Testimony of Yewande Oladeinde
Health and Government Operations
Support HB0334 with Amendments (FWA)
January 27, 2025

Good afternoon, Madam Chair and Members of the Health and Government Operations Committee. My name is Dr. Yewande Oladeinde, and I reside in Frederick, Maryland. I am a resident of Frederick, Maryland, a leader in the immigrant community, the Chair of Frederick County Immigrant Affairs Commission, and a co-founder of Black Mamas Building Bridges (BMBB). We are a group of four committed and passionate women who advocates for equitable maternal and infant health outcomes in Frederick County. We do this through education, creating a space for dialogue that addresses inequities in health care while connecting underserved women to community resources.

According to the Centers for Disease Control and Prevention (CDC), Black women are three times more likely to die from pregnancy-related causes and complications than White women. According to the CDC, a pregnancy-related death is defined as "a death during pregnancy, delivery or within 1 year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy." More than 80% of these deaths are preventable. The leading cause of these deaths varied by race and ethnicity. According to MacDorman and colleagues (2021), late maternal deaths — those occurring between six weeks and one year postpartum — were 3.5 times more likely among Black women than white women.

In Maryland, between 2016 and 2020, the maternal mortality rate (MMR) was 17.5 per 100,000 live births compared to 20.9 per 100,000 live births nationally across all races. The 2016-2020 Black NH MMR was 2.3 times higher than the White NH MMR showing persistent racial health disparities. In 2020, the NH Black infant mortality rate increased by six percent from 9.3 to 9.9 deaths per 1,000 live births. While Maryland has made tremendous progress in reducing overall rates of infant deaths, racial/ethnic disparities persist.

The state has a constitutional responsibility to ensure that all Maryland women have a right to equitable, not EQUAL maternal and infant health care. Equality means everyone benefits from having equal or the same support, which we know is not true. Equity on the other hand means that every mother and infant, especially those who are most at risk, get the support they need to attain optimal maternal and infant health. What this bill does is to provide a universal nurse home visiting program, which is more about equality.

I was a recipient of a home visiting program when I was pregnant with my first child while I was a broke, graduate student. At the time, I was living alone, while my husband was miles away from me in another state. I met the eligibility requirements being a first-time mother, and low-income. I was visited often in my home by a community health worker (CHW) working together with a nurse to provide social support, education, check my vital signs throughout my pregnancy and after I delivered my son, before relocating. I was fortunate to be matched with a

CHW who shared similar African cultural background as me. She put me at ease, because I felt she could understand and incorporate culturally appropriate practices related to birthing into my care. I had a lot of anxiety due to my negative experience with the health care system, the implicit biases I had faced from clinicians, and my past reproductive health history. Participating in this program helped me tremendously, and I am certain it was a key contributor to me having a successful birth outcome.

We urge you to support HB334/ SB156 with amendments to ensure that the bill is equitable by:

- Revising the language of "universal newborn home visiting program" to one that prioritizes a **targeted universalism** approach where the overall goal of the program remains the same for all families, such as supporting healthy child development, maternal health, and strengthening families, but providing a targeted approach to those families with identified risk factors. The home visiting program will be offered to all families, but with individualized and culturally appropriate and tailored support provided to families identified as being at-risk due to having greater risk factors or needs based on factors like socioeconomic status, health risks, or geographic location, allowing for more intensive support and focused intervention while still reaching all families with basic support.
- Revising the language that limits the home visiting programs to only registered nurses. This should be expanded to include **community health workers**, working with registered nurses. This will be an effective strategy for reaching high-risk individuals, improving care and outcomes, addressing health-related social needs and inequities. The bill should offer provisions for expanding the perinatal workforce capacity by engaging CHWs as part of the home visiting program. This will help reduce the risk for adverse birth outcomes, improve prenatal and postnatal care.
- Revise the language that states the service will be provided to birthing individuals within 12 weeks after delivery. This is inadequate as data from the 2017 - 2019 Maternal Mortality Review Committee, suggests that most (30%) pregnancy-related deaths occur 43-365 days postpartum. The home visits should be provided starting during pregnancy and **up to 365 days postpartum**, at a minimum.
- Prioritizing the collection of equity-focused data tracking metrics, disaggregating data collected by race, ethnicity, income, and zip code (geographic) location to see if there are any differences between different population groups.

Thank you for your time and consideration. I urge you to support HB0334 with amendments that emphasize the critical role of Community Health Workers in achieving these goals.