and black pregnant or post-partum people. So,
18 both of those cases, mortality rates more than twofold
19 higher in the pregnant and post-partum population compared
20 to non-pregnant, non-post-partum counterparts.
21 I wanted to share this analysis of the 2020
22 data that was very recently available and quickly analyzed

1 by myself, with a caveat that this is not yet published,
2 but it is currently under review. It was a quick analysis
3 because I wanted to get this out, given our interest in
4 everything that happened during 2020.
5 And so unfortunately, but perhaps not
6 surprisingly, we saw a substantial increase in pregnancy
7 associated homicide relative to the two prior years.
8 Homicide among non-pregnant, non-postpartum women of
9 reproductive age increased as well. Homicide increased for
10 the general population in 2020 but not quite to the same
11 degree that it did among pregnant women.
12 And so here, shown here are again, patterns of
13 victimization, these remain similar to previous years
14 where we see younger women and Black women really
15 experiencing the highest rates.
16 So some reasons from my sort of social-
17 epidemiologic perspective, reasons behind these population
18 level inequities and victimization may include things like
19 inequities and unplanned pregnancy, which has been shown
20 to add stress and conflicts between two partners. We know
21 that also at play is racism.
22 As Dr. Campbell mentioned, occurring at multiple

1 levels, including interpersonal, systemic, structural.
2 Structural racism, itself, being the root cause of
3 violence and associated with higher rates of unintended
4 pregnancy, barriers to accessing timely and respectful
5 prenatal care, proof of discrimination, and it would make
6 that place a space where women felt safe and comfortable
7 and disclosing violence and accessing services when they
8 want to.
9 My last and final key point I wanted to send
10 home with you is that most maternal homicides are
11 committed by an intimate partner and most involve
12 firearms. Again, I bring you the data Dr. Campbell
13 showed. So, just hear again, you know, about 60 to 70
14 percent of homicides are known to involve intimate partner
15 violence. I put an asterisk there because I think that's
16 an underestimate. That's what we know, and there are a
17 lot of places we just don't have the information to
18 discern that information around each case.
19 I think the same is true for any estimate you
20 see of pregnancy-associated homicides. I would believe
21 that those are conservative estimates of the truth, given
22 that it's really difficult to ascertain pregnancy status

1 for victims who may be in the very early stages of
2 pregnancy at the time of their death or maybe they're not
3 in custody of their children at the time of their death,
4 and so they are incorrectly identified as not being
5 pregnant or post-partum.
6 Again, published studies find that anywhere from
7 60 to 70 percent of cases involve firearms. In the 2020
8 data I just shared, we saw 80 percent of maternal
9 homicides involving firearms. Another notable increase and
10 to my knowledge one of the highest estimates that has been
11 reported. And so, you know, thinking about the surge in
12 firearm ownership and purchasing that happened during
13 2020, and just the surge of firearm violence in general
14 that we saw in that year might play a role.
15 And of course, similar research by Dr. Campbell,
16 herself, show a gun in the home is key factor in
17 escalation of nonfatal that leads to homicide.
18 Abusers who possess guns inflict the most severe
19 abuse. So, gun ownership is actually associated with
20 fatal violence due to other causes as well. And that
21 rates of firearm-related intimate partner homicides are
22 greater in states where firearm ownership prevalence is

1 highest.

2 So, I do not like to give such a presentation of

3 research without receiving some suggestions about what can

4 be done. So first, identifying and addressing homicide

5 with the same imperative and rigor given to obstetric, and

6 pregnancy related causes of death is important. And I

7 think that you probably are aware because you see funding

8 opportunity by the Office Of Women's Health, which I think

9 is a promising first step in establishing violent maternal

10 death review committees at state levels, and I hope that

11 these committees that -- you know, some of which have been

12 going on prior to this as the Illinois example that was

13 just shared, but I think that these committees, you know,

14 they're challenged with generated recommendations for

15 intervention at multiple levels. So, they parallel the

16 work of maternal mortality review committees but really

17 focusing on cases of homicide and intimate partner

18 violence and having a composition that includes people

19 with those sorts of expertise.

20 So, it's really promising to be able to generate

21 recommendations via those committees.

22 Second, as I alluded to previously, maternal

1 mortality--so those pregnancy-related or obstetric-only
2 causes--and violent maternal death share root causes. And
3 so, some work by my own team's research has, you know,
4 linked, you know, broad socially and structural factors,
5 such as income inequality, areas related to violence and
6 structural racism to both pregnancy related mortality and
7 to pregnancy associated with homicide. So again, the idea
8 being that if we move far enough upstream, as we all like
9 to say in public health, in our efforts we could see sort
10 of this cascade of benefits, not only for reducing violent
11 maternal death, but maternal mortality from obstetric
12 causes as well.
13 Which in terms of the racial inequities in both
14 maternal mortality and pregnancy-associated homicide, I
15 think these are a manifestation of structural racism and
16 social inequalities and so efforts that really address
17 both explicit and implicit racism has been helpful, and
18 other social systems have really helped to advance health
19 equity. And so policy-level intervention is really key
20 here and policies that ensure that equitable distribution
21 of health promoting resources and opportunities will
22 dismantle the inequalities of structural racism.

1 There are some health systems interventions that
2 I think can offer some immediate windows of opportunity to
3 identify and support women experiencing violence before it
4 becomes fatal.
5 So, as I know you all know the longstanding
6 recommendations for universal screening for intimate
7 partner violence during pre- and post-natal care visits
8 have been on the books and have been longstanding for
9 many, many years, and that screening rates remain
10 extremely low. And so studies on interviews with
11 providers themselves find that, you know, sometimes this
12 could be because there's a lack of universal procedures
13 for responding the process being ineffective in non-
14 communicative ways, but there are certainly resources
15 including Futures Without Violence about integrating
16 better universal practices and education and procedures
17 into healthcare settings to identify and support women who
18 are experiencing violence.
19 So, there are resources out there. Another
20 health system issue involves improving correct
21 coordination and communication gaps between emergency
22 departments and OB/GYN offices. For example, we've had

1 some antidotal cases in Louisiana where women have been
2 seen multiple times in the emergency department during her
3 pregnancy for injuries related to intimate partner
4 violence. This information was never conveyed or known by
5 the OB/GYN office, and so it's a sort of missed
6 opportunity for them, these providers who would regularly
7 see her at prenatal care, to offer some support and in
8 that case, it ultimately ended in a homicide.
9 Another intervention, a policy-level
10 intervention, that I think holds promise is state laws
11 that restrict possession of firearms by persons convicted
12 of domestic violence or under domestic violence
13 restraining orders. In a recent publication out in
14 "Health Affairs," we found that these laws were associated
15 with a substantial reduction in homicides in pregnant and
16 post-partum women. And this works for findings that have
17 been related to intimate partner homicide in the general
18 population. So, evidence that these policies reduce
19 intimate partner homicide in general. Also now, we find
20 that it certainly proves as well for the pregnant and
21 post-partum population.
22 And then finally the extent to which pregnancy,

1 itself, is a significant risk factor for homicide, I show
2 how pregnant women are at much higher risk for homicide
3 than when they are not pregnant. The ability, I think, to
4 control one's pregnancy status was serious implications
5 for experiencing violence and risk of fatal death.
6 And so upholding reproductive rights, including
7 the right to decide whether or not to become pregnant and
8 to carry your pregnancy to birth is critically important
9 to reduce violence against women, including pregnancy-
10 associated homicide.
11 So thank you so much for your time and I'm so
12 happy to share these brief thoughts with you and contact
13 information is there, I'm happy to take questions now or
14 you know, at any point.
15 ED EHLINGER: Yeah, let's take about five
16 minutes. If anybody has a question, just raise your hand
17 and I will call on you. Jacob, Dr. Warren, Dr. Jacob
18 Warren.
19 JACOB WARREN: Thank you for this very important
20 presentation. Dr. Wallace, I was curious, when you were
21 mentioning the alignment with almost creating separate
22 tracks for maternal mortality or if you could be specific

1 on violent outcomes. Has there been any discussion or
2 looked at aligning this with child fatality reviews,
3 because it's kind of interesting to me that our child
4 fatality review in Georgia focuses specifically on this
5 type of outcome, but maternal mortality review
6 specifically excludes it. So, we have this weird dimetric
7 process.
8 Has there been any examination of how to loop in
9 maybe with CFR's because that would have existing
10 stakeholders at the table, that kind of thing?
11 MAEVE WALLACE: Not to my knowledge. That's a
12 really interesting point, but I don't know anything that's
13 going on related to that. You know, it's sort of, I work
14 a lot with these CDC definitions, and so I'm always coming
15 up with the rules, like that's not what we found in
16 maternal mortality, and we're having to be really careful
17 about never saying maternal mortality when we're talking
18 about homicide, because they don't count that.
19 So, I do feel like there could be some kind of
20 real innovation of all of all of the terminology and the
21 thing that we used to talk about, death during pregnancy
22 and post-partum. And thank you for that example on child

1 psychology.
2 ED EHLINGER: Dr. Peck and then Dr. Collier.
3 MAGDA PECK: Thank you so much for an excellent
4 presentation. I would love to be spotlighted so you can
5 see me, but so it is. I want to follow up on Dr. Warren's
6 comment, and that was a question that I raised in the
7 earlier presentation as well, Dr. Wallace, about the known
8 overlap between maternal intimate partner violence and
9 child abuse. And so, the notion that the lens that you're
10 looking at is through pregnancy and through women's health
11 through the life course, what is the opportunity for
12 looking at it through the pediatric door once child is
13 born, and having that routine screening for intimate
14 partner violence, not be specific to child abuse, but be
15 about looking and listening, hearing where Mom is at.
16 So, I'm wondering both in -- and I'll raise this
17 again at the end with our prior speaker, and both of
18 yours, I so appreciate the maternal perspective and be
19 given, I think it's a 40 to 60 percent overlap in some
20 earlier studies that I was aware of, how do we go at this
21 from both directions? Any thoughts on that, building on
22 Dr. Warren's comment?

1 MAEVE WALLACE: Thank you, that's a really
2 wonderful point. I know that – so the data source that I
3 never put on, I was just presenting our stats records, but
4 I know there are other data sources like the NBGRS, which
5 Dr. Campbell spoke some on, which would allow us to get a
6 lot more protection and detail around each event. And so,
7 I think an area that it would be great to look into to
8 reenforce your point is to characterize these stats as,
9 you know, we know that they are occurring at the same time
10 as other family deaths, and also to be able to understand,
11 especially in these post-partum cases, the children and
12 the potential newborns and other children of older ages
13 that are left behind when a maternal homicide occurs. And
14 so, I think there are potentially data out there that can
15 put the research on what we know with the fact that – so
16 I'm thinking about this one event of family violence as
17 opposed to just a maternal or a child's abuse case.
18 And I think, you know, I talked about improving
19 screening with OB/GYN offices, but I think that even that
20 could be broadened to think about anybody who would be
21 coming in contact with pregnant or post-partum, you know,
22 doing the training and screening and support for

1 pediatricians, for example, who might see women who are in
2 the post-partum period and the children as well. So, I'm
3 sure experts here have more ideas but those are my
4 thoughts and thank you for the question.
5 MAGDA PECK: Yeah.
6 ED EHLINGER: Thank you very much.
7 JACQUELYN CAMPBELL: There has been quite a bit
8 of work done around how to ask about domestic violence in
9 pediatric visits. And there are numerous articles that
10 have been written. There are pragmatic challenges with
11 that that are difficult, especially around electronic
12 medical records, where does that information go?
13 And again, to reiterate what I was saying in
14 terms of that so often women, moms feel like they are
15 going to be told if they disclose abuse, they're going to
16 be told they have to leave, that that is our knee jerk
17 kind of thing, and even being referred to our wonderful
18 domestic violence service organizations, I had a woman
19 tell me just less than a year ago, oh, well, if I go to
20 House of Ruth -- we have a wonderful domestic violence
21 service organization. If I go to House of Ruth, they're
22 going to want me to leave, and I don't want to leave. I

1 want to have this man, who's the father of my children,
2 who doesn't abuse me all the time. I just want him to be
3 helped to know be abusive. And where does that happen?
4 And you know, at the House of Ruth, our offender
5 intervention program is les punitive, less dependent on
6 having to have a Court order to the program, but still,
7 that's often the way it goes. So, I think that that's one
8 of our basic premises, is that we need to be clear that we
9 need to have better ways to help fathers not be abusive to
10 moms or children, and there is that overlap.
11 ED EHLINGER: Dr. Collier, hang onto your
12 question, we've got to move on. So, we'll come back.
13 We'll have a little time at the end.
14 So, we're going to change direction a little
15 bit. We've got Heather Burner, R.N., Executive Director
16 of the National Safe Haven Alliance and Director of the
17 Arizona Safe Baby Haven Foundation, and Director of NSHAC
18 Crisis Prevention Safety and Prevention. Hi there, you're
19 on.
20 HEATHER BURNER: Hi. Good morning, everyone.
21 Thank you very much for having me. I'm honored to be here
22 to present with you all today. These presentations have

1 been very informative, and I really appreciate the work
2 that's going into this.
3 So, let me just make sure I can – let's see.
4 All right. I think I -- it doesn't look like I can share
5 the screen quite yet. Maybe it's getting fixed now.
6 Okay, so I'll just start with an introduction
7 while this is catching up, because I don't see -- you
8 can't see my screen yet, can you?
9 ED EHLINGER: No, I can't.
10 HEATHER BURNER: Okay. I don't see the
11 presentation at this point. So, okay. So, my experience,
12 as you know, is pediatric ER nurse. That's really where
13 my heart was for 20 some years. I've been a nurse at busy
14 emergency rooms here in Phoenix, Arizona, and about 12
15 years ago we actually had a 15-year-old pregnant young
16 woman come into the ER, and she did not disclose that she
17 was pregnant. She complained of abdominal pain, and she
18 was triaged, placed back in the waiting room where she
19 then went to the bathroom and delivered her baby by
20 herself and put that infant into the trash can in the
21 bathroom.
22 We ended up working a code on that bathroom

1 floor about 15 minutes later when the baby was found by a
2 housekeeper. And at that time I had heard of safe haven
3 laws but I really hadn't been exposed to what they looked
4 like, and long story short, moving forward, that young
5 woman had been assaulted by her stepfather, and so had
6 kept that pregnancy a secret from everyone and did not
7 even feel that she could share that with medical staff,
8 not knowing that that could be confidential or she could
9 receive that type of support.
10 So, I started to volunteer. I helped create
11 some triage methods that we could identify and ask when
12 their last menstrual period was, which some of that
13 happens later in a room, but in a triage aspect. So, I
14 don't know if -- let me see if I can share this screen
15 now. There we go.
16 So, I began to volunteer with different
17 organizations, and then also provide – develop and provide
18 education on a healthcare level at this very large
19 healthcare system I worked at. And then moving forward
20 was asked to take over the non-profit in Arizona and a few
21 years after that was asked to step into the director role
22 for the National Safe Haven Program.

1 So, I get to work on many different levels and
2 work with healthcare providers as well as with mothers and
3 families that are experiencing crisis pregnancies.
4 So, ever year infants are illegally abandoned in
5 the U.S. So, this part is obviously very difficult for
6 us, but as you guys are doing your work, you know that
7 babies are placed in dumpsters in backpacks in different
8 locations and most of the time these infants do not
9 survive. Occasionally, they are found.
10 Last year 73 babies were saved by the safe haven
11 laws that exist in our country. And our organization is
12 dedicated to providing those safe alternatives for women
13 and parents to prevent harm or death to their infants.
14 But it goes a bit further than that, when initially we
15 created the hotlines for -- we were really focused on the
16 safe haven laws -- and I'll get into this a little bit
17 more, but what we have seen is the need for expanded
18 services, to really support a mother, to support parents
19 where they are and what their situation is. It's usually
20 very traumatic and there's a lot of situations that go
21 into that.
22 But I do want to hit on this that in 2022 -- so

1 just since December 31st, we have actually had -- this is
2 only listing four, but we've had six abandonments in the
3 U.S. Two of them in which occurred just a couple of days
4 ago, so they're not added onto this, but a mother
5 delivered her baby on a sidewalk in Portland, Oregon and
6 walked away from that baby. Luckily, someone found the
7 child and the mother was found a little bit later and was
8 taken to receive mental health services. But another baby
9 last week was found wrapped up in a bag on a sidewalk in
10 Memphis, Tennessee.
11 So, we know that this is actually happening, and
12 we know that these parents are in obvious crisis. So,
13 it's very important for us to identify the needs and how
14 we can reach them.
15 So, one of the ways that most of you are
16 probably familiar with, that the safe haven law allows the
17 parent to surrender an unharmed infant to a safe haven
18 provider, and this is anonymous and confidential, so the
19 parent does not need to face any type of prosecution. The
20 law gives these parents, these safe alternatives from
21 putting their babies in dangerous locations.
22 So, every state in the U.S. has a safe haven

1 law. Although they do differ as far as the age limit of
2 the child and the safe haven locations. We also assisted
3 Guam with passing legislation just recently, so they have
4 a safe haven law as well.
5 Safe haven providers most often include this
6 list, but I will tell you right off the bat, hospitals are
7 a safe haven provider in every state. So, if there's only
8 one thing, remember that hospitals are a safe haven
9 location. But also that can include fire stations, law
10 enforcement agencies, emergency departments, obviously.
11 Churches, adoption agencies, health departments, and there
12 are some states that have some other locations that are
13 child welfare agencies that could be listed.
14 These are statistics since 1999. Now, these are
15 unofficially recorded by the National Safe Haven Alliance
16 and folks that are on our board. There is no Federal
17 oversight so this is the best we can do. We check in with
18 the states every year and this is the numbers that we
19 actually have. So, safe haven relinquishments are 4,524
20 and illegal infant abandonment at this time are 1,610,
21 which as you can see on here, the majority of those babies
22 are found deceased.

1 So, when we look at how we can prevent this, how
2 we can address the issues, the National safe haven
3 alliance was started in 2004 by a group of safe haven
4 advocates from across the country. And they actually came
5 together to try to discuss what best practices were, what
6 model legislation looked like, the laws and how to prevent
7 these infants from being abandoned. So, that’s our focus,
8 is to see how we can help support parents. And the
9 biggest way is through this crisis hotline. And the
10 hotline is staffed 24/7 by case managers, social workers,
11 and we also have other staff that assist us.
12 We provide immediate emergency referrals; help
13 facilitate safe relinquishment if that is what the parent
14 chooses. Connection to community resources, and I’m going
15 to get into that a little bit more, but it directs support
16 for parents in need, and then we provide the comprehensive
17 training for the providers and these different agencies.
18 We actually contract with state agencies and our
19 hotline is utilized by the Department of Health or the
20 Department of Child and Family Services instead of -- in
21 lieu of the Child Abuse Hotline, which we have found when
22 a parent is calling in a crisis pregnancy situation, the

1 Child Abuse Hotline is very frightening for them. So,
2 they potentially see, especially if they have other
3 children, that when they call, they would lose their other
4 children and oftentimes will not reach out for that help
5 if it is through the Child Abuse Hotline.
6 So, the fact that we can contract with the
7 states and provide a more supportive approach is really
8 important.
9 The communication model that is used with this
10 24-hour hotline, and I'll go through each step real
11 quickly, but we ask the question when we have these calls,
12 what prevents you from feeling you can parent this child?
13 And what we have found is that the baby is generally not
14 the crisis. Their life is the crisis. And that is where
15 we see that they have been abused, they've been sexually
16 assaulted, they've been trafficked, they're homeless,
17 they're substance abused. There are many, many times they
18 have experienced pregnancy denial syndrome, post-partum
19 depression and other mental health issues.
20 So, what we – when we talk about how we provide
21 assistance, that's how we partner with other agencies to
22 provide the support that they need. This is very

1 important because we don't want to only have a focus on
2 the infant. We have a mother or parents, both parents,
3 that might be in a crisis and how can we help support them
4 and assist them? So, we utilize those resources to
5 develop a safe plan for the baby and for the parent.
6 So, the first option that we discuss with these
7 parents is parenting. So, when we identify the crisis,
8 many times, for instance, I had a mother that was sitting
9 outside of an emergency room getting ready to walk in and
10 surrender her baby when she called the hotline to make
11 sure she was following all the protocols, and when we
12 asked her what prevents you from parenting, she had lost
13 her job because of COVID. She lost her home. Her other
14 children were living with her parents and her and her six-
15 day old baby were living in a car. And so, she felt that
16 the baby was safe and wanted to make sure that she could
17 provide what the baby needed. So, when we were able to
18 pause and identify her needs, then can we address that and
19 can we address the fact that you need shelter, basic needs
20 to be met, and would that change the fact that you would
21 surrender this child or not. And it did change that if we
22 could get her into house and get her that support, she

1 wanted to keep her baby.
2 So, like I said, when we expanded the
3 communication model with the hotline, it really is to
4 determine what factors are leading up to this and we were
5 able to keep that family together.
6 So, we also discussed temporary placement.
7 There are oftentimes that we get calls from parents that
8 have hidden this pregnancy. They can't take a baby home
9 because of their parents or because of whoever they are
10 with, and they need a little bit of time and would
11 alternately surrender the baby using safe haven law, but
12 if they have more time, maybe we can help facilitate and
13 coordinate communication and support. So, we offer
14 temporary placement through agencies such as adoption
15 agencies or other programs throughout the country that
16 provide this option.
17 We also talk with them about adoption, because
18 safe haven, when a baby is surrendered, this is anonymous
19 and confidential, so there is no determining what family
20 receives this baby, receiving picture or updates or any
21 type of communication. So, we really want them to explore
22 what adoption looks like prior to surrendering their baby.

1 And then as we discuss safe haven as a
2 lifesaving resort, but we want to make sure that we help
3 coordinate that care with the safe haven provider so that
4 a parent understands what the decision that they're
5 making.
6 So, this is just an example. When we are
7 combining the fact that we are talking about maternal
8 violence, I can't tell you how often we see these women
9 that are in very unsafe situations, and identifying these
10 crises are so important.
11 In Louisiana last year we had a woman that was
12 admitted to the emergency department for injuries. She
13 was found to be 34 weeks pregnant. She had received no
14 prenatal care. And when doing these assessments like you
15 all were talking about in your presentations, it was
16 determined that she was assaulted by her partner. She had
17 arrived to the ER with only a backpack. And so that was
18 observed by staff, hospital staff, which thank goodness,
19 we're paying attention, and brought in social work.
20 After her assessment, it was -- she had to
21 actually have an emergency induction. So she was – the
22 baby was born and at that point they were able to talk

1 with the mother afterwards, and she did verbalize that she
2 had been trafficked when those questions were asked.
3 So, we were able to assist with that in
4 identifying what her crisis was, to identify the process
5 for the baby. We worked with social work and the hospital
6 to determine what her needs would be, and we were able to
7 connect her with an agency that helped her get back to her
8 home state and give her the resources long term that she
9 was going to need other than just what was needed in that
10 emergency room.
11 So, it's really been an ongoing process that we
12 are educating and looking for the identifiers so that we
13 can connect these mothers and parents to the right
14 resources.
15 So, identified needs, you now, the National Safe
16 Haven Alliance, these laws were put in place 20 years ago
17 and most states did not provide funding for education
18 awareness, the appropriate signs at locations. And so,
19 the needs that we have identified during assessments are
20 truly an awareness and education campaign, how we can
21 identify these crises before they actually occur, and a
22 woman is then feeling pressured and putting her baby in a

1 garbage can.

2 So, we also are looking at the national hotline

3 contracts, so this hotline used, instead of a child abuse

4 hotline, that, I mentioned.

5 And then the National Registry of Reporting, the

6 CDC did an MMWR article about infant homicides, came out

7 last year in 2020. And there were a lot of identifiers

8 that are showing that the safe haven laws are improving

9 outcomes. And so, it's really important for there to be a

10 national type of database for us to, like I said, someone

11 I think just popped up a question as far as abandonments,

12 and the statistics, we don't actually know if these are

13 accurate, because most of the states say that an infant

14 needs to be unharmed. But we also know that substance

15 exposure is technically harm. So, when these babies are

16 surrendered at a fire station or at a location, because

17 they are exposed to substances, they are not being counted

18 as safe haven relinquishments, they're being counted in

19 the statistics as abandonments.

20 And so, the numbers are very skewed to

21 understand if these safe haven laws are really successful,

22 although this report from the CDC did show that there is

1 some success and improvement.
2 And then we would like to see some type of
3 funding or some type of implementation of oversight.
4 There has been no oversight from the governments and even
5 state governments that folks that have experience with
6 safe haven laws and how we can reach these parents before
7 these crisis situations. So, you know, I know that
8 everyone is doing really important work here, and I'm
9 really honored to be here because I see the connection of
10 all these different pieces, and I have been honored to
11 work with mothers in hospitals and outside of the
12 hospitals and see these different violent situations that
13 they are coming from and how that does then lead to these
14 potentially violent situations for their babies. And so,
15 I'm really honored to be able to participate in this
16 meeting with you all, so thank you very much.
17 ED EHLINGER: Thank you, Ms. Burner. Any
18 questions? Time for one or two questions.
19 TARA SANDRA LEE: I just want to say thank you.
20 I think these laws are so important and so I would thank
21 you for taking the time to present this data and
22 information. Thank you so much.

1 HEATHER BURNER: Okay, thank you.
2 ED EHLINGER: Well, then let's move on with our
3 final scheduled presenter. Sylvia Bennett Stone has more
4 of a personal prospective on this. She's the director of
5 voices of Black Mothers United. Ms. Bennett Stone, the
6 platform is yours.
7 I saw her on the list before. I don't see her
8 on the list now. So, Emma, do you know if she dropped
9 off?
10 EMMA KELLY: I'm not aware. If you're in the
11 attendee portion, if you can raise your hands so we can
12 promote you to panelist, that would work.
13 ED EHLINGER: All right, let's just open it up
14 for questions for right now for any of the presenters.
15 So, just, you know, raise your hand and I know Janelle had
16 a question and Charlene had a question. Janelle.
17 JANELLE PALACIOS: It was to go back with Dr.
18 Campbell, and I believe Dr. Wallace answered a little bit
19 of it, and it was just, you know, what has happened since
20 the pandemic, we knew that there were antidotal cases of
21 concern or IPV to increase with lock downs and so I --
22 that was a question that I had, and I also saw it in the

1 chat, but it was a questions that I had, and we've
2 discussed this before in previous meetings, but it looks
3 like the 2020 data shows that we had homicide rates
4 definitely go up.
5 JACQUELYN CAMPBELL: Yeah, unfortunately, that's
6 what, you know, the data suggests and especially Dr.
7 Wallace's fabulous data suggests. And sometimes people
8 think that domestic violence, that the prevalence of
9 domestic violence has increased during COVID, and I'm not
10 sure that's true. It doesn't make sense to me
11 theoretically that the stresses of COVID would make
12 someone start abusing a partner.
13 However, it is clear that it can increase the
14 severity, and that's why we would see the homicide rates
15 go up. When people are confined to homes, when there's
16 stressors related to financial difficulties during COVID,
17 perhaps someone lost a job during COVID, that existing
18 abuse would get worse, and unfortunately escalate to a
19 homicide.
20 There's also been this increase in guns being
21 purchased, which I believe is incredibly important and one
22 of the things that I think we need to also help new

1 mothers understand is how to store guns safely at home,
2 that that needs to be in our teaching.
3 JANELLE PALACIOS: Right. What you're sharing
4 just about the firearms that have been purchased, I was
5 curious to think about, you know, when it came out looking
6 at states and kind of identifying states that have more
7 firearm purchases, and they're linked to homicides, how do
8 you work with states in trying to mitigate this link, this
9 understanding of linkage of homicide rates and especially
10 IPV and you know, death to mom or you know, harm to infant
11 children, especially when -- and I don't know if Texas is
12 the only state, but when you have state laws that protect
13 firearms and you can't speak out against firearms and a
14 particularly funded venue, so I -- that was something that
15 was new to me, having given a talk in Texas and having to
16 sign a waiver, something that I would not speak ill
17 against firearms.
18 Any thoughts on how to deal with, you know,
19 something for the future as well, but just how do you get
20 around that?
21 JACQUELYN CAMPBELL: Yeah, I think if anything,
22 and maybe Maeve cam talk about this because she lives in a

1 state that’s different from mine around firearm laws, but
2 I think if we can approach legislatures around safety of
3 infants and pregnant women, but particularly about safety
4 of children, that perhaps that would help persuade them.
5 Because we have seen many states adopt laws that make it
6 illegal for an abusive person to purchase a gun, where the
7 rest of their laws are much less that way. And we have to
8 realize we have an organized opposition around this. And,
9 you know, be savvy.
10 But anyway, maybe Dr. Wallace has a thought
11 coming from such a state.
12 MAEVE WALLACE: Yeah, exactly. Just that, you
13 know, I’m in a very pro-gun state, very conservative
14 legislature, and actually, you know, one of the states
15 that passed these firearm relinquishment laws disallowing
16 possession of firearms by abusers, and so that happened
17 back in 2018, much to the surprise of everybody, because
18 of how pro-gun all of our Iowa legislation is, and I think
19 it’s just that, it’s the angle that, you know, first of
20 all, it’s a tremendous amount of efficacy by a number of
21 groups in this state, but the angle looking at the harms
22 to children and women and pregnant women, and I hope sort

1 of a universal proclamation that we're all committed to
2 protecting and keeping safe and really emphasizing the
3 victimization of those populations, help to convince some
4 of the pro-gun legislators to pass those laws.
5 Now we're dealing with the fact that we have
6 those laws on the books and we don't seem to be being
7 enforced. And that comes down to local agencies and just
8 a lack of -- I don't know that it's a lack of
9 understanding that those are the laws on the books, or
10 it's just an unwillingness to enforce those laws.
11 ED EHLINGER: Dr. Collier.
12 MAEVE WALLACE: And I'll just mention, just to
13 follow up on your comment about speaking about firearms, I
14 think, you know, the National Institute of Health recently
15 put out a call for research programs on firearm violence.
16 CDC is now able to count firearm violence, so I think that
17 speaking about it in terms of federally funded research
18 and this is coming from, you know, research finding may
19 seem less subjective to someone who thinks that we might
20 be coming in with our subjective viewpoint on firearms
21 when we're talking about them.
22 JACQUELYN CAMPBELL: Yeah. I have a fantasy

1 that we give a gun safe to new moms and dads going home
2 along with the baby carrier for the car. You know,
3 because oftentimes it's not having the means or the place
4 to store a gun safely, or the means to purchase something
5 like that.
6 ED EHLINGER: Dr. Collier.
7 CHARLENE COLLIER: I think, Dr. Menard, were you
8 before me?
9 KATHRYN MENARD: Go ahead.
10 CHARLENE COLLIER: Okay. Well, thank you all for
11 your presentations, they were excellent. I wanted to
12 thank, particularly, Dr. Campbell, for your recognition of
13 the struggle that exists around addressing the needs of
14 the abusers, and just really acknowledge, I don't think,
15 at least in medicine and much of society, we're out of
16 place of being ready or comfortable to take care of
17 abusers, or to help abusers, or to address intimate
18 partner violence as a symptom of a mental health problem
19 or a trauma. It is fully aligned with a criminal act at
20 this point when, in fact, in our relationships, community,
21 it is not just a criminal act. But I would just
22 acknowledge, we're not comfortable with the idea of

1 helping abusers, nor do I imagine funders are comfortable
2 with the idea of funding programs for abusers. HRSA, I
3 don't' see creating -- like you can correct me if I'm
4 wrong -- funding to help them, although I will acknowledge
5 I fully believe it is a symptom of a mental health, a
6 familial trauma, generational trauma, particularly if
7 we're looking at Black men, fathers completely isolated
8 from our healthcare system, and this is all related to
9 trauma that goes completely unaddressed.
10 So, if we're not comfortable with caring for
11 abusers, then I think if you take a step out from that,
12 it's preventing abuse and how do we go – we may be more
13 comfortable with that concept of preventing it from
14 happening the fist time, and what are your thoughts around
15 that, and where that should be localized, because is it
16 within schools, is it – we're seeing a little bit more in
17 football teams now, given the very public acts of that,
18 but where else could prevention take place, and I don't
19 that it's in medical care, because if you look
20 particularly at fathers and men, they don't have access to
21 the healthcare system as much.
22 So, what are your thoughts around what are

1 fundable, palatable, like likely next steps to help, you
2 know, particularly men? I know it’s not just men, but
3 that is the big population, I think that is not -- and
4 it’s not to take away, of course, from all that we need
5 for victims, but I think it’s a big gap right there, and
6 I’m just curious on your thoughts on that. What can we do
7 I that space around those who are abusers or potential
8 abusers? Thank you.
9 JACQUELYN CAMPBELL: Yeah, and I think it’s
10 through the fathering lens, through the early Head Start
11 fathering programs, through the new parenting programs
12 that it very intentionally be around fathers as much as
13 around mothering. And that, you know, if the relationship
14 -- if there are problems in the relationship, and
15 oftentimes women will say yeah, there’s some problems in
16 the relationship, but they’re not going to call it
17 violence, they’re not going to call it abuse, but they do
18 want to improve the quality of the relationship. And if
19 we center it around that’s the best thing for kids, you
20 know, most young men want to be good fathers, they want to
21 be connected with their kids. And if we can convince them
22 that the way to go about that is through being -- having a

1 healthy relationship with mom, and you know, healthy
2 relationship is probably lousy language to appeal to these
3 young men, but we need to figure out that language and get
4 them involved in that.
5 ED EHLINGER: Kate, Kate Menard.
6 KATHRYN MENARD: First, I deferred to Charlene
7 because she always takes us in a place where we need to
8 think. But I have three things maybe that if we can -- if
9 it doesn't take too much time, I would touch on one, I'm
10 touching on screening, another touching on identification
11 of the deaths and a third, related to actually reviewing
12 these deaths.
13 So, the first about screening, and I'm speaking
14 from my North Carolina perspective now where we have --
15 you know, I speak from experience. And Belinda, set me
16 straight if I go astray too much.
17 But in North Carolina, we do screening for
18 intimate partner violence as part of our universal screen
19 of individuals that are Medicaid beneficiaries. It's an
20 aspect of the medical home program that is a uniform
21 screen for -- that's just one of the social determinates
22 of health. It's a paper screen, you know, a question

1 that’s administered and the individuals complete it. You
2 know, it’s in English and Spanish and they complete it.
3 If the need help, they get help.
4 But it’s not an interview, you know, where you
5 can, you know, preview it with the lead in questions that
6 Dr. Campbell so nicely suggested, and the assurance of
7 information about how that information is going to be
8 used. It’s just not administered that way.
9 And in truth, it’s a matter of efficiency,
10 right, to be able to do it this way. So, where there’s
11 that – and there’s a lot of conversation about, you know,
12 do we do these interviews for social determinates of
13 health, those interviews or paper screen, and I’m
14 interested in Dr. Campbell’s perspective on that.
15 JACQUELYN CAMPBELL: Yes, we did a lot of work
16 on that early on, and you know, if you do a paper screen,
17 you’re going to get an underestimate. You’re going to get
18 people who are, in this case, women who are really worried
19 about this and, you know, that it’s quite severe. So,
20 that’s better than nothing, but you know, if we can have
21 some sort of follow up conversations somewhere, even for
22 people who say no on those paper screens.

1 But we do find some women do disclose on paper
2 screens, because they're really worried about what's
3 happening in their relationship and they, you know,
4 they're not sure what's going to happen to that
5 information, but hopefully, at the beginning of the survey
6 there's some sort of something about -- some sort of
7 confidentiality piece.
8 KATHRYN MENARD: Yeah, thanks for that. The
9 second thing is in our experience in North Carolina using
10 the Violent Death Reporting System and actually using that
11 as one of the linking mechanisms to identify these deaths,
12 I think we found – one of my colleagues, Kathrine
13 Fladincia (phonetic), did this work, where we found that
14 there's like about a 33 or 40 percent increase in the
15 number of deaths identified. So, I wonder if Dr. Wallace
16 can comment on use of that to really kind of find these
17 violent deaths?
18 MAEVE WALLACE: Yeah, definitely. That's some
19 of what I said and had in all the data I showed, I think
20 it's all conservative estimates. It's based only on the
21 death records. So, as I mentioned, National Violent Death
22 Reporting System, using death record in addition to law

1 enforcement records, medical examiner and so much more
2 contextual information that reviewers while looking at the
3 data are able to review and decide whether or not it was
4 intimate partner violence related, and to determine
5 whether or not the person was pregnant or had children
6 under one year old at the time of death.
7 So, data issues abound, and I think it’s safe to
8 say everything you see is a conservative estimate, but I
9 think it’s getting better, just as maternal mortality rate
10 are getting better. I mean death records are what the CDC
11 used to report the the national maternal mortality rate.
12 And so, we use it to report the homicide rate, and it’s
13 what we have nationally. I think NDVRS is national as of
14 maybe 2019?
15 JACQUELYN CAMPBELL: Yes.
16 MAEVE WALLACE: So, I think that will certainly
17 help.
18 JACQUELYN CAMPBELL: Yeah, and it really – I
19 mean, this gets into the weeds, but it depends on the
20 state, how well their pulling in that contextual
21 information. When we did our review from the NVDRS, tons
22 of missing data, tons of, you know, the recoding that

1 needed to be done was massive.
2 So, it's easier to work with now, and CDC has
3 done a lot of work to make it easier to work with and try
4 and get states to fill in the missing fields. But a lot
5 of the states that were really late adopters of the NVDRS
6 are, you know, they're less condensed. It's worth having
7 somebody spend enough time to make it a quality data set.
8 So, you get vastly different, you know, amounts of
9 information, especially about prior domestic violence,
10 depending on the state and the state health department's
11 commitment to making it a good database.
12 ED EHLINGER: All right, Kate, I'm going to jump
13 in before your third point and before Jacob gets to ask a
14 question. I would like, given the time that we've got, I
15 would like to have Jeanne Conry give us sort of an update
16 on the other sort of violence that we're experiencing
17 right now, that we're seeing right now through war. And I
18 know Jeanne has some slides. She's been working on this
19 with her work overseas with the Red Line Initiative.
20 So, Jeanne, give us an update on what you have
21 with this extreme form of violence. And unmute yourself,
22 Jeanne and then you'll be able to go.

1 JEANNE CONRY: There, thank you, sorry. I'm
2 going to address the Red Line Initiative. And for those
3 of you who know Dr. Denis Mukwege, he is the Nobel
4 laureate from 2018 and OB/GYN who has done more than
5 almost anybody to apprise us of war crimes against women,
6 and specifically women who are used as what he would call
7 weapons of war.
8 So, I'm going to talk about weapons of war,
9 violence against women and put in a prospective on Ukraine
10 right now, because I know it's in everybody's thoughts.
11 And I'll apologize because my numbers were from
12 last week, and we'll see that the numbers are worse every
13 day. And this is specifically about women and children.
14 We know where Ukraine is, it's the second
15 largest country in Europe, second only to Russia with a
16 population of 44 million. The countries that border it,
17 Poland, Belarus, Russia, Slovakia, Hungary, Romania,
18 Moldova and the Black Sea and the Sea Assaf. They
19 regained their independence in 1991 after the dissolution
20 of the Soviet Union. And the thing to remember is in 1994
21 they became a partner for peace status in NATO. So,
22 they've got longstanding partnership with NATO.

1 We’re seeing a mass exodus. These numbers
2 aren’t correct. This was when I gave a talk in Ireland
3 last week, 650,000 citizens already displaced. You know,
4 we’re looking at two-and-a-half million now.
5 80,000 women expected to deliver within the next
6 couple of months. The World Health Organization says it’s
7 a thousand women a day really is what we’re looking at
8 that are delivering their children under the worst
9 conditions we can manage. Hospitals are being targeted;
10 care is interrupted. Physicians are literally not able to
11 get to work. They’ve moved their families into subways
12 with them and moved maternity units down into subways so
13 that they, at least, can have some protection.
14 We’ve been unable to reach the president of the
15 Ukraine society, but just to give you a perspective,
16 they’ve been doing very, very well in driving down
17 maternal deaths, and we just are worried about what this
18 area – what this is going to mean.
19 Physicians are being asked to take up guns.
20 They are told they can sleep for six hours. The next
21 shift is working on labor and delivery, and the shift
22 after that is to pick up guns and guard the subways and

1 hospitals so that they can keep their patients safe. The
2 hospitals are just -- clinics aren't even able to open, so
3 women are not getting any of the urgent need that they
4 have. The children aren't being taken care if, and it
5 doesn't matter what we're talking about, there are urgent
6 needs that are just ignored.
7 So, FIGO has asked our member societies, you
8 know, what supplies we can get. We're working with the
9 World Health Organization right now, and we've written
10 statements about what their needs are.
11 We published one statement last week and then
12 this week updated that statement, and I won't go into all
13 the wording, but it's that health is a human right, and
14 again, this is focused on women because it's FIGO. Women
15 deserve the highest possible standards of physical,
16 mental, reproductive and sexual health and wellbeing
17 throughout their lives, no matter where they live, no
18 matter what the circumstances are.
19 If we look historically at what war has brought,
20 whether it's World War II, Bosnia, what we're seeing with
21 ISIS or the Democratic Republic of Congo, women are used
22 as specific weapons in war. It's not a happenstance, it's

1 a specific weapon.
2 There are three methods of warfare. We're
3 actually seeing -- although this says that most of this
4 has gone by the wayside, you know, a century-and-a-half
5 ago, it's not true. Here, right now, starvation,
6 pillaging and rape and acts of sexual violence are
7 considered three types of warfare, the first two having
8 almost been done away with in the last century.
9 But if we look at what happened with ISIS
10 kidnapping, sexual slavery, forced marriages and rape,
11 selectively in front of husbands, in front of the
12 community so that the community is so intimidated they
13 won't fight. In Bosnia from 1992 to '95, policy of mass
14 systematic violence targeted against women went anywhere
15 from 10 to 50,000 women, 10,000 to 50,000 women being
16 raped. Again, it's a weapon, specifically to intimidate
17 the children, the family and to make a husband feel
18 useless.
19 So, it's not a byproduct, and that's the
20 important thing to remember, it is not a byproduct of
21 conflict, but it is a pre-planned military strategy.
22 Democratic Republic of Congo where Dr. Mukwege

1 is, is probably the worst in the world. Second largest
2 country in Africa with riches that just are beyond belief.
3 They had blood diamonds. Now they've got blood cobalt to
4 drive our electronic industry. And to keep communities
5 intimidated, women are being raped, used as sex slaves,
6 imprisoned. The children are abandoned and left to die.
7 The armed forces are part of it, even the Democratic
8 Republic of Congo has been part of it.
9 There are legal considerations, so you can read
10 that there's a Geneva Convention that says women shall be
11 especially protected against any attack of their honor, in
12 particular against rape. And we've got the Bosnia war.
13 It was the first time in judicial history where a tribunal
14 actually said that there was systematic rape that was used
15 and sexual enslavement and held that at least for trial.
16 But I'm not a legalese person, I don't
17 understand all the intricacies, but when we are talking
18 about women as weapons in war, even though we know what
19 that means, because it's not defined, we have no recourse.
20 So you and I know what rape is. We know what sexual
21 violence is. We know that there's a problem, but legally
22 we've got nothing to stand on. There's no legal agreement

1 about method of warfare, and until there is, nothing's
2 going to be done.
3 States and international organizations must
4 agree on a legal definition of what constitutes sexual
5 violence as a method of warfare. And when I talk about
6 the violence, it is not just rape, it is violence, so the
7 women are destroyed. They need major surgical procedures
8 after what they've experienced. It is not - it's
9 unbelievable what these women are going through with guns
10 being used in their lower part of their pelvis, you name
11 it, it happens.
12 So, we are supporting the Red Line Initiative,
13 and I'm bringing it here because we are going to ask every
14 medical society around the globe to sign on and say we've
15 got a Red Line in the sand, that it's a convention that
16 says it is a strong tool. We will shame the states who
17 violate the norm. We will let them know; we will ask
18 countries to hold them accountable.
19 Dr. Mukwege has been talking for 20 years about
20 what's happening and still we haven't seen changes. He's
21 hoping that the physicians and the healthcare providers
22 around the globe, if we all unite and say we have no

1 tolerance about what’s happening, and still we haven’t
2 seen changes. He’s hoping that the physicians and the
3 healthcare providers around the globe, if we all unite and
4 say we have no tolerance for this, that it’s a different
5 voice, he’s spoken to the United Nations twice. He’s met
6 with all the precedence, and still we haven’t seen a
7 change.
8 So, this is both monitoring, tracking, training,
9 getting medical experts and holding accountable. It
10 includes sanctions against countries when women are used
11 as weapons of war.
12 So, if you would join all of us with the Mukwege
13 Foundation for a United Voice, FIGO is leading the
14 OB/GYNs, but I will ask that all medical societies, all
15 practitioners, bring this to your academies and ask them
16 to sign onto a Red Line Initiative.
17 Now, when you say that you – you know, you think
18 oh well, this was Bosnia, or this was a different time,
19 there is no reason to think it’s not going to be taking
20 place. We’ve got an urgent need right now with what’s
21 taking place in the Ukraine. We know that women’s and
22 children’s needs are not going to stop, and we know very

1 clearly from what happened in Crimea, so just a couple of
2 years ago that women there were raped and used as weapons
3 in war. So, there's no reason, and women in Syria,
4 exactly the same thing. Dr. Mukwege has been counseling
5 both Syria refugees and Crimean refugees and taking care
6 of them and overseeing surgical procedures for them.
7 So, we know that there is – that women are not
8 going to be safe, and our children are going to face the
9 same abuse. So, we're recommending an international
10 convention with a red line in the sand.
11 And just to say -- again, this was addressed to
12 physicians, we respond to needs and we respond to crisis.
13 We have empathy. We see our colleagues in the most
14 unimaginable circumstances and ask how we can help and
15 what can I do? So just to bring this home to everybody,
16 there's a feeling of desperation, you know, trying to get
17 humanitarian aid, get people out of the country so they
18 even feel safe. A thousand women a day, trying to get
19 those thousand women and their children out of the country
20 is a top priority. Thank you.
21 ED EHLINGER: Thank you, Dr. Conry. Obviously,
22 the violence is a huge issue, both interpersonal violence,

1 societal violence. We'll add a couple of minutes to this
2 session. Steve, did you have a comment or a question?
3 STEVE CALVIN: Yeah, I was just going to ask. I
4 appreciated Heather Burner's presentation too, and just
5 wondered if the abandoned, deceased babies are included in
6 the infant mortality rates in the states?
7 There's that, and also appreciate Jeanne's
8 presentation. My wife and I have traveled to Ukraine six
9 times. We have a lot of friends there, and what's
10 happening there is just – it's horrible.
11 HEATHER BURNER: As far as the infant mortality
12 rates, I do believe that they are being reported, but as I
13 said, I think that there needs to be an overhaul of this
14 because of the fact that they are so skewed. As these
15 babies are being relinquished, they are being surrendered.
16 What we really don't know is if those are accurate
17 compared to the abandonments, that those numbers are
18 accurate as well.
19 But yes, I do believe that they are being
20 reported by states, yes.
21 STEVE CALVIN: Thank you.
22 ED EHLINGER: Obviously, we've learned a lot in

1 this session about violence and how important it is. And
2 I'm hoping, and this is an issue that we really haven't
3 addressed as a Committee and I'm hoping that this next
4 iteration of SACIM can take what we've learned today and
5 move it forward, you know, and coming up with the kind of
6 recommendations that are needed to really address violence
7 in all of its permutations. This was just sort of really
8 some excellent background work, consciousness raising
9 about the importance of the issue. And I want to, you
10 know -- and it's pervasive, more pervasive than we
11 realize. And I want to end this session before we take
12 our break with this statement by Coretta Scott King. On
13 June 9th, 1968, just a few weeks after her husband was
14 killed, she said the violence of war is understood by
15 everyone. But I must remind you that starving a child is
16 violence, suppressing of culture is violence, neglecting
17 school children is violence, punishing a mother and a
18 child is violence, discrimination against a working man is
19 violence, ghetto housing is violence, ignoring medical
20 need is violence, contempt for poverty is violence. Even
21 the lack of willpower to help humanity is a sick and
22 sinister form of violence. Violence is pervasive in our

1 society in so many ways.
2 And so, we need to broaden the definition of
3 what creates health. We need to broaden the definition of
4 maternal mortality and the implications and what causes
5 infant mortality, take all of these forms of violence, the
6 social issues, the cultural issues, the economic issues,
7 the political issues, the power issues that are all part
8 of the violence, particularly violence against women and
9 children.
10 So, thank you for all of the work on this
11 session. This was wonderful information. I hope it leads
12 to more action within this group as we move forward.
13 **BREAK**
14 ED EHLINGER: So now, let's take a 15-minute
15 break.
16 (A break was taken.)
17 **INTRODUCTION OF WORKGROUPS**
18 ED EHLINGER: Welcome back everyone. We had one
19 other presenter that was scheduled and Sylvia Bennett
20 Stone, a woman whose child was killed by a handgun, and so
21 she was going to give some personal stories, and she's
22 been working with families across the country on

1 decreasing gun violence and its impact on kids, but she
2 dropped off and I don't know where she went. So I'm sorry
3 that we didn't get to hear her story.
4 One of the things I learned, there are few
5 things that have tight timelines, and one is the public
6 comments. Since we advertise what public comment is going
7 to -- when it's going to happen and people tune in for
8 that, so we have to be ready for public comment right at
9 3:00 o'clock because that was put on the agenda.
10 So, between now and then I want the leads of our
11 workgroups to sort of give a pitch for what they're doing,
12 because we don't have standing committees in SACIM, but we
13 have ad hoc workgroups. And for the last two years we've
14 had three ad hoc workgroups. One related to health
15 equity. One related to data and research and one related
16 to access and quality of care. And that's where a lot of
17 the work has been done.
18 The leaders of two of those workgroups are going
19 to be transitioning off after the end of the next meeting.
20 Steve Calvin is going to be continuing on and I'm hoping
21 that he will continue to lead the workgroup on access and
22 quality, but we may -- if the group wants to continue

1 those workgroups. I don't plan on starting any new
2 workgroups or any other committees between now and when I
3 leave at the end of this year. But I want these group
4 leaders to give just a quick pitch of what have you been
5 doing, what's the focus and trying to convince some of you
6 to say I'll volunteer to take a leadership roll or be on
7 one of these workgroups.
8 So, let's start with Steve since you're -- you
9 know, you don't have to make a type of pitch because
10 you're going to be on for a while, but let us know what's
11 up.
12 STEVE CALVIN: Sure. Well, we have --- I have
13 to say we haven't been as active as the data group and the
14 equity group. There have been a lot of -- there's been a
15 lot of overlap. And some of the work -- we did hear some
16 things, particularly from Suzanne England, who has a real
17 Indian Health Service perspective that's really valuable
18 and kind of within the Native lands in South Dakota or
19 thereabouts.
20 But what I would say is to encourage any of the
21 new members to consider being involved and trying to
22 strategize and how we, as a committee can really enhance

1 or promote what we already know work, the kinds of things
2 that we already know that work and making sure that we
3 figure out ways to facilitate that. I mean, I've been
4 doing some deep dives into state funding of Medicaid for
5 maternity care. And many of the states do have contracts
6 with managed care organizations, some non-profit, some for
7 profit. You know, I certainly give kudos to some of the
8 work that's being done, but there's just a lot of
9 obstruction in the system for better care, and I think
10 that it fits maybe with a lot of what I've heard from the
11 new members, their passion for figuring out ways to
12 improve care.
13 I did a presentation a couple of sessions ago,
14 just an overview of the financing of maternity care in the
15 United States, and Wanda Barfield, I'm sorry that she's
16 not going to be part of the Committee in an ex-officio
17 capacity, but I used the terminology Scott Adams is the
18 Dilbert cartoonist. He uses a term called the
19 confusopoly, and the confusopoly in the healthcare
20 financing world is things are so confused that nobody
21 knows how to fix it.
22 But the truth is, there is money in the system.

1 Some states are underfunded. There's no question. But
2 there are many states that are fairly well funded, but the
3 money is not getting to the kind of proven care models,
4 particularly midwife -- midwife led is probably -- I mean,
5 midwife primary midwifery care integrated with physicians
6 and safety nets. And so, I'm excited, you know, Kate
7 Menard, you have a lot of expertise in levels of care and
8 our other colleagues on this committee can give a lot of
9 insight.
10 So, my pitch is that's where I would like to
11 focus and just finding where the blockage is. And it's a
12 state-by-state thing, so that's why it's a challenge. But
13 there's a lot of overlap. So, that's my pitch.
14 ED EHLINGER: Workforce is another issue that –
15 STEVE CALVIN: Absolutely, yeah.
16 ED EHLINGER: All right, Magda, the Date
17 Research and Action Workgroup.
18 MAGDA PECK: Let me unmute because I've learned
19 to do that, and you all can – I believe you can spotlight
20 me. Excellent.
21 So, first of all hats off to a dedicated group
22 of probably 10, sometimes 15 who have solidly shown up,

1 and for our new members, essentially it's a combination of
2 members of SACIM, and in our case it would have been
3 Jeanne Conry and Paul Wise, and Ed Ehlinger and Janelle
4 Palacios joined by our ex-officio members, including Wanda
5 Barfield, previously, and Allison Cernich from NIH, and
6 among others, Danielle Gille, from NCHS and among many.
7 And then folks who've asked, can we join,
8 because the thing about an ad hoc group is that you don't
9 need to go through all that approval process that got you
10 onto the SACIM Committee. And so, hats off to Ellen
11 Tilden and Dee Dee in Boston and Rosemary Frona and Cheryl
12 Clark and others who have regularly shown up. So, it's
13 this interesting mix of regular SACIM members, ex-officio
14 members, particularly those in government that allow us to
15 work across sectors and silos, and then leaders in the
16 field of different ages and stages of their career who
17 learn and serve on this ad hoc committee. So, that's the
18 who that I want to make sure you have the context for.
19 And in setting up these three working groups it
20 was very similar to the tripartite model of Dr. Richmond
21 that I spoke about in my story. Now, there's the data and
22 research piece and then there's the program piece, access

1 and quality. Then there's the political will,
2 particularly focusing on health equity. And so, you've
3 got that triangle model.
4 So, our job is to do a couple of things, and
5 this is what I want to pitch to you in my final minute or
6 two that I get to make the pitch. The first is, our
7 number one is to inform the other workgroups. We're the
8 workhorse. So, if you want to do race concordant care or
9 if you want to focus on housing, or want to talk about
10 finance, in addition to what will happen within those
11 committees, those working groups, we try to make sure that
12 the evidence-based is strong, solid, credible.
13 The second is that sometimes we get
14 opportunities to be able to respond to say improving and
15 enhancing the next version of PRAMS, where we can
16 coordinate a data and research response. We also get to
17 elevate some very specific not yet touched issues in SACIM
18 such as housing or new issues that you have talked about
19 in the last two days, about is anybody doing something in
20 transportation. Where now, we kept hearing about data
21 issues and research and gaps and missing information that
22 allow us to address violence as a particular domain to

1 improve and reduce.

2 And then last, we get to then make and embed

3 specific recommendations in the letters that our interim

4 Chair, Ed Ehlinger, has sent on to Secretary Becerra, and

5 there's been a series of those letters, and I encourage

6 you to read them as he has already pointed out in each of

7 your orientation.

8 A good example, and that's what I'll close with

9 is when we look at the DRAR, Data and Research to Action

10 Recommendations from about a year ago -- actually, not

11 even that, August 2021, we said we wanted to strengthen

12 research and data for equity, that we wanted grater

13 enhanced data systems, interoperability. And we wanted to

14 augment mortality and morbidity reviews and make them

15 stronger. We wanted to assure the inclusion in research

16 that affects women and infants so that women of

17 reproductive age, pregnant and breastfeeding people are

18 part of health services research and not an afterthought.

19 And we wanted to advocate for monitoring the

20 impact of social inequities, particularly during

21 emergency. So, take a look at the data specific

22 recommendations, because there will be some that will

1 accompany all future SACIM recommendations. So, we have
2 data and research that lead to action.
3 One last thing that I want to highlight that is
4 near and dear to my passion as a storyteller, as somebody
5 who's a story maven and believes in the power of stories
6 to link and grade with data for public health. And in one
7 of our recommendations, we said expand the traditional
8 concepts and definitions of evidence with the valued
9 inclusion of community voices and lived experiences,
10 especially individuals from Black, Indigenous and people
11 of color communities. And so this notion about what are
12 data, we get to influence that. We get to stretch the
13 boundaries and make sure that we lift up voices and
14 stories for fuller inclusion to bring the data to life, to
15 humanize the data and catalyze that political will.
16 We may, a couple of times between meetings, you
17 get to opt in. I will be looking to transition to another
18 leader. Sure wish you'll follow up with me. And if
19 you've been part of the SACIM meeting and presented on
20 violence or otherwise and you want to opt into this
21 particular workgroup for the next year or two, please let
22 me know. I welcome you and I will be confident that we're

1 handing off an essential part of our three-legged stool.

2 And Ed, I'll pass it back to you to then go to

3 Belinda and Janelle.

4 ED EHLINGER: Thanks, Magda. And the Health

5 Equity Workgroup has had co-chairs, which has been – co-

6 leads, which has been really nice, Janelle Palacios and

7 Belinda Pettiford. I don't know which one of you would

8 like to speak to the group about what your work has been

9 about.

10 BELINDA PETTIFORD: Janelle, do you want me to

11 start and then we can both chime in? So, Janelle and I

12 have had the pleasure of really working together on the

13 Health Equity Workgroup. It has been amazing to work with

14 Janelle. You just got a touch of Janelle in today's

15 meeting, but I get to work with her one on one, so please

16 know anybody coming to this group, the pleasure that I've

17 had.

18 So, we've been able to work with an excellent

19 group of folks. We have representation on the Federal

20 level from the Office of Minority Health, from CDC. We've

21 had some HRSA folks, specifically the Maternal Child

22 Health Bureau. We've had ACOG at the table. We've had

1 ACNM at the table. We've had AMCHP, we've had Healthy
2 Start at the table and numerous others.
3 I think initially much of our work was focused
4 on COVID and specifically making sure our recommendations
5 were covering historically marginalized populations in all
6 of the work that was going there. We were seeing the
7 challenges with social determinates of health that
8 everyone was seeing, and we wanted to make sure some of
9 those recommendations got back to the Secretary.
10 We also have spent a great amount of time, which
11 is definitely needed, with focusing on American
12 Indian/Alaska Native Indigenous populations in general and
13 making sure we have strong recommendations. I mean, we
14 were fortunate to have Janelle's passion in the group, but
15 the rest of the group was definitely very supportive, and
16 the more we delved into it, the more we realized what was
17 missing and how much more needed to be done.
18 We have spent time looking at and diversifying
19 the workforce, and that has been much of the reasons
20 around having our recommendations and conversations around
21 race concordant care and all of those components that are
22 a part of it. And you know, we still value that

1 importance of community engagement, so to us, we wanted to
2 hear the voices of people that were impacted on a regular
3 basis. So, we opened up our meetings. We tried and
4 (voice faded away) sometimes more frequently, depending on
5 what we're working on, but it has been really nice to have
6 a co-chair. And I would encourage you all as you move
7 forward to consider this committee, to consider it as a
8 co-chair model. It has worked very well for us having a
9 co-chair model. And I think Janelle and I won't be going
10 far, so I think as long as we can, we would love to stay
11 engaged in the work and will not move too far away from
12 you all, but our time will be ending sometime this summer.
13 I don't know, Janelle, what is missing, what
14 else do you want to add?
15 JANELLE PALACIOS: I guess one other piece that
16 I would add is that for the people who are doing the
17 health equity work, especially for people who have the
18 experiences of how important health equity is and infusing
19 and everything that we do, that aside from the distinct
20 recommendations and work that we're doing targeting
21 maternal child health and maternal infant health, that we
22 also think more globally in terms of how can we change

1 norms in our American culture to support health and
2 wellbeing for all people?
3 And so, I'm asking, really, to think about long
4 term of like what's the hand washing for our time, when
5 hand washing was introduced and we saw dramatic decrease
6 of infections for all people, what's the hand washing of
7 our time? And so, I'm just asking the future committee to
8 think about what's going to be the hand washing of our
9 time? Is it that we help facilitate our country to come
10 face to face with its history? How do we do that? Or is
11 it something else?
12 I think that's the only thing I would add.
13 ED EHLINGER: As you can see, a lot of work has
14 been done with these three workgroups and a lot of work
15 remains. We will never be at a loss for things to do.
16 This needs to be an ongoing effort. So, if anybody would
17 like to participate in one of the workgroups, either as a
18 lead or as a member, just send me a note or send a note to
19 the current workgroup chairs.
20 MAGDA PECK: Ed, if I could, I just want to
21 acknowledge the role that you have played insofar as these
22 three workgroups don't work independently, and you have

1 put in the extra work to assure the cross talk and
2 integration so that we leverage these three focus areas.
3 And so, in many ways there's a quiet group of the leaders
4 that have gotten together or you communicate with on a
5 regular basis, and that is hugely attributing to the
6 success of our being able to move forward with strategic
7 speed and with focus. So, thank you, Ed.
8 ED EHLINGER: All right. Thanks, Magda.
9 **PUBLIC COMMENT**
10 ED EHLINGER: All right Lee, do we have people
11 for public comment?
12 LEE WILSON: Yes, we do. Good afternoon. Thank
13 you, Ed. First, I just want to introduce that at every
14 advisory committee meeting we do provide an opportunity
15 for public comment. We make that announcement in the
16 Federal register, and we allow for a written comment and
17 for verbal or oral presentation to the Committee. We have
18 set aside this time on the second day at 3:00 o'clock for
19 that presentation. I would like to point out that Frances
20 Crevier from the National Council of Urban Indian Health
21 submitted a written comment to the Advisory Committee and
22 that statement was shared with Committee members at the

1 end of the day yesterday. And for the record, that has
2 been submitted.
3 We've received two requests for an oral
4 presentation to the Committee and I'm going to ask our
5 logistics people to make sure that we can bring those
6 people on to provide public comment. One is Sylvia
7 Edwards, who is the immediate past president and current
8 treasurer of the National Lactation Consultant Alliance,
9 and Yvonne Bronner, who is a professor at Morgan State
10 University.
11 So, we will provide approximately three to five
12 minutes for each of the speakers to present to the
13 Committee. After each presentation, if Committee members
14 would like to raise a question, that is fine. We are not
15 opening the floor, though, for observers to be asking
16 questions.
17 So, if Sylvia Edwards is available, I'd like to
18 ask her to make her comments to the Committee.
19 EMMA KELLY: Sylvia, if you're in the audience,
20 can you please raise your hand so we can allow you to
21 speak? But Professor Bronner is on in the meantime.
22 LEE WILSON: Okay. While we're waiting for

1 Sylvia Edwards, why don't we begin with Yvonne Bronner.
2 YVONNE BRONNER: So, I am unmuted?
3 LEE WILSON: Yes, you are.
4 YVONNE BRONNER: Thank you. Thank you, Dr.
5 Ehlinger and ACIMM Committee for the opportunity to
6 present our initiative to bring MCH academic programming
7 into our HBCUs. The purpose of this initiative is to
8 address the historical and legacy disparities in infant
9 mortality and the rising maternal mortality ratio.
10 Why do we need MCH academic programming in our
11 HBCUs? It's because they are geographically located where
12 the disparities are very high. Students often come from
13 these high-risk areas, and students go back, our HBCU
14 students go back to these areas to practice.
15 So, why don't we already have MCH academic
16 program in our HBCUs? It's because you need to be a
17 school of public health to be eligible for the funding,
18 and with one exception, we only have public health
19 programs. In 1999 we formed the Consortium of
20 African/American Public Health Programs to facilitate the
21 growth of our HBCU public health programs to become
22 schools, but only one has reached the status, and that's

1 Jackson State in 2018. And therefore, our first
2 recommendation to MCHB is that this funding barrier be
3 removed.
4 There are three partners in this initiative. Of
5 course, the first is the Consortium. But we have ten HBCU
6 partnering universities, Howard, St. Augustine, Chicago,
7 Morgan State, Jackson State, Tuskegee, Bethune Cookman,
8 Tennessee and Morehouse. And of course, we're being
9 supported by the Maternal and Child Health Bureau and I
10 wish to thank Dr. Michael Warren for his embrace of this
11 initiative and for them helping us to have alterum to
12 support us.
13 Now, this initiative has three short term
14 objectives and our long-term proposal. The first one is
15 to develop a strategic plan, and this plan will have smart
16 objectives. It will be problem solving. We want academic
17 programming that is informed by community needs
18 assessments and environmental scans, and we want to use
19 this kind of local measures and metrics to hold us
20 accountable for progress in terms of infant mortality and
21 maternal mortality in the areas where we're located.
22 We also want to address the social determinates

1 of health that are upstream drivers of these disparities,
2 such as education, income and housing. And while at the
3 same time addressing two MCH strategic objectives, which
4 are equity and workforce production, diversity.
5 Now, we also want to provide recommendations to
6 MCHB, and these are emerging from our strategic planning
7 process. And then finally we want to produce a funding
8 proposal. And this funding proposal will have two parts.
9 One is that it will produce a coordinating center, and
10 then two, it will have a staff of people working at each
11 one of our ten institutions that are trying to have MCHB
12 academic programming.
13 In terms of the coordinating center, it will
14 have two parts. Of course, one will be to provide an
15 administrative infrastructure for this project, but the
16 most important piece will be that it will house a think
17 tank of interdisciplinary MCH specialists who will help us
18 vision and inform an emerging MCH academic program that
19 will be centered on the community. And it will also train
20 the new faculty that we have to hire in this paradigm.
21 In the interest of time, I will not be able to
22 provide any further details on this initiative, but I

1 welcome you all to the Thrive Summit on Thursday, April
2 the 7th, and this has already been mentioned by Dr.
3 Warren, at 12:00 noon, where I will be providing a more
4 in-depth presentation on our initiative.
5 I want to thank Dr. Ehlinger and the ACIMM
6 Committee for this opportunity to present, and of course,
7 I welcome your questions.
8 LEE WILSON: Dr. Bronner, thank you for your
9 comments, for your address to the Committee. If you would
10 like to submit additional follow up information with
11 additional specifics, we'll be sure to share that with the
12 Committee. Do the Committee members have any questions?
13 Dr. Peck.
14 MAGDA PECK: Thank you so much. What a
15 thrilling and exciting area to see developed. I'm putting
16 on a different hat. I'm a recovering dean of a school of
17 public health and if you will, a new school of public
18 health and I have actually been the co-founder of two
19 schools of public health, and I was curious about the
20 intersection between you looking for MCH academic
21 programming from MCHB with the other support organizations
22 such as the Association of Schools and Programs of Public

1 Health, or the accrediting body, the Council and Education
2 in Public Health, so that one could anticipate some
3 creative models for durable infrastructure that's not
4 about a one off program when the money dries, it goes
5 away.
6 And so, in the gap between where you are not and
7 an accredited school of public health and having lived
8 that gap multiple times, I'm wondering how you are
9 reaching out and connecting in your summit and in your
10 conversations with the Bureau with those other schools and
11 programs of public health support organizations, and if
12 you're looking towards future models for accreditation,
13 including a consortium model across a couple of different
14 HBCUs. We can follow up later, but I am delighted to hear
15 this, putting on my former academic hat, and I applaud you
16 all for investing in this essential area.
17 YVONNE BRONNER: Well, thank you so much for
18 that question and I certainly will be happy to follow up
19 with you later, but let me just state that we are in the
20 process of reaching out across the existing school of
21 public health that have MCH programming, and we will be
22 working with SPH and other organizations that are

1 important at the local level, state level, Title 5 level,
2 all levels. And we're doing this as a part of our
3 strategic planning process.
4 MAGDA PECK: Excellent.
5 YVONNE BRONNER: Thank you.
6 LEE WILSON: I don't see any other hands. I
7 just received a note on the side that we have not had
8 Sylvia Edwards identify herself at this point. While we
9 wait, I'll give another 30 seconds or a minute. I do want
10 to acknowledge that there may have been somebody who would
11 like to make a public comment and has not yet. So, if you
12 would be interested in doing that, if you would put a note
13 in the box and we do have a couple minutes left, so we can
14 provide an opportunity for that. This is something that
15 we have done in the past and we'll just continue with
16 that.
17 So, I'll give 30 seconds for that.
18 All right, then. That is all of our public
19 comments. Thank you all for sharing – thank you for
20 sharing your input, Dr. Bronner, and we'll return it back
21 to the meeting.
22 **DISCUSSION AND NEXT STEPS**

1 ED EHLINGER: And I do note we've got some
2 discussion time set up, but I do know that Colleen Malloy
3 is now on the phone and -- or on the Zoom, and Colleen,
4 would you give your little two minute introduction, you
5 know, the rest of us gave earlier today about, you know,
6 what was your story that brought you to this Committee and
7 the work that you do.
8 COLLEEN MALLOY: I thought I was off the hook.
9 ED EHLINGER: Never off the hook, never off the
10 hook.
11 COLLEEN MALLOY: Well, this is going to be a
12 little bit off the cuff then but let me go to a better
13 place for my Wi-Fi, hold on. I have been listening for
14 the past two hours, but I apologize, I had some clinical
15 stuff this morning, so I couldn't get out of it.
16 But let me find a better spot. I'm actually in
17 between my next hospital, so hold on one second. I just
18 go from all these different hospitals, so I have to keep
19 all my passwords straight and all my sign in logos
20 together, so here we go. Okay.
21 Sorry, you're not supposed to do a Zoom in front
22 of a mirror. Okay, so my name is Colleen Malloy, and I

1 did have the pleasure of hearing all the new members
2 introduce themselves yesterday, so welcome to this
3 Committee.
4 So, I guess this is more of a story than my CV
5 facts here. I guess my story, I was thinking about, since
6 I had mentioned that would be requested of us, I mean, I
7 think about, obviously maternal morbidity and infant
8 mortality, and my great grandmother, in having her tenth
9 child in Minnesota, she was an immigrant from Ireland, and
10 she was giving birth to my grandfather, and she died in
11 childbirth. And so, you know, I think of how far we've
12 come, and we have a long way to go, obviously, it still is
13 not perfect, but I do think about the situation from, you
14 know, a woman who is my great grandmother who probably
15 didn't have much beyond an eighth grade education dying in
16 childbirth to my grandfather, and then here I am, you
17 know, was able to get an education, go to school, become a
18 neonatologist and have three children of my own, which was
19 not – oh, hold on. I knew that would happen. I've got to
20 go check a – hold on.
21 ED EHLINGER: We're holding on.
22 COLLEEN MALLOY: Okay, can you hear me? There.

1 So, I think that, you know, everyone has struggles. I
2 think that sometimes it's easy to forget that. So, like
3 even my own personal story of having children was brought
4 with issues and difficulties, and everybody has, I think,
5 a journey and a struggle. And so, what I -- you know, my
6 story is really when I go to work like to – oh, my gosh,
7 my kid just walked past. Please go away. This is my
8 journey, this is my struggle, because it's always trying
9 to balance everything. And I really look at, you know,
10 how can I impact the families and help them find happiness
11 in child -- brining their families to fruition, and you
12 know, I really, as I've said this before in this group,
13 that I'm a fierce defendant of babies and the unborn, and
14 I really feel like, you know, that is a group when you
15 talk about violence, like they're so fragile, they're so
16 delicate, they're so helpless. And when I look at like a
17 newborn in the NICU, like they're completely relying upon
18 what help we can give them, and as much as their families
19 can do, which is a lot. I mean, I think that it's
20 interesting the babies can kind of sense when their
21 family, their parents are around. I feel like getting the
22 mom to be able to pump breast milk for the babies makes a

1 huge difference.

2 So, I feel very honored to be able to

3 participate in that special interaction with the babies

4 and their families, and the people always say to me, how

5 do you do neonatology, it has to be so hard and such a

6 difficult field. And to be honest, like 95 percent of the

7 babies go home to an intact family, and it’s so rewarding

8 to be able to be a part of that.

9 The five percent that doesn’t go well is beyond

10 tragic and so sad, but I still feel like I have a role to

11 play in that as well, and I think that that’s where even

12 helping be a part of like a graceful, respectful dying

13 process for a baby is a very important role for a doctor

14 or anyone, a nurse, a provider.

15 I actually had a situation recently at the

16 hospital where it was an older child who passed away in

17 the ER, and she had a number of genetic issues, and so

18 maybe for people who haven’t kind of walked that road, one

19 might think, okay, you know, that was her -- she lived

20 beyond what she was told she could probably live, she

21 outlasted her diagnosis and she, you know, passed away at

22 about a year-and-a-half. And for maybe people who hadn’t

1 witnessed that journey would think, okay, you know, that
2 makes sense, that's kind of how it's supposed to be. And
3 to see the mother hysterical beyond -- I mean, that is
4 still her baby, like, and no matter what problems or
5 genetic issues or shortcomings that this child had, this
6 mother, I mean, it was the same as if you or I lost our
7 child.
8 And so, I think it was important, even for me,
9 I've been doing this for over 20 years, and like it's
10 important to see how, you know, that is so important. And
11 so I think when I come to this committee and my focus has
12 always been to try to keep the focus on the infant of the
13 infant mortality, because a lot of other people here are
14 speaking for the mothers, including the mothers,
15 themselves, and I feel like, you know, that's been my kind
16 of role, is to keep reminding people how this committee
17 originally was titled, and I think it's fine that we added
18 maternal to that, but I think like the truly voiceless
19 ones are the babies, so they kind of need, in my mind, at
20 least, to come first.
21 But I have appreciated my role here. It's been
22 -- sometimes I think like maybe this job would be better

1 served when I was in retirement one day because I wouldn't
2 have had all these different like levers pulling at me,
3 but you know, I do what I can and I'm kind of the silent
4 observer. So, even if you think I'm not participating,
5 I'm still actively listening, and I think that it's just -
6 it's hard to kind of carve out.
7 Sometimes I see people in their office and I'm
8 like so jealous that you have four hours to be able to sit
9 uninterrupted in your office, but it's just that's not my
10 time right now. Eventually that will probably be my time.
11 So, I apologize if even today was chaotic, but I did think
12 that I was off the hook. But thank you for your friendship
13 and everything, and I'm hoping that I can make it to the
14 June meeting, and I appreciate everything I've learned,
15 it's been fabulous.
16 ED EHLINGER: Thanks Colleen. You did a great
17 job off the cuff, and I'm glad you didn't get off the
18 hook. So, thank you.
19 COLLEEN MALLOY: Thank you.
20 ED EHLINGER: So, before we sort of move into
21 sort of the next steps, I would like to kind of close out
22 what we've heard over the last couple of day. I would --

1 and I know, you know, we haven't done Myers-Briggs Type
2 Indicators for everybody on this Committee, but my guess
3 is there are some introverts who, you know, just didn't
4 want to jump in and have some conversation.
5 So, I'm going to take just a few minutes. I
6 don't want anybody to give long speeches because that
7 could go on forever but are there things that you just
8 really wanted to say during any of the conversations that
9 wen on over the last day, any sort of insight that you
10 would like to share, or any question that you would like
11 to pose, not to be answered right now, but that you'd like
12 to pose for us to think about as we move forward?
13 So, let's just take a little bit of time to get
14 that, you know, particularly from the introverts, things
15 that you really wanted to say, jump up into the space, and
16 so just unmute yourself. You don't have to raise your
17 hand, just unmute yourself and jump in.
18 You all want me to pick out the introverts and
19 say all right, come on, you got to ask a question.
20 BELINDA PETTIFORD: I'll jump in, Ed. And I
21 have introvert and extrovert tendencies, so it just
22 depends on which day you find me.

1 I do want to -- and I, unfortunately missed part
2 of the conversation about intimate partner violence. We
3 had a Medicaid meeting here in North Carolina that I could
4 not miss. I want us to be cautious on how connected with
5 the fatherhood work, because I don’t want us to turn
6 fatherhood into just an intimate violence program,
7 intimate partner violence program because, you know, our
8 experience in fatherhood is that they need the same
9 support that moms need. So, I just want us to be very
10 careful with that and how we frame it.
11 I know we talk about parenting; we talk about
12 fatherhood, and we all know the importance of fatherhood.
13 We are very fortunate here in North Carolina, we have
14 three Federal Healthy Start programs in our state, and so
15 we value the fatherhood piece that have integrated into
16 other areas. But we are moving into intimate partner
17 violence. It has to be broader than that and that can’t
18 be the opening that you start with fatherhood.
19 We really want to make sure it’s a welcoming
20 space and that dads feel that in the whole part of being
21 supportive as a parent themselves.
22 So, that’s the one area I want to make sure

1 we're careful on.
2 ED EHLINGER: Thank you. And everything I've
3 learned with introverts, you have to let some time, quiet
4 silence is not a bad thing to give people time to think
5 and generate their courage to move forward.
6 JACOB WARREN: One thought I had is we were
7 discussing some of the screening for intimate partner
8 violence and some other things. As a resident of a non-
9 Medicaid expansion state surrounded by other non-Medicaid
10 expansion states just, you know, keeping at the forefront
11 of our mind as we're thinking about clinic-based
12 recommendations and things that are predicated on access
13 to healthcare that for a large portion of the women in our
14 state used to be 90 days after pregnancy. Now, we've
15 recently thinking it's expanded to six months that they
16 have access to healthcare. And so, we had to think about
17 sort of broader access points and gatekeepers and capture
18 methods to be able to make sure that we're continuing to
19 provide the support that sometimes we assume that is
20 continuing through medical care settings.
21 ED EHLINGER: Thank you. And Jacob, I thought
22 it would -- I cut you off, you had your hand raised on an

1 earlier presentation and I cut it off before, so I
2 apologize, so I'm glad you spoke up.
3 And I'm going to ask – and so I got a note from
4 Charlan Kroelinger, who is our now CDC ex-officio member.
5 Charlan, do you want to say hi and make a statement? It
6 would be good to introduce yourself.
7 CHARLAN KROELINGER: Hi everybody. Can you hear
8 me, Ed?
9 ED EHLINGER: Yes.
10 CHARLAN KROELINGER: Apologies for the technical
11 issues yesterday. I did want to let the panel know, and
12 the public know that Dr. Barfield has really enjoyed her
13 time on the Committee and sends her regards to everyone,
14 and that certainly, I'll communicate everyone's comments
15 and thoughts to her.
16 There are a couple of things I did want to add
17 from the prospective of the Division of Reproductive
18 Health at CDC. I know we are one of a couple of divisions
19 that support the work of this Committee, and I just wanted
20 to add that the discussions on health yesterday are very
21 important. And at CDC, I think you all know the director
22 acknowledged that the Agency is transforming its public

1 health research surveillance and implementation science
2 efforts to shift from simply listing the markers of health
3 inequity to identifying and addressing the drivers of
4 these disparities.
5 And we have an initiative called the Core, and
6 I'll drop that link into the chat for those who are
7 interested in more information, but specifically for our
8 division, we are very focused in implementing routine data
9 collection or linkage of data elements related to the
10 social determinates of health and our major surveillance
11 systems. So, we hope to have in that integration we lead
12 in in the next couple of years.
13 And we are also interested in incorporating the
14 community patient perspective, and all major programmatic
15 initiatives, and in particular, the work we do with
16 maternal mortality review committees, which I know we
17 talked a little bit about today, and some of the
18 presentations, and we really hope to incorporate that
19 information to reduce disparities among disproportionately
20 impacted populations.
21 And if you haven't had a chance to see or hear
22 her campaign, I'll drop that link into the chat too.

1 We've just released a new component focused on maternal
2 warning signs and are interested in focusing on other
3 underserved populations in the future.
4 So, I also wanted to add a comment about some of
5 the discussion that was made yesterday on tribes. We're
6 hoping to better engage tribes in our division's work. We
7 hope to partner with tribes, tribal leaders and tribal
8 serving organizations. To better examine maternal
9 mortality.
10 I think the discussion of the Committee was loud
11 and clear yesterday, and we're also engaged in a new
12 funding opportunity led by our center to support good
13 health and wellness in Indian country.
14 So, there are investments in that area, but I
15 think we can continue to mobilize and always appreciate
16 the thoughtful discussion of Committee members.
17 So, thank you for allowing me to sit in and I
18 look forward to continued conversations at future
19 meetings.
20 ED EHLINGER: Well, welcome, welcome. I know
21 Wanda has done a great job and I expect you to do the
22 same, so thank you.

1 CHARLAN KROELINGER: Thanks, Ed.
2 ED EHLINGER: Any other wrap up comments from
3 what you learned, what you heard, what impressed you, what
4 you really wanted to say but didn't have an opportunity to
5 say before we move on?
6 MARIE-ELIZABETH RAMAS: Ed, I was trying to give
7 some time because I know I've been vocal and that's a
8 reflection of my excitement to be on the group. One of
9 the things that I'd love to explore here is how can we
10 help the Secretary in bringing medicine and how we see
11 maternal infant health into the 21st and 22nd century, how
12 can we use innovation in order to bring these very
13 important public health medical mental health materials
14 and opportunities to our patients and to the community as
15 opposed to the community coming for access.
16 We are at an extremely exciting time, I think,
17 in our history where we can take advantage of our
18 technology in a way that we've never been able to leverage
19 before. And so, while we're looking at leveraging
20 technology as a resource recognizing as well that
21 technology is also a social determinant, and you know, how
22 can we as an advisory help propel and reduce disparities

1 regarding technology access and usability, and literacy as
2 well?
3 So, that's something that I think has emerged
4 over the last couple of days and I'm going to be
5 marinating on that over the next several months.
6 ED EHLINGER: Great. And Joy, you have your
7 hand up?
8 JOY NEYHART: I do. I'm sorry, I'm having a
9 technical difficulty with my camera. But I am a new
10 person to this committee. I feel like after two days or
11 two half days of this meeting, I know a lot less than I
12 did two days ago. So, I have a lot to learn, but I also
13 feel like I will have a lot to contribute. And I think,
14 you know, listening to what goes on in our country, we
15 have great medicine. We don't have great foundation to
16 get people to the medicine that they need. I don't think
17 advances in medicine are what we need. We need advances
18 in decreasing the social determinates that cause these
19 problems that we're trying to alleviate.
20 So anyway, I really look forward to working with
21 everybody over the next four years. Thank you.
22 ED EHLINGER: Thank you, Dr. Neyhart. So, one

1 of the things that struck me, particularly during that
2 violence presentation, how underappreciated violence is
3 among the MCH population from healthcare, and yet how
4 crucial it is to overall health. I mean, just the data,
5 that 25 percent, up to 25 percent of maternal mortality is
6 by homicide. And like that just shocked me. I mean, I
7 sort of knew it, but I didn't sort of viscerally bring it
8 in. And hearing all of those things about how important
9 it is, it's just -- and we haven't had much time to talk
10 about it. It was one of the things that really struck me
11 during these last couple of days.
12 All right, then let us move on. So, let me just
13 first start -- we have our next meeting is going to be, I
14 hope -- I think we have to make some decision by April 1st
15 or something, depending on what's going on with COVID and
16 travel, but I'm hoping that things will stay and we'll
17 actually be able to have an in person meeting in June in
18 Minnesota with a travel day of June 13th, which is a
19 Monday, then have a three-day meeting, the 14th, 15th and
20 16th.
21 Now, first of all, it's going to be -- we've
22 only had -- this will be our first in person meeting in

1 two years. And this is going to be a unique meeting
2 because I think this is probably the first time ever that
3 SACIM met outside of Rockville. And we're going to be on
4 a tribal land for this meeting. And the first day of this
5 meeting is planning to have – just basically be an open
6 mic for community groups, for individuals, for
7 organizations focusing on the Indigenous health to come,
8 and basically testify before this Committee. It's almost
9 like a congressional hearing where people will come -- I'm
10 hoping that they will come in and share the stories.
11 And I plan on having it at the Shakopee
12 Mdewakanton Sioux community, which is just outside the
13 Twin Cities. So, it's about 30 miles, 20 to 30 miles from
14 downtown Minneapolis, which will allow for both focusing
15 on Tribal Indians and Urban Indians, because Minneapolis
16 has a large Urban Indian population, so we will get both
17 reservation and non-reservation, urban and rural folks.
18 Also, at a place where a tribe that has -- a lot
19 of times we focus on the deficiencies and the problems
20 facing, we don't focus on the assets. The Shakopee
21 Mdewakanton Sioux community is a thriving community that
22 has lots of positive things going on. So, I want to both

1 look at the problem issues, but also the resiliency and
2 the creativity, and the imagination that they have
3 bringing things forward, so we'll do that.
4 And so, the first day, which will basically be
5 an open meeting for presentations by the American Indian
6 community. It's in the Bemidji area, so I'm hoping that
7 we also have the Indian Health Service, and because we're
8 focused on Indigenous folks, and because we got -- I won't
9 say it -- we didn't have a presentation by HIS. I want HIS
10 leadership to be there.
11 I also really want to try to push to have
12 Secretary Becerra there. This is going to be a big deal,
13 because I'm going to -- I don't know if I can do it -- our
14 Lieutenant Governor is an American Indian. I hope she
15 will attend, or the governor. I hope our two senators
16 will attend, just to raise the visibility of Indigenous
17 health and the health of moms and babies. So, I'm hoping
18 that we get some good Federal participation from HHS
19 folks. So, that's going to be a challenge for HRSA and
20 MCHB to try to get Secretary Becerra there.
21 So, that's day one, which is June 14th. June
22 15th will then be focusing on coming up -- from what we've

1 heard and from the work that's going to be done between
2 now and then on the recommendations related to Indigenous
3 health.
4 And then the final day, June 16th, which will
5 basically be a half day. The first two days will be
6 probably from 9:00 to 4:00, something like that. The last
7 day will get done at noon so you can travel out on
8 Thursday. But that morning will basically be talking
9 about the transition. Where do we go from here? How do
10 we hand off some of the work that's being done? What are
11 the issues that's going to be forward?
12 So, first day, listening to the stories of the
13 American Indian community. Second day, focusing on the
14 recommendations and finalizing those. The third day
15 basically planning the transition and moving forward.
16 So, between now and then, you know, we need to
17 meet with Indian Health Service. And I'm assuming the
18 Health Equity Workgroup, I'll try to work with them. But
19 anybody else who would like to be at that meeting, please
20 let me know so that we can hear from IHS because we have
21 more ears in listening to what they have to say.
22 We then need to draft some potential resolutions

1 based on all of what we've learned over the last year and
2 what we learned from IHS, draft some draft resolutions and
3 distribute those to all SACIM members so we can get some
4 feedback and some input on that.
5 We need to develop all of the support documents
6 that go to support those recommendations because we can't
7 just pull something out and say, y 9ou know, this is our
8 belief. We have to have some documentation and supporting
9 documents.
10 And then we have to be fascial enough and
11 flexible enough so that when we get the firsthand input on
12 that first day of our meeting to take that in and
13 incorporate whatever recommendations are input from the
14 community on those recommendations. So, there's probably
15 going to be some homework the night of the very first day
16 of our meeting to put those things into place.
17 So, that's the work that I see needs to happen
18 between now and June, and that's my goal. So there are
19 lots of other issues that we can bring up, but I really --
20 I think we can make a statement about American
21 Indian/Alaska Natives, Indigenous folks that is going to
22 be really powerful, because I don't think anybody's quite

1 focused on it quite this way.
2 So, this is an opportunity for us to really have
3 an impact on a group that has really been ignored, and as
4 we know from, y9ou know, the work of the Children's
5 Bureau, back when it first got started, that the work
6 dealing with the people who are most disadvantaged
7 actually helps everybody. It is not just -- I think if we
8 focus on the needs of the Indigenous population,
9 everybody's going to benefit.
10 Our senator here in this state, Paul Wellstone,
11 he said we all do better when we all do better. And I
12 think that is sort of the focus that we want to make sure
13 we take.
14 So, questions about that? And Lee, any
15 particular logistic pieces related to that?
16 LEE WILSON: So, we're at the process right now
17 of modifying the logistics contract to make it possible
18 for us to have this meeting. We had given ourselves until
19 April 1st to see what the health conditions were and the
20 sort of pandemic potentials there. So far, it's all
21 looking good. We will hold the trigger for definitely
22 making that decision on or around April 1st, and so,

1 please don’t make any plans until then, but please mark
2 your calendars to be available for those times.
3 After we cover this, I do have proposed dates
4 for the following two meetings, but from a logistics
5 standpoint, we are working with Dr. Ehlinger to arrange
6 the location for the meeting in Wisconsin and to make it
7 possible for all of you to be there.
8 I know that there are a couple members, at least
9 one member whose appointment expires midway through, and
10 we will be in touch with you about -- midway through that
11 meeting and we will be in touch with you about trying to
12 modify that to make that possible.
13 ED EHLINGER: Thank you. And I really do hope
14 that all of you can be at that meeting in person. I mean,
15 we have not been able to meet in person and that’s been a
16 real loss, because you miss so much, particularly, you
17 know, just those stories that we heard over the last two
18 days, even though they were virtual, they were really
19 powerful. Those are the kinds of things that you can
20 sometimes hear over lunch, or over dinner, or over an
21 adult beverage, you know, just something that gives you
22 some time to really get to know each other.

1 So, we're going to be -- Colleen, we're going to
2 be in Minnesota just outside of Minneapolis. Kate?
3 KATHRYN MENARD: Thanks. Just that logistics
4 question of Minneapolis. That helps a lot so we can kind
5 of begin our planning. I think for some of us there's a
6 lot of advantage of having advanced notice. You know,
7 clinical schedules get made out four or five months in
8 advance, so, perhaps, you know, dates for such quick
9 meetings will be, you know, released, you know, the sooner
10 the better. That way we can -- it won't be disruptive to
11 our partners when we have to step away. I'll do my best
12 to step away for Minnesota, but it's summertime, you know,
13 and we have to work around clinical schedules sometimes.
14 ED EHLINGER: We hear you loud and clear.
15 You're not the only one.
16 KATHRYN MENARD: I know. Tara.
17 TARA SANDRA LEE: Yeah, my one question was
18 related to that. Is there any way that we could --
19 especially for those that have medical clinic
20 responsibilities, is there any way we can condense it to
21 two days? I just wonder if that would be more convenient
22 for a lot of people, if there's any way to do that.

1 ED EHLINGER: I personally believe that we have
2 never had a ---we always talk about hearing community
3 voices, and we never build – we've never had enough time
4 to really build those. And this is one way, really having
5 a day to hear those voices.
6 Now, we are going to -- I'm sure we're going to
7 have capabilities for virtual attendance, because that has
8 to be part of, I think, what goes on, if we're going to
9 have testimony from others who are not able to travel,
10 we'll have that virtual kind of thing, and I'm sure that
11 would be possible for one of those days, you know, if you
12 couldn't make it for the full time.
13 But I hope you can. I know schedules are tight
14 and three days is asking a lot, I appreciate that. But I
15 also think it's important, and I think just showing up is
16 a statement to people of the community that you're here to
17 listen, you're really committed to this.
18 So, I would like not to condense it to two days.
19 I think we'd miss a big piece of what both can come out of
20 this in-person meeting on tribal land.
21 All right. Any other work that needs to be done
22 between now and then that I didn't highlight?

1 MAGDA PECK: Ed, this is Magda. As you know,
2 you know, we will continue to utilize the infrastructure
3 of the workgroups, and so both Belinda and Janelle and I,
4 and I assume Steve, you know, as we are continuing to
5 advance the work, including Indian Health Service and
6 Indigenous health related, but also related to the
7 potential other recommendations coming forward. We will
8 just know that those meetings, virtually, will be
9 initiated by the workgroup leads. And so the sooner we
10 know where our new members would like to land - and it can
11 be more than one, you can check it out - the better it
12 will be.
13 The way we tend to do this is to target the
14 people who are signed up as opposed to doing a blanket
15 announcement to all of SACIM. So, looking forward to
16 doing that work for Data and Research to Action.
17 ED EHLINGER: Thank you. I forgot to mention,
18 one of the other reasons that it’s nice to meet, I’m
19 hoping at the Shakopee Mdewakanton Sioux community. It is
20 eight miles from the Minnesota Women’s Prison. And I
21 don’t know about your state, but American Indians get
22 imprisoned, incarcerated more than any other population

1 group. And pregnant women in the criminal justice system
2 are abused. Talk about violence. Shacked while they give
3 birth, not able to have their babies with them, not able
4 to have breast pumps. I mean, it just -- and I'm hoping,
5 and there's a prison doula program here in Minnesota that
6 we could highlight as part of that, which also raises –
7 are there issues that you would like to hear about related
8 to Indigenous women and infants at this meeting in June.
9 So, if there are, if there are some individuals that you
10 would like us to reach out to or some issues that you'd
11 like to particularly raise, please let me know. Send me
12 an email or whatever to raise those issues. But, you
13 know, it just -- we have an opportunity, like I said, to
14 make a difference here.
15 MAGDA PECK: One last thing, Ed, I'm just noting
16 that we have some members of SACIM who are not with us
17 today. I wanted to acknowledge the hard work and
18 contributions of Dr. Paul Jarris, who was a member of
19 SACIM until just recently, and it was people come, people
20 go, but I just wanted to acknowledge the camaraderie and
21 the contributions that Dr. Jarris has made to SACIM until
22 he stepped down.

1 And there may be others that are in transition
2 who may not be in June, but I just wanted to make sure
3 that Paul was acknowledged with appreciation. Thank you.
4 ED EHLINGER: Thank you, yes. And also, and I
5 mentioned Paul Wise, who has been a contributor and who is
6 doing other MCH work in Poland at this point in time. So,
7 I'm hoping that he will also be able to join us in June.
8 All right, Lee, other work that we need to be
9 aware of?
10 LEE WILSON: So, Kate, you asked and so I will
11 share what we're looking at currently as potential dates
12 for upcoming meetings through the remainder of the year.
13 We have two additional meetings to keep with our four
14 meetings -- our four meeting per year schedule, and this
15 is a request for all of you to weigh in on whether or not
16 those dates will work or not.
17 So, none of this is set in stone. We are
18 currently looking at September 13th and 14th, which is a
19 Tuesday and Wednesday for a virtual meeting or Rockville,
20 Maryland. It is not defined yet. We will be sort of
21 playing things by ear as we progress through reopening due
22 to COVID.

1 The December meeting that we're looking at, that
2 would be the fourth meeting of the Committee. We're
3 currently looking at December 6th and 7th, again, either
4 virtual or in Rockville.
5 Our schedule currently, as we're completing our
6 new logistics contract, is designed to have tow in person
7 meetings and two virtual meetings. Virtual meetings are
8 generally two days, and we'd like the idea of having the
9 virtual meetings to provide an opportunity for the
10 Committee to bond, to engage on sideline topics to talk
11 about ad hoc working groups and the special projects that
12 they may be working on, so we do encourage that, and we
13 support the travel and reimbursement for your expenses for
14 those activities.
15 And I also wanted to update you on the Committee
16 nomination process. We welcome the eight new members who
17 are on board, came on board this time, this time around.
18 We have a second package that we are winding through the
19 process. It is going to take some time before those
20 members are brought on. The current number that we had
21 proposed for the package that came on is less, which is
22 typical than what was originally proposed. So, we are

1 continuing to strive to bring our numbers up to the target
2 of 21, which is the maximum number of full-time members –
3 of full members that the legislation provides.
4 So, we hope over the next cycle or two that we
5 will be able to get to a number close to that 21, and we
6 do provide opportunity for public input and for Committee
7 input in future members, and they do go through a process
8 of looking at representation, both geographically, gender,
9 ethnically and professionally. So, we will be serving you
10 over time to identify options for new members. But for
11 the current package, that one was put together a number of
12 months ago and that is continuing through the process
13 right now.
14 I think those are, and Anne Leitch, you can jump
15 in here if I have forgotten any other talking points here,
16 but I think that covers my housekeeping items.
17 ANNE LEITCH: Lee, that does cover your
18 housekeeping items, so thank you, and I don't have
19 anything further to add.
20 ED EHLINGER: Well, there's one. My guess is
21 that some members who are going to be cycling off of SACIM
22 may actually hit that place where they have to fill out

1 all those damn forms, particularly the ethics forms, so I
2 -- which is a royal pain in the you know what. But I'm
3 encouraging you, if you don't do that, you won't be able
4 to come to the June meeting and we really need you at the
5 June meeting, so take the time to respond to whatever the
6 ethics requirements are, because we really need you there,
7 your voice is so important.
8 JANELLE PALACIOS: I want to share a personal
9 experience that learning about stocks was not the best
10 time when filling out these forms. I went on a shopping
11 spree with a few hundred dollars on an app and bought tons
12 of like penny stocks and I had to report all of those.
13 Don't do what I did.
14 ED EHLINGER: All right. Any other questions?
15 Let's go around. We've got ten minutes at the max. I
16 don't want to go over, but I do want to give you an
17 opportunity to just, any, you know, brief reflection, even
18 just a word if necessary or a few words about, you know,
19 what you're taking away from these two days together. And
20 I'll start on the second page, that's sort of the middle.
21 Janelle.
22 JANELLE PALACIOS: What I've learned so far is

1 that we all have -- we all come from backgrounds and
2 experiences that are going to really shape our nation for
3 the next 20, 30 years, and I'd like us to look farther
4 down the road. And I believe that the way that HRSA is
5 able to shape this Committee that that will be done, and I
6 look forward to that for my grandchildren.
7 ED EHLINGER: Great. Magda.
8 MAGDA PECK: SACIM was empaneled in 1981 --
9 1991? 1991, thank you -- 1991. I have two responses to
10 today. One is an extraordinary sense of confidence in the
11 capacity and the leadership of the folks who will continue
12 this work into its fourth decade. So, thank you to our
13 incoming new members. You are spectacular. We've missed
14 you. We're so glad you're going to take the mantle and we
15 will be on call to you. So, there is a sense of optimism.
16 And I'm ticked that we're still doing this and
17 having the same conversations that I had back in that
18 conference room with Julie Richmond, or ten years later at
19 the beginning of SACIM. It should not take 40 years in
20 the desert. I would like to add urgency to getting this
21 stuff done. We have things we can do, and it is essential
22 for us to figure out how to accelerate the pace so that

1 moms live well and long, and babies blow out first
2 birthday candles.
3 So, I’d like to light a fire or urgency that
4 we’ve been waiting way too long for the major change to
5 happen, and we should not underestimate our power to be
6 agents of change. Thank you.
7 ED EHLINGER: All right, Belinda.
8 BELINDA PETTIFORD: My comments are very similar
9 to Magda’s. I’m so excited about the new members. I feel
10 like you are not new members, you just jumped right in and
11 hit the ground running and you just joined the family
12 really quickly, and it is so great to have you all here.
13 We are excited about it. I think a few of us may be a
14 little sad that we won’t be on a little bit longer to get
15 to work with you all, but you know how to find us because
16 many of us already know each other, and if we don’t, it
17 won’t be hard to locate us.
18 But I am also, you know, concerned that I
19 started in public health and MCH in the 80’s and we’re
20 still dealing with inequities and issues. So, we have got
21 to prioritize this and do better. And I know no one
22 person has the answer, but we have got to figure this out.

1 It is not getting better for our families and the
2 individuals we work with; it's getting worse. And part of
3 our responsibility is to move these recommendations
4 forward so that we can try to see those improvements. But
5 I'm so very excited about having this new team joining the
6 rest of us.
7 ED EHLINGER: Thank you. Marie.
8 MARIE-ELIZABETH RAMAS: I've already expressed
9 my enthusiasm with the caliber of new colleagues around
10 the virtual table, so I at once commit to being a voice
11 for those that I serve, but also am extremely excited to
12 get to learn from the -- both the institutional knowledge
13 and wisdom, professionally, from the group here. To think
14 that as a first generation American, that I would be
15 sitting amongst esteemed colleagues is a living out of the
16 dreams of my own parents for which they came to the United
17 States for, and I hope to serve in a way to continue to
18 bring new babies and birthing parents that same
19 opportunity. So, I am looking forward to working with
20 everyone and hope to serve you well and serve our country
21 well.
22 ED EHLINGER: Thank you. Dr. Sharps is not able

1 to be with us today because of some other things, so
2 ShaRhonda?
3 SHARHONDA THOMPSON: Hello. For me, the last
4 two days have been an eye opener. Just the grand scale of
5 inequity is amazing. It's definitely something that which
6 is my cause to go forward and to get this taken care of
7 because in order for the future to be better for my
8 children and my grandchildren we have to get this in
9 order. We have to make sure that everyone – that equity
10 is for everyone in order to make this world last, to make
11 the human race better.
12 ED EHLINGER: Thank you. Dr. Jacob Warren.
13 JACOB WARREN: Yeah, I just wanted to say I've
14 been struck by all the diversity representing the
15 Committee, and I mean that in the broadest sense of the
16 word, diversity. Diversity of thoughts, backgrounds,
17 experiences, perspectives and voices, and I think that is
18 the strength of this county and I think that it's amazing
19 to see it represented here and in the work that's going to
20 be done. So, I'm just really honored to be here. Thank
21 you.
22 ED EHINGER: Good. And Dr. Alderman had to

1 leave, so I couldn't get to her quick enough. Steve
2 Calvin.
3 STEVE CALVIN: Yes, I would echo Jacob's
4 statement as well. I have learned so much over my two
5 years. I'm really grateful for the new colleagues,
6 looking forward to additional ones, and you know, the core
7 mission of the Committee of addressing infant mortality
8 and maternal mortality and morbidity. They're goals that
9 we're right now in a country that's so divided on so many
10 levels, but that's something that everybody really can
11 agree on. So, it's fun to be part of that kind of effort.
12 ED EHLINGER: Good. Thanks. Charlene.
13 CHARLENE COLLIER: Thank you, again. I feel like
14 I've spoken a lot, but I appreciate -- truly humbled and
15 appreciate this great opportunity and being able to
16 connect with people I truly admire and I'm very humbled to
17 be here, and I think something I've taken away is sort of
18 being in this space where I feel so encouraged and
19 supported by such great advocates for this issue, I
20 actually am facing, even at the state level, quite
21 contrary of what Dr. Calvin presented or people in
22 opposition to the things we recommend, and in opposition

1 to extending post-partum Medicaid, in opposition to
2 doulas, in opposition to racial equity and things that I
3 think this Committee accepts as truth and good, that there
4 are folks out there that believe the absolute opposite of
5 what we are convinced in our soul will improve maternal
6 and infant health, and I think that's something I have to
7 grapple with, and I hope this Committee grapples with, not
8 shies away from what is standing in our way and how to
9 really understand those ideas, because I don't understand
10 them. To be honest, you know, once you believe something
11 is good and right, it's really hard to understand that
12 other side, but I think I really appreciate this
13 Committee's ability to confront those hard things and
14 hopefully challenge ourselves and push us as Janelle and
15 others have -- and Magda has pushed us to do and not, you
16 know -- and although I think we have those tools, but
17 simultaneously recognize and address those things that
18 have not allowed those tools to work.
19 So, it's not to be negative, but I think it is
20 to say that we have to bring, you know, that perspective
21 with every great idea of how to address whatever might
22 stand in its way. So, I'm very encouraged and excited,

1 and I appreciate your leadership, and it's been a great
2 two days. I look forward to being there in June in
3 person. I'm going to start working on that right away.
4 ED EHLINGER: Jeanne Conry.
5 JEANNE CONRY: Thank you. I really want to echo
6 Magda and Belinda's comments because I'm absolutely
7 heartened when I see this group that's coming on. You do
8 represent diversity, but you represent this positive
9 attitude. We cannot see 30 years taking place and still
10 being where we are. When I started, it was finally to
11 have OB/GYNs be able to have a voice. It's not moms or
12 babies, it's moms and babies, and we have to realize that
13 we're talking about the package and the package has to be
14 together and we'll speak on behalf of a healthy mom if
15 we're going to hope for a healthy infant, and all of the
16 social ramifications that comes with it.
17 I'm absolutely heartened to see the
18 administrative support that we've got, our current
19 administration and the attitudes that they have,
20 especially, you know, starting, certainly at the top but
21 with having Javier Becerra leading HHS. I think it's a
22 very exciting time for this Committee to be working. So,

1 good luck to everybody.
2 ED EHLINGER: Thanks. Tara. Tara Sandra Lee,
3 are you still on?
4 All right, Kate Menard.
5 KATHRYN MENARD: I have to say I’m feeling a
6 whole lot of weight on my shoulders. I’m delighted to be
7 part of this group, but I look at the people who are going
8 to be returning off, I feel like in two short half days
9 I’ve made some new friends, and Magda and Janelle, people
10 like Marie-Elizabeth, people I can call by first name
11 already, which is wonderful. I think it’s because we all
12 have this heart, you know, for the collaborative spirit
13 that is in our work outside this community and will be
14 pulled together in this Committee.
15 So, I’m really excited about that, but the task
16 is -- you know, the others that are rotating off, you’re
17 going to have to hold me up, because I’m feeling a weight
18 on my shoulders, and I’ll count on you.
19 ED ELINGER: All right, Joy.
20 BELINDA PETTIFORD: Ed, she put a note in the
21 chat that she needed to head to her next meeting.
22 ED EHLINGER: Oh, okay. All right. And

1 Colleen, I know you said you didn't need a spot, but you
2 got to say at least something, say goodbye if nothing
3 else.
4 COLLEEN MALLOY: Okay. Well, I'm driving to my
5 next hospital. So, again, I have to apologize to the
6 group, but I guess thank you for all the information and I
7 enjoy learning with you. I want to say with you instead
8 of from you because I think we all learn from each other
9 and thank you for all the time and energy everyone is
10 putting into it, and I do feel that same weight that Kate
11 mentioned, but I think the benefit is there's a lot of
12 people to kind of shoulder everything. It seems they
13 (audio faded away).
14 ED EHLINGER: All right, thank you. You're
15 cutting out, Colleen, so I'm going to move on. Dr.
16 Warren, Dr. Michael Warren.
17 COLLEEN MALLOY: Thank you and I look forward to
18 seeing you all in June.
19 ED EHLINGER: All right. Finally, Dr. Warren.
20 MICHEAL WARREN: Thank you, Dr. Ehlinger. It's
21 been such a great two days and someone, I think it was Ed
22 referenced the Children's Bureau just a moment ago, and

1 I'm reminded by the second chief of the Children's Bureau,
2 Grace Abbot, who gave the speech once that she called the
3 Washington traffic jam, and she described this great line
4 of vehicles that were moving toward the Capitol, the
5 Department of Agriculture, the Department of the Army, the
6 Department of State all sort of moving toward the Capitol
7 to make their voices heard on particular topics. It's a
8 very stirring sort of visualization of what she was
9 seeing, and then she ends with this really sort of
10 poignant note, and she says and then, because the
11 responsibility is mine, I grab the handles of the baby
12 carriage and I wheel it into the traffic.
13 And so, I'm so struck that there is this
14 continued cadre of people who are wheeling the baby
15 carriage, metaphorically, into the traffic, and I just
16 want to thank you all for that continued work. You
17 continue to challenge us. You continue to be such a pool
18 of ideas and wisdom for us as we think about how we design
19 and implement our programs and really appreciate all your
20 time and your expertise and look forward to getting to see
21 many of you in person in the summer, so, thank you.
22

1 **ADJOURNMENT**

2 ED EHLINGER: Michael, I'm going to end this
3 meeting by expanding on your metaphor. You know, today is
4 the birthday of Ruth Bader Ginsberg, and she said if
5 you're going to change things you have to be with the
6 people who hold the levers. If you are going to change
7 things you have to be with the people who hold the levers,
8 or I expand that to the people who know the people who can
9 control the levers.
10 You have knowledge of people who control the
11 levers in your state, in your organizations, and I think
12 collectively, nationally, we have some way to know the
13 people who hold the levers. So, that is our challenge.
14 And just like I started out with a quotation from Gaius
15 Cassius, the fault, dear Brutus is not in our stars but in
16 ourselves that we are underlings, that we don't use the
17 power that we have. It's not forecast what's going to
18 happen, we make things happen. You have the levers; you
19 can make the change.
20 We've got a great group. It's been demonstrated
21 over the last couple of days. Lots of knowledge, lots of
22 experience, lots of ideas, lots of creativity. So, we'll

1 move forward, and I look forward to seeing you in June,
2 and I look forward to volunteers for the workgroups and
3 people who want to join us with the Indian Health Service,
4 and we'll move forward with great gusto. Pull those
5 levers. Take care.
6 (Meeting concluded at 4:00 o'clock p.m.)