



ISSUE BRIEF

COMMUNITY CHALLENGES ENGAGING WITH MMRCs: HARMFUL DYNAMICS IN MMRC CULTURE

BACKGROUND

The United States (U.S.) has the highest maternal mortality rate among high-income countries;^{1,2} moreover, significant racial and ethnic disparities exist in maternal mortality.³ MMRC data has shown that 60% of these deaths are preventable.¹ Maternal mortality review committees (MMRCs) are in a unique position to collect and analyze information on maternal deaths to identify opportunities for prevention.^{4,5} MMRCs are intended to be multidisciplinary committees that conduct comprehensive reviews of pregnancy-related deaths to prevent future deaths.⁴⁻⁶ **However, MMRCs have struggled to identify, engage, and meaningfully include diverse community members who can speak to the essential context, including the strengths and needs of the communities they represent.**

In 2021, the Black Mamas Matter Alliance (BMMA) conducted an environmental scan of nine state MMRCs in the U.S. to gather information

about the opportunities and challenges MMRCs face as they work to broaden committee membership and community engagement. The purpose of this scan was to capture the challenges and opportunities as described by community members who have engaged, or attempted to engage, with MMRCs in an effort to help strengthen the capacity of public health leaders, including those administering and serving on MMRCs, and to better integrate strategies toward equitable practices across MMRC processes.

MMRCs are in a unique position to collect and analyze information on maternal deaths to identify opportunities for prevention.

PARTICIPANTS OF ENVIRONMENTAL SCAN DISCUSSIONS AND CONVERSATIONS

BMMA KINDRED PARTNERS AND COLLABORATORS (N=11)

Black women-led organizations and individuals who are guided by birth justice, reproductive justice, and human rights

COMMUNITY REPRESENTATIVES (N=11)

Members of state MMRCs who represent local community constituents

OTHER MMRC MEMBERS (N=8)

Chairs, coordinators, and abstractors of select state MMRCs

More information on the project and findings have been reported elsewhere,⁷ but this issue brief highlights one of three major themes that arose from these conversations: **harmful dynamics experienced by community members in MMRC spaces**. The brief centers the experiences of KP/Cs and community representatives (henceforth

referred to as “participants”) in reporting the findings. We also share potential opportunities for improvement that the CDC and MMRCs can take to better integrate and value the expertise of community members in the MMRC process.

KEY FINDINGS: HARMFUL DYNAMICS IN MMRC SPACES

Participants discussed the harm they experienced from participating in and serving on MMRCs. Respondents reported that the culture and dynamics of MMRCs could be unwelcoming; their viewpoints were frequently challenged, and other MMRC members were hostile towards them if they

expressed different views. Participants carried the burden of teaching MMRC members about racism and discrimination in maternal mortality, and they described the challenges of identifying bias in medical records, which often centered the voices of care providers versus the deceased birthing person.

CHALLENGES AND STRATEGIES ENGAGING WITH MMRCs AS IDENTIFIED BY COMMUNITY MEMBERS

CHALLENGES

Participation in MMRCs can be detrimental to communities:

- Culture and environment are unwelcoming and harmful
- Harmful and disrespectful conversations about patients
- Community representatives carry burden of teaching about racism and discrimination
- Centering of provider narrative, not the deceased birthing person

STRATEGIES

- Ensure proportional representation and BIPOC leadership
- Eliminate burden of proof mentality for evaluating racism and discrimination
- Integrate family interviews
- Improve orientation of MMRCs
- Institute anti-racism trainings
- Provide training and guidance on trigger tools

The following **CHALLENGES** were identified by participants:

1

MMRC culture and dynamics can be unwelcoming and harmful

Participants described the culture of MMRCs as unwelcoming and hierarchical whereby clinical viewpoints were valued over non-clinical perspectives. Participants reported experiencing or witnessing hostile behavior by other MMRC members when community members stated different viewpoints. One participant described how community members were accused of causing ‘tension in the meeting’ for expressing different perspectives when they were “just simply stat[ing] how we felt.” So that was one of those microaggressions that we felt as Black women that had spoken up.” When raising concerns about these issues, participants indicated they received no to little support from MMRC leadership.

2

MMRC members engage in harmful and disrespectful conversations about patients

Participants said conversations around maternal death cases could be trauma-inducing, and that the case narratives prepared by the abstractors have “offensive and inappropriate” language. They reported that there was a lack of respect for the deceased birthing person who were “blamed for their substance abuse, color of their skin and economics;” essentially birthing people were blamed for their own deaths. One participant described a time when an MMRC member laughed and used dark humor to say that the death could have been prevented by “us[ing] a condom.”

3

Community members carry the burden of teaching fellow MMRC members about the role of racism and discrimination

The burden of teaching fellow MMRC members about racism, both interpersonal and systemic, fell on community members as the role of racism and discrimination in maternal deaths was not well understood among MMRC members. Participants described that members were “stuck on blatant racism,” “don’t understand microaggressions,” and “don’t understand the different time period of racism we are in.” Participants indicated the need to “embed, acknowledge, and name racism as a root cause” in order to “automatically examine maternal mortality data through an [anti-racist] lens.” This lack of understanding among MMRC members frustrated efforts to identify the root causes of health inequities in maternal mortality and discuss adequate solutions that move beyond the status-quo.

4

Bias in medical records and the case abstraction process leads to a centering of the provider narrative

Participants stated that the medical records and abstraction process prioritized the viewpoint of the provider, not the deceased person. As one abstractor reported, “there is a lot of bias and medical documentation based on a nurse’s perspective,” and participants discussed the challenges of reviewing case narratives that were written by abstractors who had their own implicit biases and/or included biased information from medical records without context. Participants also shared instances where clinical staff used stigmatizing and racist language or failed to document discrimination in medical records or other data sources like family member interviews.

The following **OPPORTUNITIES FOR IMPROVEMENT** were identified:



Ensure anti-racist BIPOC* leadership and representation from those most affected on MMRCs

MMRCs should predominantly consist of the communities disproportionately affected by maternal mortality. This means including BIPOC or birthing persons with training in anti-racist praxis, holistic perspectives, and the social determinants of health, as well as those who have nearly died from a pregnancy complication or had a family member affected by maternal mortality. Shifting power towards BIPOC members and chairs who are trained in anti-racism could create more equitable, welcoming, and respectful spaces for communities to engage in identifying solutions to address maternal mortality. It could also help shift the focus from individual behaviors as the sole cause of maternal mortality to systemic racism and its root causes. This shift could also ensure that the experiences of the deceased birthing person are centered in the case narrative and subsequent MMRC recommendations.



Eliminate the burden of proof mentality for evaluating racism and discrimination

Participants described how efforts to document discrimination were hampered by interpretations that CDC required absolute proof in the medical records. Thus, using this standard was said to lead to an undercounting of the role of racism and discrimination in maternal deaths. MMRCs should move away from a medical model that requires burden of proof when evaluating the role of racism and discrimination in maternal deaths.



Integrate family interviews into case review

Family member interviews, conducted by health workers with trauma-informed training (i.e. social workers, counselors), should be integrated into the case review process to provide a more comprehensive perspective. Adequate trauma support services must be offered to family members who participate in the interviews to mitigate any harm from recalling the death of a loved one. Participants expressed that including the family member perspective would help to humanize the deceased birthing person and provide additional social context to be considered when discussing the cause of death and solutions.



Improve the orientation, training, and support for community members who are joining and serving on MMRCs

MMRCs need to improve their orientation for community members by informing them of the full responsibilities and expectations of being an MMRC member before joining. Community representatives want clarity regarding expectations as a committee member, the technical nature of the committee, and the demands of the position. This includes informing participants of potential secondary trauma and providing support for their wellbeing if they choose to join.

* BIPOC stands for Black, Indigenous, People of Color



Institute anti-racism trainings

MMRC members need anti-racist trainings that go beyond implicit bias and delve into structural racism. When MMRCs are reviewing cases and determining whether racism and discrimination played a role in the maternal death, they should look at both interpersonal and systemic racism as a contributing factor to the death. MMRCs would benefit from shifting their focus more holistically to address systemic racism and explore the root causes of health inequities in maternal mortality.



Provide training and guidance on tools that help assess racism and discrimination

MMRCs should use trigger tools, or simple and effective methods to systematically identify and document racism and bias in medical records. Tools like Texas' Discrimination Assessment and Social Determinants of Health Facilitated Discussion tool⁸ were recommended to help standardize the process and to help check implicit bias while abstracting cases. MMRCs must be given access to these tools and adequately funded to work with equity consultants to operationalize them to identify racism and discrimination in medical records.

CONCLUSION

Participants presented a variety of challenges and potential opportunities for MMRCs to integrate equitable practices throughout their processes. They maintained that all conversations regarding maternal deaths, policy solutions, and improvements needed to address the systems contributing to maternal mortality should start and end with communities. Community members have the expertise and ability to bring new solutions to MMRCs. However, this requires incorporating BIPOC leadership and proportional representation* onto MMRCs to shift power to community members, and to move beyond token efforts to diversify membership.

Integrating equity into MMRCs requires systemic change and that can only be achieved when the communities who are most impacted are meaningfully engaged throughout the data collection, review, recommendation, and implementation phases. State and local MMRCs need funding, training, and support to accomplish this, and CDC has the opportunity to provide these tangible supports to MMRCs in their pursuit to create a more equitable review process. Below are brief recommendations that participants identified as useful starting points for both CDC and MMRCs to consider in addressing the challenge of harmful dynamics experienced by community members in MMRCs.

* The intent of this recommendation is to broadly increase community representation on an MMRC by encouraging MMRCs to shift its representation and leadership towards the Black and Brown people who disproportionately represent maternal deaths nationally. This recommendation is not intended to be applied as a formula to fill a quota on an MMRC.

RECOMMENDATIONS



Listen to and center the experiences of community members



Increase transparency of MMRC processes and data



Diversify membership and meaningfully engage communities



Strengthen capacity of MMRCs to better examine and address racism and discrimination



Provide training, guidance, and resources to strengthen the capacity of MMRCs

REFERENCES

1. Petersen E, Davis N, Goodman D, Cox S, Mayes N, Johnston E, et al. Vital signs: pregnancy-related deaths, United States, 2011–2015, and strategies for prevention, 13 states, 2013–2017 [Internet]. Centers for Disease Control and Prevention; 2019 May [cited 2021 Sep 3] p. 6. (MMWR Morb Mortal Wkly Rep). Available from: <https://pubmed.ncbi.nlm.nih.gov/31071074/>
2. Tikkanen R, Gunja M, FitzGerald M, Zephyrin L. Maternal mortality and maternity care in the United States compared to 10 other developed countries. [Internet]. The Commonwealth Fund; 2020 Nov [cited 2021 Sep 3]. Available from: <https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries>
3. Hoyert D, Miniño A. Maternal mortality in the United States: Changes in coding, publication, and data release [Internet]. Hyattsville (MD): U.S. Department of Health and Human Service; 2020 Jan. Report No.: 2. Available from: <https://pubmed.ncbi.nlm.nih.gov/32510319/>
4. St. Pierre A, Zaharatos J, Goodman D, Callaghan W. Challenges and opportunities in identifying, reviewing, and preventing maternal deaths. *Obstet Gynecol*. 131(1):138–42.
5. Report from maternal mortality review committees: A view into their critical role. Building US capacity to review and prevent maternal deaths [Internet]. CDC Foundation; [cited 2021 Sep 13] p. 50. Available from: <https://www.cdcfoundation.org/sites/default/files/upload/pdf/MMRIReport.pdf>
6. Review to Action. *7 Things To Know About Maternal Mortality Surveillance and MMRCs* [Internet]. Review to action: Working together to prevent maternal mortality. [cited 2021 Sep 13]. Available from: <https://www.reviewtoaction.org/learn/7-things-to-know>.
7. Black Mamas Matter Alliance Research and Evaluation Department. *Maternal Mortality Review Committees: Sharing Power with Communities*. Atlanta, GA; 2021 Nov.
8. Howell E. Identifying racism & discrimination as contributing factors in pregnancy-related deaths [Internet]. [cited 2021 Sep 21]. Available from: <https://portal.ct.gov/-/media/DPH/Maternal-Mortality/Identifying-Racism--Discrimination-as-Contributing-Factors-in-Pregnancy-Related-Death.pdf>

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THE BLACK MAMAS MATTER ALLIANCE (BMMA) is a national network of Black women-led organizations and multi-disciplinary professionals that work to ensure all Black Mamas have the rights, respect, and resources to thrive before, during, and after pregnancy.

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