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BOSTON UNIVERSITY
BIRTHING AND RAISING THE NEXT GENERATION: HOLISTIC APPROACHES TO ADVANCE RACIAL AND SOCIAL EQUITY

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>> MICHAEL STEIN: Hello, hello, hello. To your seats, please. Good afternoon, my name is Michael Stein, and I serve as interim Dean at Boston University School of Public Health. On behalf of our school, welcome to today's public health conversation. These conversations are meant as spaces where we come together to discuss the ideas and issues that matter most for health.

Through a process of conversation guided by expert speakers we work to build approaches that get us to a healthier world. Thank you to everyone who helped make this conversation possible including the Dean's office and our communications team.

We are here today to reflect on the current landscape of maternal and child health in the United States. The U.S. has the highest rate of maternal deaths of any high income nation, a challenge worsened by the racial inequities that too often characterize maternal health in this country. Today we reflect on those challenges as well as on opportunities at this moment to improve our national health outcomes.

We are hosting this program in honor of the 30th anniversary of the BUSPH Center of Excellence in Maternal and Child Health, Education, Science, and Practice.

(Applause).

Following today's speaking program, we welcome all persons

to join the MCH 30th anniversary reception taking place in the Talbot Building. We will get you there if you don't know where that is. I look forward to learning from our speakers today. Before we get them up there, I would like to take the opportunity and I have the distinct privilege of introducing the Keynote speaker, our Keynote speaker, Dr. Melissa Gilliam. She is Boston University's eleventh President. She is a physician and interdisciplinary researcher focused on adolescent health and wellbeing. She joined the Boston University from The Ohio State University where she served as Executive Vice President and Provost from '21-2023. Dr. Gilliam spent most of her career at the University of Chicago where she was the LNH Block Distinguished Professor of Health Justice and Vice Provost. Throughout her career, she has been committed to academic excellence, access and affordability, student success, creating an inclusive culture and external impact. Thanks for being with us here today.

>> MELISSA GILLIAM: Thank you so much, Michael. Good afternoon, everyone. I am so happy to be with you today. It's just in the sincerest way, I am just happy to be with you and within this company. I wanted to congratulate you for your 30th anniversary. What an amazing thing, and what an honor and it's just so exciting to celebrate this with you.

This is a place that has been educating MCH practitioners, clinicians, scientists, students for generations so congratulations to you in all that you do. Last week I had the opportunity to visit the School of Public Health and I spoke to a number of you all and your colleagues, and I know that there are a number of concerns that many of you all are experiencing, so I just wanted to take a moment to acknowledge that. I know that you are worried about your research, about the communities that you impact and so I really acknowledge that and I'm so, I am so sorry that you are feeling these things, but for a moment, let's leave some of those things out of the room because this is really a critical time. It is a critical time, yes, for us in academia and in organizations, but it's really a critical time for the people that we care about and the people we serve, and to I think these are moments that we have to think with both optimism and tremendous resolve because this is what you do when you are committed to service.

And so today your conversations and I'm so sorry I will not be able to stay for them, but it's about raising and birthing the next generation. This is an incredibly important topic, but it gives us an opportunity to think about the ark of maternal child health, the ark of women, communities of color and the history of racial and social disparities in maternal and child health, and this is really a long one.

It's rooted in systems and structures that carry inequality, and that go back to quite a long time. When we think about the history of families, black and brown families in the 19th Century, we know that there is distinct and unethical behavior in the ways that, and I'm an OBGYN, so how black women were experimented upon, how segregation and housing and other opportunities have really contributed to the challenges that we are experiencing now.

One of the things that was so helpful for me as I left the medical center and came into universities was how precisely we have been able to measure the ways that biases and attitude lead to disparities in health. And so I would say it's not a fiction. We know that people get actual differential access to pain medication based on their race and ethnicity. We know that if you come in for cardiac catheterization, the time to which the balloon will be blown up in one of the vessels of your heart will differ based upon your background. And so we have in public health and in medicine the ability to measure the inequalities.

And so we are living at a time when we know so much about what causes disparities in maternal child health and obviously we have a lot more to know, but the concern is that we could roll back.

And so as we are starting to think and think again and think anew about how we take these advances we have in science and medicine and reimagine our relationship with the communities and the policymakers and the people who need to take up these advances, I think that is the critical question.

And so I'm really excited that today you will be having these types of conversations that you will be asking about the future of maternal child health and I encourage you to think broadly and to understand at times like this things we took as fact we might have to reimagine and rethink.

And so I've also been asked to share some of my own experiences thinking about issues of health and justice, and I actually welcome that because it gives me an opportunity to talk about how this idea of rethinking the dogma, rethinking the things that you thought you already know as a way of innovating and thinking of moving forward.

So my own work has been as an OBGYN, I focused on adolescent reproductive health. And this has shown me just how important it is to think about not only our own training, but also the communities with which we work and bringing these communities in as true partners. Now, for me this has been an adolescent health and I have worked predominantly with young people, and my work has really been in promoting adolescent health and wellbeing.

And this started about 25 years ago when I was conducting my first ever research study. I was a resident and it was the early 2000s, and I was starting to look at this body of research, and it was really driven by thinking about the clinical care of black and brown adolescents, and I keep seeing one statistic after another. What it was doing is it would compare black teenagers and say they are more likely to get pregnant and they are more likely to get a sexually transmit the infection, they are more likely to smoke, more likely to get HIV than white teenagers. In other words, throughout my training, well-intended, I think, but was persistent negative narrative about black sexual health and parents were so worried that they would bring their children in and say give them contraception, give them a three month shot, put an implant rather than listen to what their children were saying about their own sexuality and their health.

And so as I started to think about where I would focus my research, I decided to focus on black and brown teenagers who became pregnant within one year of giving birth, and if you have ever had a pregnancy, you know a year, within a year is probably not what you desire, so it felt like a pretty important interval.

But what's more important from a maternal child health aspect is it carries a tremendous amount of risk, preterm delivery, multiple other challenges for both the mother and the offspring.

And so in the study I wanted to understand whether a high quality counseling intervention alongside birth control pills which was the predominant form at the time could decrease rates of rapid repeat pregnancy for first time adolescent mothers and I thought I have done everything right. I involved young people in the design of the intervention, I held focus groups, I did everything that was considered a best practice at the time, and off I went to do my study.

And so in OBGYN your postpartum visit, the six-week postpartum visit, you come back and I will teach you the things you need to know. So I was sitting in clinic and it dawned on me, nobody is actually showing up. And if I had just looked at my clinical list I would have said, oh, this person canceled, this person, and I wouldn't have noticed. I would have had a full day, but when I was actually tracking the young people, I suddenly realized they hadn't shown up. So I started calling them and they said, Dr. Gilliam my elevator broke and I'm on the tenth floor and I would have to climb down ten floors or I had a pediatric visit or I got kicked out of school because I couldn't get to school on time and that's more important.

So here I had this intervention all about counseling,

right, I'm going to explain how to take birth control pills but I hadn't actually understood their setting. So I about this time I had read this article, it was in The New York Times, it was called Separate But Unequal. And it was talking about the segregation in the City of Chicago, and their idea, what they talked about is there are disparities in everything from transportation to child care or access to banks, access to schools, and right nestled in there was teen pregnancy. A

nd it was, the light you bulb went off, and, again, you have to give me some grace because this is early 2000s, and so I said oh, my gosh, these are what we now know as the structural and social determinants of health, but we were designing best practices without taking those into account.

So and then here I was, I just trained, I spent all of this time training in medicine and then going to public health school and I thought where is this gap? I trained in this city in medicine, so this truly was a good training.

And so around that time I read the work of a psychologist Vonnie McLoyd and it stayed with me. What she said, and I'm quoting, we do not need to create databases on black and brown children that parallel non-Latinx white middle class children. Instead we need ultimately relevant constructs and to systematically document the precursors and developmental outcomes by young people in a culturally sensitive framework. In other words, understand people on their own terms, not in comparison to people who have had different opportunities and different life courses.

So really how do we start to understand people on their own terms? So I started thinking about a whole new way of conducting research, and working with adolescents, and so for that study I left the clinic, got a van, started working directly in communities, sat in living rooms, visited schools, went to community centers, meeting adolescents in their homes, in their living rooms, using their own words. Eventually I created a center called CI3 and this center is still going, but it was really about thinking about the assets of young people, thinking about positive youth development instead of counseling at young people, but codesigning with young people. I started to ask this question, what if the process of research could leave you with more than it took away? What if doing research was an opportunity to actually build skills in young people? Take them and make them part of the project, not the subject of the research.

So what we did is we helped them tell their stories through writing, drawing, coding, animation, recording, presenting. We trained them as designers and content creators, we cocreated everything from podcasts to graphic novels and digital stories.

They spent the summer at the university meeting students and faculty and learning that they belonged in the classroom. In short, too many young people are told what they should not do, don't smoke, don't drink, don't have sex. These admonitions come from a good place. We want a lot for young people.

But what young people really need to know is what they can do. They need to know how they can excel and what special gifts they and only they can bring to the world, and this has been shown to be an effective strategy to prevent smoking, drug use, pregnancy for adolescents regardless of their socioeconomic background, status, country of origin.

And so when you help young people build skills and feel their power and ability in the world, then they live healthier lives. So I like to say that piano lessons prevent teen pregnancy, after school programs prevent teen pregnancy, being an athlete prevents teen pregnancy, education prevents teen pregnancy, so we need to help people focus on their strengths and minimize their limitations.

So you will recognize this as human capital, which is kind of the combination of health and education and skills that individuals possess that in turn drive innovation and productivity within organizations, cities and societies, and I use this term from economics because I was at the University of Chicago so long my collaborators were economists, but I want you to understand that the commitment that we can make to young people is not just because I'm a doctor or an educator or a person of color, but it's actually enlightened self-interest for us as a society not to waste talent. And if we invest in all young people, then we are not wasting human capital, and we are not losing their contributions to society.

And that investment just happens to prevent bad health. And is far more cost effective and far more rewarding than healthcare.

So I know a lot about human capital, in black communities from a firsthand basis. I know a lot about maternal child health under my own experience. So my grandmother, she was I think originally from Memphis and then my mom was raised in Louisville, and my grandmother originally had ten children. Only five who lived to adulthood, one with Down Syndrome, so it gives you a sense of intergenerational, of generations and maternal child health over generations. My grandmother was born in 1900.

My daughter was, I'm sorry, my mother was the daughter of a minister and was raised in Louisville, and when she was 12 her Father became very, very ill and could no longer lead his Church so the family moved to a rural area of Kentucky and that allowed my grandmother to work and care for the family. And essentially

they became a sharecropper. They went to be the first family of the Church to essentially sharecropping with a bathroom outside of their house.

But the one thing is my mother had a really, really good high school that she was able to go to. My grandfather died when he was 14, and she, this was devastating because he was so important to her, and she was the Apple of his eye and he really put education first. So they lived in difficult situations. She went to a great high school. At 16 she went off to college. And she went to a school that she was one of five black young women in an all-women's college in Kentucky, but at the same time she started working in the black weekly newspaper. And so initially she had a job at the Louisville defender and they asked her even though she was young to cover stories and she covered stories of black society, and so she went to the Kentucky derby and covered black businesses and she started to see how rich and complex the black community in Kentucky was.

And eventually she would just continue to scaffold that, this is a whole other story I will save for another day, but she ended up going to journalism school, she ended up at Colombia for journalism and became the first black woman at the Washington reporter, at The Washington Post.

So I tell you that story because it shows you why I believe, but I want you to believe that when you empower a young person, you changes that young person, and you change a family and you change a community, and you change society.

So that's what I mean by human capital, that idea of good health and education is why I became a physician, and now a University President. So I became a doctor to help people and in turn I learned that the solutions lay outside of the clinic, and outside of the hospital, and in the lives and experience and wisdom of patients themselves.

And now I lead a university because I believe that it is the combination of research and education and clinical care that heals people, will heal society, will heal the planet and change the world.

So I don't have to tell this audience, probably I should give this talk to another audience, invest in people, right, invest in people. Recognize the power of community, and the role of collective action in driving measurable change.

So I will finish by telling you a little bit about Boston University where we are, and last week I was so excited to publicly announce a new presidential initiative to reimagine the partnership between our university and the Boston Medical Health System.

So the hospital is actually a separate entity from the university. We formed a joint Executive Committee of senior

leaders from the Medical Center and the University to look for new strategies so we could maximize our institution's shared impact. Now, I know this is a really tough time in healthcare, in public health and higher education, but we see very real political and societal head winds challenging us to do the work that we all know matters.

But it is more important than ever that all of the work that we do, that we all work together to do this work, whether it's through research, whether it's through clinical care or through supporting our communities of students, faculty and staff and the people of Boston who rely on us for this care.

One of the things that I really like about talking to Dr. Bell who runs the Boston Medical Center systems is we talk about the things that happen here, the things that happen in these communities have an out sized influence on the national landscape. People will say, oh, that thing that you are doing is, you know, we are doing this thing, and it's like, yes, it started here in these communities.

And so I know that you all are worried. I know that people are already overworked. I know that people are already tired and we are asking us to work even harder with even more head winds, but each of you is such an asset to this community, to the work that you do, to the communities that you serve so I encourage you to just listen deeply and I hope that you leave with renewed energy and optimism and determination for the very important work that you do. Thank you so much, thank you for letting me have some time with you, and I just, I really appreciate it.

(Applause).

>> MICHAEL STEIN: Well, that's a great way to start. So thank you, President Gilliam. And I have the pleasure of introducing Lois McCloskey Director of the Center of Excellence for Maternal and Child Health, and she will introduce our speakers and today's conversation. Lois, over to you.

(Applause).

>> LOIS McCLOSKEY: Thank you, Dean Stein. I must begin by thanking you, President Gilliam. I am so honored that you took your time, particularly right now to spend time with us and share your experiences, your insights, your research with us. How inspiring it is and heartening at this moment to know that the person leading -- I'm going to tear up. Excuse me, the person leading our University gets it in her bones what it is for children and women and mothers and families to flourish without the constraints -- with, and then without the constraints of racial and social inequities.

And to know that the person leading our University is a public health thinker, a systems thinker, a solver, a community

engagement committed person. And has led health justice initiatives and been a clinician throughout her year. It is inspiring, heartening, and very, very reassuring. Thank you, thank you.

I thank you, Dean Stein and your amazing team that has put it together with their usual aplomb. And in honor of the Center of Excellence.

I want to thank you for coming, those in person and those online as well. It is important that we gather together now more than ever in person to be together and to remind ourselves of what we know and what we are already doing and will continue to do despite the disruptions that are occurring in our values and in our work.

So let me now begin by introducing our speakers, I'm first going to introduce the birth justice panel, three people, and they will speak, present one after the other, and then I will introduce the economic justice panelists and this will end with a moderated conversation with all of them inviting questions from you both here and online. Starting off is Nashira, she is the daughter and great granddaughter of midwives with a Master's Degree in maternal and child health from Boston University. And 20 years of experience designing and implementing public health strategies to advance racial equity, Nashira founded the neighborhood birth center in 2015, ten years ago, and co-founded the birth center equity in 2020.

So as many of you may already know, the neighborhood birth center will be the first of its kind community birth center in Boston providing full scope community midwifery to strategically address the maternal health crisis we are in the midst of.

Nashira brings structural analysis and embodied practice so all that she does. She has worked at Boston public health commission as well as the Harvard School of Public Health and human impact partners. We are proud to have you join us. I will introduce the next speaker so she can come up one after the other. Next we will hear from Dr. Ndidiamaka Amutah Onukagha -- not so good on pronunciation, but I will keep working on it. She is the Julia Ocoro of black maternal health at Tufts university in the Department of Public Health and Community Medicine at Tufts University. Dr. Onukagha is the Founder and Director of the Center for Black Maternal Health and Reproductive Justice and Maternal Outcomes of Translational Health Equity Research Lab.

She is the founder of the largest conference on black maternal health in the United States convened every April.

She received her master’s in public health from the George Washington School of Public Health and her Ph.D. in public health from the University of Maryland.

In her research she investigates maternal health disparities, infant mortality, reproductive health, social justice and HIV all as it is experienced by black women. She served as the inaugural Dean of Diversity, Equity and Inclusion at Tufts University School of Public Health and professional programs.

And third on the justice panel, Dr. Viveka Prakash-Zawisza is an experienced physician leader and innovator with a passion for exploring how public policy and systems impact healthcare delivery and social justice. At Mass Health, that is Massachusetts Medicaid, she is our senior Medical Director and clinical lead for accountable care and also for maternal health policy.

She also helped to lead strategies for member and community engagement at the agency and she is an Assistant Professor of OBGYN and is a Board Certified OBGYN. She holds a degree in global health policy and still provides clinical services in low resource settings in this country and internationally. She is passionate about social justice to address social inequities and promote a healthcare system that promotes joy and wellness for everybody.

>> NASHIRA BARIL: Thank you. It's good to be here. I will set myself a time. I want to start with my own birth story. It was 1979. My mom a single white mother gave birth to me in a Connecticut hospital, denied by nurses to have her best friend present, she had an emotionally traumatic labor and delivery and when they took me away to the nursery so she could rest, she wept inconsolably to which they responded by calling for a psych consult. Fast forward seven years she opts to have a home birth with my sister and, again, two years later another home birth with my brother and I not yet double digits bear witness to the care of midwives to my mother's power and to how home and community have always been vessels for sacred care.

I came to BU, I was thinking about this I walked out of the parking garage, in 2003, so a really long time ago. I was such a baby.. And in time I learned about their decades long vision for a birth center in Roxbury and how systematic power had been wielded against them continuing to advantage hospital obstetrics over community midwifery as it has been since the turn of the century which midwifery was nearly rendered illegal in many states.

Fast forward to 2013, I have my own world changing world shaking transformative home birth, and as a public health student, live long student I was driven by how to scale that experience that I had to the population level, right, because it was a story different than all of my peers, and certainly different than the data that I knew so well. So I turned to

Dr. Rory and other midwives and said can we try again. And thus began the next ten-year chapter of trying to open Boston's first birth center. I will talk more about neighborhood birth center but I want to ground in the vision for birth justice, which is a vision for reproductive justice. I spent time just a week and a half ago at Smith College with Loretta Ross, one of the godmothers, grandmothers of the reproductive justice movement so it feels important in this, the 30 year anniversary of the coining of that phrase to speak it into the room that reproductive justice is to have bodily autonomy to have children, to not have children and to parent the children we have in safe and sustainable communities. Rooted in that framework brought to us by the black feminist leaders 30 years ago, I think birth justice is the autonomy to birth in safe and autonomous ways and supported by ancestral technologies and modern technologies we have access to. I'm guided by this quote, this Alice Walker quote, how we come into this world, how we are ushered in, met, hopefully embraced upon our arrival impacts the whole of our time on this earth.

I often say, and I think it would be affirmed in this room in particular, that how we birth matters for our public health, for our economy, for our climate, and for our collective wellbeing. I also have been trained up by social workers so shout out to the dual degree program, BU School of Social Work. Yes. Some dual degree holders in the room. And what I have learned from my social work colleagues is that when we experience trauma it lives in the body. And also when we experience power, that creates markers, neural pathways, brain wiring that live on in the body. I think about how I gave birth in my living room twice, how I have touched a power in me that is so powerful that shapes the way I walk into a room. It shapes how I haven't had to show up for an interview in a long time, but it shows how I advocate for myself and family and it shapes how I show up for this organization.

When we map that transformative experience across a population and across time, I think we are clear that that potential, that experience has the potential to heal generations. But we need to center our interventions, our design and build power right where the inequity is and design interventions at the intersection of all of the systems of oppression, build power there and in doing so we build, usher in the future and build in our case a birth center, but I think a world that's better for all.

And so neighborhood birth center is about reimagining care that is about remembering and reclaiming midwifery, and we are thinking about how we weave justice into policies, programs, practices, real estate development, and I want to just share a

few examples of how we are thinking about that. When it comes to the design of our space, the guiding question that I have offered to our architects many years ago at this point is how do we design a space that feels like it rises up to meet you? A space that interrupts the often impersonal and hierarchal design of healthcare spaces that are set to first meet a receptionist and then a nurse, a PA and then a nurse and physician if you are lucky, and how do we really create home-like spaces and bring that into practice.

So what that looks like for us is designing a space with a sanctuary so people who are experiencing miscarriage or medical abortion can seek comfort in a quiet space maybe supported by a chaplain and exit the building without passing back through a waiting room with pregnant bellies.

We have spent hundreds of hours trying to crack the code on what is known in the birth center world as the impossible Math. How do we cover our costs while relying on atrociously low and inequitable reimbursement rates from insurance. She knows what's up. We have talked about this.

And how do we do that? How do we build our motto at neighborhood birth center while we commit to serving the majority of our client base being Mass Health and paying competitive salaries so no midwife or nurse or administrator takes a pay cut to live a Boston healthcare institution or another practice and to serve their community and how do we do that with reasonable clinical schedules. That has been the impossible path and we are close to figuring out how to sustain neighborhood birth center turning the cost back to commercial and subsidized insurance.

And Lois invited me to speak to the challenges. I was like how long do I have? And my timer wasn't working that whole time, so I don't know how long I am. I wasn't keeping time. But I do want to speak to the challenges that we face in realizing this vision, and I want to quote E.B. White who says, I rise in the morning torn between a desire to enjoy the world and a desire to improve the world and that makes it hard to plan the day.

Do we feel that these days, yes. And I feel that every day at neighborhood birth center. I feel like we have one foot in the new paradigm, one foot in the future that we are trying desperately to build and one foot in the current paradigm, and that means those insurance rates and inequity in pay and inequity in outcomes.

I want to just illustrate a few examples of how some of these challenges have shown up for us, there are very real lived inequities. There is mistrust and trauma from the healthcare system. What it sounds like is people saying birth is scary and

painful and people have said to us, I have seen the headlines of this crisis, this black maternal health crisis, so if it's bad for black women to give birth, why would we do it outside of the hospital? I have an answer to that, but we have to meet the question and we have to understand what that's rooted in.

I have talked about the reimbursement rates for midwifery care. One of the other channels is we have been relying on goodwill and philanthropy to build this important piece of healthcare infrastructure, and I argue that that's not a good way to build a birth center. That really is a part of Boston's healthcare infrastructure. And I don't know if you have caught it in the news or you have been following us on social media, but an antiquated zoning code in Boston means we spent the last two years designing an engaging community only to have the zoning board strike down our plans leaving us with a $2.5 million property in Roxbury that is potentially unusable. This challenge has cost us time and a lot of tears.

Speaking to paths forward and opportunities and tough times. So in the face of antiquated state regulations, anyone from DPH here, shout out to DPH? No, I'm going to shout you out. You don't have to identify yourself after I give the props. But, no, really these state regs. we have been crying about and griping about for years they were going to cost us time and money and threaten our sustainability so we joined a bold coalition of birth activists and in August successfully changed the regulations holds those regulations. As part of that we won licensure for professional midwives, any CPMs in the room. We will shout out the CPMs in the communities. This will allow home birth to be covered by insurance soon and allow the highly skilled community midwives to work in and run birth centers, Da!

And until we secure appropriate contracts that reimburse midwives and birth centers for our care, we are turning to philanthropy and we have been successful in doing so leveraging both government and foundation grants but also to community and backyard fund-raisers. We raised $3 million in our capital campaign with gifts from 5 to $500. And while I don't think that's the way to build a birth center I'm proud that that's what we did in the moment that we had.

And lastly, that in the face of all of this systematic under valuing of midwifery, worried whether or not we would ever be able to break even we cocreated a collective of organizations, all dedicated in different ways to the social justice movement, and we purchased property together. We spent the last years building a model of co-governance and sharing resources and solidarity economy, beloved economy, and we know that we are more sustainable because we share risk in that

definition of solidarity, sharing risk.

And so we call this collective of organizers and midwives and healers and community members the community movement commons, and our multipurpose real estate project is considered our love letter to the community, and it also a love letter to our ancestors and our descendants, while we are grieving the ZBA decision, we are wildly strategizing a plan and path forward. So tomorrow afternoon those 20 people will be circled in my living room breaking bread and trying to figure out what to do with that property. Working on opening this birth center in this particular city with those particular regulations and these particular zoning laws is the hardest work that I have ever done, and I am weary.

And it feels really good. Thank you for having me. It feels really good to be in a room at BU where I cut my teeth in public health 20 years ago with beloved leaders in the MCH ecosystem and people who I feel have their hands at my back as the midwives of this work. So thank you very much.

(Applause).

>> NDIDIAMAKA AMUTAH ONUKAGHA: Give it up for Nashira again. That was incredible.

Good afternoon, everyone, really excited to be here. Can someone show me how to work this thing? I did it. All right. Here we go. Good afternoon, I would not be an academic if I did not have slides so through for the invitation, thank you Dean Stein, a pleasure to be with you here today. I will talk about, I was asked to talk about the data and where we are with the system. Looking at a little bit about me. I am proud of the work that I have been able to do, gene is my co-PI on my RO1 in the past five years and a lot of the work we are doing in the maternal health space is because of what we are seeing in the data.

We have done work here in the Commonwealth. How many people were at the State House on that day in late August? I was 37 weeks pregnant, belly to the ceiling getting the legislation signed. It was incredible. My team was like I think you are done. I said are you sure. It was so good.

And a lot of the things we've done here also thinking about the successes of the Racial Inequities and Maternal Health Commission, that was an amazing opportunity as well really set the precedent for the work happening today. Massachusetts is a leader in maternal health, I think all of you know that. We can rest on those successes, but we have a lot of work to do as you have heard here in the City of Boston and what is happening nationally tremendously in a time like this. So the data. I think a lot of people were excited when the data was first released, yes, we see a reduction, but it's not really a

reduction in maternal mortality, we went back to the baseline where we were preCOVID. So we haven't moved a lot of the need will. What we have done is returned to baseline.

I think the other part of the conversation when we are talking about maternal health and birthing and raising the next generation, President Gilliam's remarks was so powerful, that centered me, but it's to talk about what does it mean to be in this work and how do we provide messaging and opportunities for different populations so we know that for black women in particular the maternal health crisis is quite large. The disparities are there. We think about it when you add the layer of race and age, that makes even more of a burden, so we are thinking about infant mortality, I did my dissertation on infant mortality a few years ago. We still had the twice as likely gap. We have not moved the needle on infant mortality. I think we have a lot of opportunities and I will talk about the things happening in the City of Boston, but this is another area where we know when we improve the health and moms and babies, everyone wins.

Thinking about the rates here in Boston, as I mentioned, we are doing a great job in Massachusetts, but we have a lot of disparities. This is the most recent data in the state and the city. Black women in Massachusetts are twice as likely to die during pregnancy or within one year postpartum and when thinking about the infant mortality rate we see disparities there as well.

When we are talking about funders and philanthropists, they are like you guys are Massachusetts you couldn't have inequities. We have insurance status, and the list goes on. So these are the things we are prioritizing here and maternal mortality rate is quite high for black women.

So this is, you can't see it, but I was 37 weeks pregnant. So good, she is six and a half months now. This maternal health omnibus that was passed is incredible. And we are still in the process of advocating and pushing for this. I have the privilege to testify last week at the joint Committee on public health co-convened by the Senate and the house and they asked me to talk about what they should be prioritizing for the next legislative agenda and we talked about this. We passed this, now we have to do this and put it into practice. So that was a tremendous opportunity, and I do think that the Committee was quite amenable to the things we raised.

Some of the things that we are advocating for the maternal health omnibus bill, investing in a maternal health workforce. This is the beauty of this event today. We are celebrating 30th anniversary. This particular opportunity has raised generations of maternal child practitioner leaders. We need a diverse

maternal health workforce. How many people are familiar with the mother lab. Mother lab.org, and mother lab is my group of students and I started this lab virtually during the pandemic to garner and support the next generation of maternal child health leaders.

Improved maternal health data collection and reporting. I don't know if anybody from DPH is here, looking at gene in the back, there is a real opportunity that we have in data collection and reporting as well. So we are collecting the data. How do we churn it out? How quickly are we able to churn it out? Working with academic partners and partners in insurance, that's the beauty that is able to quickly disseminate the data to get it into the hands it needs to go to.

And supporting full spectrum care. Making sure insurance are covering the full spectrum of care is very important. All of this is happening within the middle of this very, very crazy unpredictable stressful nauseating federal landscape, and I think in a moment like this, this is the time for optimism. President Gilliam said, but also the time for help. There is a lot happening that is working well, and there is a lot we don't have the cards for. And are we going to curl up and die? No. We fight harder. This quote I mentioned it in a recent media I did last month. I'm a glass half full person. And I do know that even in situations of disruption and situations of crisis there are good people still working in these places.

So I think a lot of the work happening here is in the landscape of things that are changing, things that are uncertain but we have to continue to face forward. We are raising the next generation literally and in our work.

Quickly I will talk about my center. I started it three years ago, the Center for Black Maternal Health and Reproductive Justice. My team is here. And the center has six units. We are focused on the middle level which is my students, policy, education, development and grants, data and epi and community engagement. We are an academic-based center, but we are community faced and community driven.

I would be remiss if I did not mention our conference is coming up this weekend. How many people are registered for our conference, the largest in the country. It's virtual, so you can be anywhere, but it's focused this year on fathers.

We have been doing this conference every year since 2018 and we changed it. We have done nurses, policymakers, Doulas, this year it's fathers because they are in the room and things are happening in a pregnancy and labor and delivery. They are watching the mistreatment. The parents and fathers are right there watching it and feel they can't support their partners. We are bringing a panel of experts around the country. Some

have experienced maternal mortality in their own partners. Our opening and closing Keynotes have lost partners to preventable complications. We have a day full of practitioners, fathers, parents leaders. And last year we did the role of technology and the year before that we did the role of nurses and midwives. The mother lab is quite unique. Some of your students here are in the mother lab. We focus on creating the next generation of maternal health activists.

And they are focused on the skills they are learning, while publishing, creating and supporting dual initiatives and focusing on the role in the community.

I'm going to leave you with this quote because I'm at time, but to reduce the overwhelming gaps between black birthing people and their counterparts reproductive justice initiatives values the voices of communities and black birthing people to hold stakeholders accountable and to commit to anti-racist approaches that deconstruct foundationally racist beliefs and practices. This is the premise of the event today. This is why we are celebrating the work of the BU center, the work we are doing in the maternal and child health space is to deconstruct the racist beliefs and practices. The system is broken and needs to be rebuilt and sometimes I'm like the system is functioning how it was designed to function. Unfortunately, and if you have seen my TED Talk which I did, I was like six weeks postpartum with my second child, I don't know why I did a TED Talk at that point because it's all verbatim not a teleprompter to be found and I talk about this in my TED Talk how broken the healthcare system is. But it's not functioning how it was designed to do, but we are the chosen ones. If not us, then who? And if not now, then when? I use this quote in our living room downtown and we have it on the wall, if not us, then who? Who is coming to support the next generation? So help raise and birth the next generation of leaders? We are. Neighborhood birth center is? Academia is. We are. Policymakers. If not us then who, if not now, then when. This has been the moment, it's always been the moment but particularly now with the chaos and uncertainty and stress, now is the time. Thank you so much.

>> VIVEKA PRAKASH-ZAWISZA: Wow, I have the unenviable position of following both of them, but I agreed to that. That's okay.

So I first want to congratulate both Nashira and Dr. Ndidi. They are unrelenting pursuit of social justice.

I'm here to offer words around what MassHealth is doing which is our state Medicaid agency. I want to acknowledge as has already been brought up the current federal and political climate and as a Medicaid agency we are very aware and sensitive to what's going on. As of now, we are monitoring the actions

and statements from the administration, but we have not received any specific directives as of now from CMS with respect to the impact of the various executive orders on Mass programs or services including those for birthing people, children and families. If we receive any of these directives, we will carefully analyze them and communicate them to the providers and members that we serve. But I do want to make it clear that as of now MassHealth is not pausing or stopping any programs or payments or anything that we currently are doing.

I'm very proud that secretary indicate Walsh and Assistant Secretary Mike Levine have emphasized their commitment to high quality care and access to services for Medicaid enrollees in the Commonwealth. There is a lot of good work happening at MassHealth in general and especially within maternal health and I'm proud to work with an incredible team who show up every day devoted to serving this uniquely vulnerable population. I do want to say that that team is pretty new. We just created a dedicated maternal health team a couple of years ago, and to me that is a really powerful statement about the agency's commitment to maternal health.

One of the most important things that we have been able to do, and the initiative I'm proud of is our Doula benefit, which was launched in December of 2023. And I'm really happy to report that as of now, there are over 200 Doulas enrolled as Mass health providers and we have served over 1700 unique Mass health members. We did ask some of the Doula providers to share a little bit of their information so I can report that as of March, about 43% of our enrolled Doulas responded and what we found was one third of themself-identify as black or African-American, about 18% self-identify as Hispanic or Latinx, 41% speak at least one language other than English. In total our providers speak 18 different languages and we have Doulas available across every region of Massachusetts. This was important to us when we created this benefit, we put a lot of thought and community engagement into truly making it a community-based Doula benefit. We wanted our Doulas to represent the communities they serve so our members feel like they are getting the support they need, and it's not perfect. We have a lot of work to do, but I'm proud that at least from the start I feel like we are getting close to that.

Both mentioned the maternal health Bill signed by Governor Healey in August. We were very excited to support that as well. There is a lot in there that is directed at insurance companies and at payers including Mass health. And so I can share a little bit about what we have done. Some of this has been completed in is still in the -- some is still in the works, as of January we have pay parity with certified nurse midwives. We

are trying. So what that means is prior to January, which is a little bit mind blowing to me as an OBGYN who has been trained by and learned from midwives that midwives in the state were only getting paid 85% of the rate as physicians for doing literally the same thing. So that has been fixed.

(Applause).

Seems like an easy thing to do. I'm glad we did it. We expanded Doula coverage to adoptive parents of infants under the age of 1. We are going to be covering certified professional midwives, that is dependent on DPH putting their licensure forth. We are prepared and ready to cover home births.

We are really interested also in that 12 month postpartum period. I think we have talked a lot about maternal mortality, I also sit on the maternal mortality review Committee and we see so many of these deaths happen postpartum. We are very interested in that. We are interested in the drivers of that, one of them being mental health, and so we do have a requirement at mass health that primary care providers, pediatricians, OBGYNs and midwives screen for postpartum depression throughout the 12 month period. The screening tends to stop or fade away, but we wanted the providers to feel empowered to continue to screen even if they might not think that this person is technically postpartum anymore, as any mother in this room knows, postpartum never ends, my child is seven and I am still postpartum. We wanted to give guidance on what to do when screens are positive. Sometimes people don't want to do the screening because they don't know what to do if it's positive.

We are also going to be covering donor milk, donor breast milk hopefully for certain high risk infants who are hospitalized. This is dependent on DPH action but we will follow with that, and then we are going to be covering universal postpartum home visiting as well. So lots of good work.

We have really good team, my colleague, Maddy is back there she has been a key leader in this as well. So thank you for uplifting as others have said the positive things. I think it's important to think about that and to know that good work is happening.

And on that note, I do want to share, Mass Health's mission statement which I do try to look up and remind myself, the mission statement is to improve the health outcomes of its members and their families by providing access to integrated healthcare services that sustainably and equitably promote health, wellbeing, independence and quality of life. And so many of these concepts have been discussed and brought up by the work being done, access, integration, sustainability, equity, health, wellbeing, independence, quality of life.

So while much is uncertain and certainly at Medicaid we are

daily just holding our breath, but I am optimistic that we do have collective power, and we have so many resources and leadership and brilliance in this room and beyond, and I do think we can keep working towards achieving justice for pregnant and postpartum people in Massachusetts. Thank you.

(Applause).

>> LOIS McCLOSKEY: Amazing all of you, thank you, thank you.

(Applause).

So by design we did focus all three presentations and speakers on the great State of Massachusetts and City of Boston because we are in fact a model, and because we live here.

And the second panel, economic justice, part by design, but really serendipitously have been doing their research and a lot of activism nationally, yes, but also have special projects going in Massachusetts. This is a time for us to focus on how we model forward looking, equity focused social policy and health policy.

So we look forward to hearing from three speakers. First will be Sharita Gruberg Vice President at the National Partnership for Women and Children in D.C. She leads the organization's work pushing for policies that advance an inclusive economy by centering the needs of women of color to promote broad economic growth in an economy that works for everybody. She was Vice President LGBTQ research project at the Center for American Progress. She received her J.D. from the Georgetown University Law Center. And also a certificate from the Institute of the Study of International Migration in Refugee and Humanitarian Emergencies.

She holds a B.A. in Political Science and Women's Studies from University of North Carolina Chapel Hill, and was recognized by LGBTQI+ Bar Association as one of the 40 best LGBTQI+ attorneys under the age of 40 in 2019.

Then we are going to hear from Jeffrey Lehman, Dr. Lehman is the Robert W. Scribner Professor of Public Policy at the Harvard Kennedy School where he teaches courses in social policy, public sector economics, government innovation and American economic policy. He studies tax and budget policies, social insurance, poverty and income inequality. For the past ten years his work at the Harvard Kennedy School Government Performance Lab has been providing pro bono technical assistance to state and local governments.

During the first two years of the Obama Administration Dr. Lehman served as OMB first as Executive Associate Director and Chief Economist and then as Acting Deputy Director. And he served also under Clinton as Special Assistant to the President for economic policy.

And finally, we will hear from Jessica Ridge. Jess is a BU School of Public Health alum. And since 2014 has led fundraising and systems change initiatives all over the northeast for UpTogether. It is a national nonprofit that works to change the way the U.S. addresses poverty.

Since 2020 she has overseen the launch of 20 direct cash otherwise known as guaranteed basic income initiatives. She specializes in building deep lasting partnership that ensure that those with lived experience are at the table, and before joining UpTogether, Jess spent eight years in Boston City Hall with then Boston City Counselor at Large and now Congresswoman Pressley first as her policy director and then as her Chief of Staff.

So whether in the halls of government, philanthropy foundations or community, just listen to this one, Jess aims to slow down and encourage herself and those around her to ideate, explore and play from a place of embodied connection. She lives in Western Massachusetts with her partner, Bruce, and her 5-year-old where playing in the mud is part of their regular routine. I think excellent practice for us right now.

So we are focused now on family economic justice. Sharita, I turn it to you.

I also, I want to note we are running behind, which is kind of normal for these sorts of events. It's possible we will have to cut short questions at the end from the audience, but we will have time for a bit of a conversation. Thank you.

>> SHARITA GRUBERG: Hi, everybody. I'm a lawyer, sorry. But not an amazing OBGYN, I have been blown away by everybody who has spoken before me. Thank you for having me. It's great to be in Massachusetts, in Boston right now. I am from D.C., where 10,000 folks who work for the Department of Health and Human Services were fired today, and including many working in maternal and child health and research, so truly terrifying times. Also terrifying times last week we observed equal payday which is the day where we recognize that women are typically paid just 75-cents for every dollar made by a white non-Hispanic man. I'm sure you have heard in the past how long it takes women to catch up to men. The truth is you don't. You don't ever catch up with the wage gap. Those lost wages make the strain women are facing supporting ourselves and our families even harder at a time when rents and the price of necessities continue to rise.

The wage gap makes it harder for women of color in particular to cover our daily expenses. Good luck saving for your future. Once again, might lose Social Security and Medicaid, so good luck to everybody.

The money women lose adds up without the wage gap on

average a black woman worker would have enough money for almost two years of child care, 16 months of rent or more than 27 months of groceries. To make matters worse in 2023 the wage gap widened for the first time in 20 years. It was not one policy that did this. It was our policymakers absolute failure to address any of the systematic barriers that women face to economic security in this country. We need strong antidiscrimination protections, we need them enforced but antidiscrimination protections alone are not going to close the wage gap. The U.S. compared to Canada, compared to Germany, compared to any of our peer countries lags fares far behind this is at a cost of $775 billion losses to annual GDP of the U.S., and the reason is simple. We are the only wealthy country in the world that doesn't offer paid family medical leave. We do not have paid sick leave. We do not have any kind of supported child care, and we don't offer supported home and community based services for our elders. If you are not already, a whole lot of people are about to be caring for kids and their parents with zero support, oh, my gosh, and though just closed down the Administration for Community Living which is the government agency that supported care of older Americans.

Getting harder and harder by the minute. Poverty though is a policy choice. We saw that so clearly around the child tax credit expansion. Congress expanded it, cut child poverty in half. The minute they let the expansion lapse, child poverty doubled again. It cannot be clear that these are solvable problems, we have the tools, we have the support, we just need the will from our leaders.

So I'm going to talk in particular about my favorite policy intervention, paid family medical leave. Over 30 years ago, we enacted the Family Medical Leave Act. This provided unpaid job protected leave for up to 12 weeks for if you are giving birth, if you are welcoming a new adopted child, if you are caring for your own medical emergency or a loved one's. It was not supposed to permanently be unpaid. We have been fighting for over 30 years to finish this, but it's been effective, it's been used over 500 million times so folks can be with their kids and loved ones when most needed and not having to worry about losing your job to step away.

That said, 44% of American workers aren't even eligible for unpaid job protected leave, and when you are talking workers of color who are more likely to be working in part time low wage job that aren't covered by FMLA, you are seeing even lower rates of coverage. At the national partnership we estimate over 2.7 million workers last year needed to take leave but didn't take it, and that was for fear of losing their job, so people who doesn't have FMLA.

Another 7.3 million had FMLA but couldn't afford to take unpaid leave because who here can afford to take three months off without pay of work? Nobody, not possible.

In the 27 states that don't have their own state paid family medical leave program, women are losing an estimated $19 billion each year from unpaid or underpaid leaves.

And so what do we know about the impact of paid leave? I'm going to tell the story of two Lous, one is any buddy Lou who is a nurse in Michigan my other is my friend's new baby Lou in D.C. a state that has not only paid family medical leave but us and New York are the only ones with paid prenatal leave as well. Both my friend Lou and baby Lou's mom had preeclampsia during pregnancies. My friend, the nurse in Michigan, no paid leave through her employer was working up until she went into labor with preeclampsia because she could not afford to take a day off because if she wasn't working she wasn't getting paid, and every cent she was getting paid she had to squirrel away so she could save up for two whole weeks to be home for her newborn. Two weeks, somebody with preeclampsia, gave birth, we were terrified that we were going to lose Lou.

Now, in D.C., much happier story. Baby Lou's mama had preeclampsia but was in a city with prenatal leave. She was able to get the bed rest she needed to make sure that she had the best birth outcome she could have. She was able to take the time that she needed to be home with her baby. When she went back to work, her husband was able to stay home with their baby and pick up and also get that so important bonding time, which we know from the evidence improves gender equity as well.

So I just want to share this as an example of how one policy can make such a difference in multiple people's and multiple generation's lives and wellbeing. Paid leave improves maternal and infant health. It lowers chances of interpersonal violence, reduces incidents of head trauma caused by abuse of children under two because lower levels of stress and abuse also lead to lower levels of abusive behavior, reductions in low birth weight, reductions in preterm births and all of this is particularly true for mothers of color, especially black mothers.

When you compare the moms who could take paid leave like baby Lou's mom the chance of being rehospitalized is 50% higher for those that don't have paid leave compared to those who do. Also the same for likelihood of your baby to be rehospitalized in the first year. We heard how important it is to make sure we are keeping moms and babies out of the hospital during those times. Paid leave does that. My team took a look at Massachusetts' program, and had the most exciting finding. So the very smart economist on my team made a model to compare

Massachusetts with similar situated states and controlling for everything else found that the existence of Massachusetts paid leave program, not even who took it versus who didn't, just having it there led to one fewer poor health day a month for people with depression. That doesn't sound big, but that is $1.2 billion in productivity gains annually from reduced absenteeism in the State of Massachusetts, just depression.

Also it's a really great deal. Employers pay $258 per year into the program per employee, the productivity benefit is $880 per year, when we are talking depression, we are talking postpartum depression. We are talking about how this is a program that improves both the physical health outcomes and the mental health outcomes for new moms, for babies for families, improves the economy. It is a win/win across the board.

Where are we now? We were two votes away from a national paid medical leave program, didn't get that. But states have picked it up. 14 states have paid leave. We are seeing momentum in places we never thought we would. Nebraska, Missouri and Alaska all red states pass the paid sick leave on the ballot. Parental leave was enacted for state workers in Mississippi and Alabama.

As states provide paid leave we are getting more and more evidence of how significant a policy this is, and it's helping us put even more pressure on our electeds to enact this across the country. Urge Massachusetts to continue being a leader and also shout from the roof tops of what you are doing here, make your neighbor states jealous because that's how we are going to win and spread it across the country.

(Applause).

>> Thank you for inviting me to be part of this event and congratulations on the 30th anniversary of your center for excellence. I've been struck by all of the speakers so far, by their power at being able to describe reality and still inspire. I'm not even a lawyer. I'm an economist. So my powers to describe reality may not be so good, but I will still try to inspire, and the way I'm going to do it is by trying to convince you that there is no reason why we can't provide high quality early education and care to every child. And I'm going to show you how easy it is to do this and I will try to persuade you that there is no reason to sit around and wait for Washington to do this.

Any state could do this. I would love it to be Massachusetts just like we were first with the Affordable Care Act but if our leadership doesn't get around to it, I would be happy to some other state got around to it too because we need a model like we had here under Romney care for healthcare reform. So the origins of the research I will tell you about is a phone

call from Amy Kirsha commissioner of early education and care in Massachusetts and I have been friends with Amy a long time. I can tell you exactly how long because our children were in a toddler classroom together and the children in question, our oldest children are now 24. I so can tell her I have known her 22.5 years. So Amy called me with an interesting question, Massachusetts was putting a lot more resources into early education, and she was thinking about how do you deploy the resources in a way that's heading towards whatever our ultimate vision is of a system of care that's available and affordable, and high quality for all. And so I lead a center at Harvard called the institute for greater Boston that does match making between local policymakers and scholars who can solve those, and so usually when I get a question like this I find someone else to answer it, but I immediately knew I wanted to work on this myself.

In part because I had just been teaching that week, my week in an American economic policy class about economic disparities. And I had seen early education show up so many times in the course of my teaching there. Early education is a key part of what one needs to do if we are going to give every child an equal opportunity to prosper, if we are going to close achievement gaps, and it's also, as the most recent speaker highlighted, it's a key part to how we close gender gaps in earnings.

My wonderful colleague, Claudine Golden who got the Nobel prize in economics for her telling the story of economic progress for women, she has written recently that if we are going to close that last step in the gap in earnings between men and women, we have to solve the problem that jobs where, that expect people to be available at any moment at a time to fly anywhere in the world pay more than jobs with dependable hours. And because women end up with care giving responsibilities, jobs that demand flexibility about when you work and that pay more are often not available to women, and better child care is part of the way that one could overcome that problem. So one of the reasons I decided to work on this was it seemed like it was the answer to several other things I was thinking about, but also I could just see so many parallels between what one needs to do to solve this problem and what we did when I was working in the Obama Administration on the affordable care Act. I will not go through the parallels but you will start to see them as I talk through the solution in the early education space.

As I parted to do this research, I identified one thing that was a puzzle and one thing that wasn't at all a puzzle. The thing that strikes you if you start working this area is given all we know about how important the early years are and

what the returns are to investments in the early years, why in the world is it that we spend $3,000 per child in terms of public sector spending when they are 0-4 and 20,000 a child once they get into kindergarten. It's sort of a pretty stunning puzzle.

The second thing that struck me immediately as I was starting to think about this is the thing that I said was not a puzzle, the things that not a puzzle is that the market will not solve this by itself. There is no reason to think that the market left to its own devices is going to give us enough early education and care or high enough quality, and it's really the same reasons why the government gets involved in healthcare or K-12 education or even in providing Pell Grants for higher education, one issue is this is something we want everyone to have, high quality access to, and then a lot of people who don't have high enough incomes to afford it. Just to give you an example, the median wage for an early educator lead teacher in Massachusetts is about $22 an hour, so that's about $44,000 a year. There is no way an early educator in Massachusetts could pay for early education for their child, not even close. It's at least $20,000 a year for early education. And if your income is 40, 50, 60,000, how in the world do you pay for that. If we want every child to have opportunity, clearly the government is going to have to step in and pay for it at the bottom like we do in healthcare and like we do in giving everyone K-12 education. The second reason there is no reason to think the market is going to get this right is a more technical argument something we call liquidity constraints which basically means if you go to the bank, and suppose you are a 1-year-old and you manage to crawl over to the bank and you say to the bank here is the deal, I will make more money later. If you give me a loan to pay for my own early education and I will pay you back out of that. Well, the bank won't give you that loan because they don't know for sure, plus the crawling part is hard also.

So it's the same reason why government steps in in other situations. And by the way, it applies to the parents as well. Parents of young children are often early in their careers, later when they are 50 or 60 they are going to wish they could have spent more money on their children's early education but they don't have the money at that moment so that's the reason to have government get involved and make sure everybody gets high quality care.

The third thing I discovered is that you really have to worry about quality before you worry about adding lots of slots. There is some very disturbing research of what happens if you just go and try to make as many slots as possible without worrying about quality. If you look at what happens when Quebec

expanded quickly the number of slots there is good research showing that it led to bad child outcomes. There is similar evidence from Tennessee where they worked hard on making as many slots available as possible without worrying about the quality.

And so I think it's quite clear you have to start with quality because the last thing you want to do is actually hurt children by putting them in centers that are not good for child development, and so the question is how do you do that? Well, there are a bunch of things you need to do about quality, but the main thing is obvious. We need to raise the wages of early educators, and there are different concepts. I heard earlier about the parity for midwives. There are a bunch of different ways you can think about, between parity for early educators and K-12 teachers. You can think about having the same annual salary even though the early educators work 12 and the teachers work 10 months a year, you could think about the same hourly salary, but just getting to the first of those would require about 6 or $7 an hour more for every early educator in a typical state than we are paying them right now.

And the question is how would you provide that? And actually we now have very good examples of how you can do this. Because what you don't want to do is have the government step in, give the center money, have the money, have the center take that in profit and not raise the wages of the early educators. So how do you do this? Well, Washington, D.C., Illinois, and every province in Canada have figured this out. What you do is you have the government pay for the additional wages. Say we are going to raise everybody by $7 an hour, the government basically pays for that increase in the salary, and then you have a floor on the wages. You say if you are a center you have to pay at least $29 an hour or whatever the floor is going to be, and that makes sure they can't just cut the wages and pocket the money. I'm already getting a sign saying I need to wrap up.

So I will just quickly say the second thing you have to do is in every state there are subsidies for low income people to access early education, but they are not entitlements like other part of our safety net, so they are huge waiting lists. You need to increase the subsidies, but you have to do after you bring additional slots online. It doesn't do any good to have more people able to pay for child care if there aren't more slots, then you get waiting lists and frustration. So the wages first, then additional slots second and making it affordable, and you have to time it right so as the new slots come on board that's when you make the subsidies available.

Last thing I want to say as I was doing the research I was trying to figure out how many slots we need in a state like Massachusetts. Right now, 52% of young children are in formal

child care setting, should we be shooting for 80%? Maybe many people don't want to be in formal care. I tried to find someone who could answer this question and no one could, so I commissioned a survey of a thousand mothers in Massachusetts of children between 0 and 4 and I asked if child care were free, would you use more formal care? More for the people who are already using it. Of the people already using formal care, 71% said they would use more. These are people who on average are using about 25 hours they want 10 more hours on average. The ones who are not currently using formal child care, 80% of them want it. So it's not that like the people, people have different preferences they want to raise children in different ways, the overwhelming majority of people want their kid in a high quality child care center and there is no, given how slow it will take us to add slots there is no risk of us overshooting we can go as fast as we can to add slots and we will not have too many slots.

I think I will stop there and wait for the panel and I can maybe get an opportunity to explain why I think states can solve this on their own and we don't have to wait for the federal government. All ask later. All right.

>>

Good afternoon. I'm Jess Ridge and I have the privilege of going last. So I'm really happy to be with all of you and those who are listening in from Zoom. Let's start by taking a deep breath together.

Notice your body in the chair, your feet on the ground and let all of the powerful information that you have just received settle into your spirit, to your being. And trust that you will retain whatever is most essential for you. You don't have to try to hold onto every bit.

And in these times, I think it's ever more important that we commit to imagining what is possible. And so for now I want you to consider what would it mean if everyone in this country had more than enough at all times and was living a life that they love? What would it do for the individual? For their family? For their community? How would it change this country? Let that settle in. You don't have to hold onto that either but let it be loosely in your heart as you listen. UpTogether is a national nonprofit. We have been around since 2001 and we work to reform systems that have kept people in poverty. Since 2020 we have implemented more than 50 guaranteed income pilots and invested $210 million in more than 200,000 households across the country.

Everything we do is based on our strengths-based approach. We understand that social connections are essential to our success. We recognize that sufficient capital is needed to

realize our dreams, and choice that every person is an expert in their own life, that every person should get to choose how they spend their time, their money, and whether or not and what kind of help they want.

Before we go any further, let's level set on direct cash terms. There is existing cash transfer policies that you may be aware of. Many of them provide an impact for families that is important but also carry what we would call deficit-based restrictions on what people have to do to use the money or who gets it. I will lift up emergency rental assistance which is critical to keeping people in their homes but sends the message about who is valuable and who we trust. We trust landlords, but not tenants. Universal basic income which is definitely worthy of discussion another time because the cash payments are unrestricted, you can use them however, you want, but the distinction is that UBI provides generally the same amount to everyone in a particular community. That Alaska permanent fund is an example of that.

Today I will talk about guaranteed income, which is unrestricted cash transfers over a period of time often monthly, cash can be used however, you want, but it focuses on those living in financial hardship and usually some other factor in addition to that, pregnant and parenting guaranteed incomes are popping up, housing instability or zip go, how do we focus cash on communities of color that have been disinvested in over decades. Why should we talk about guaranteed income? One of the reasons that UpTogether talks about it because despite ongoing in our means tested federal safety net program as everyone knows our federal poverty rate hasn't changed since the 70's, and these programs while they do provide support often have restrictions that are harmful to people, and they are also very costly to implement because of that.

The idea of guaranteed income isn't new. It was likely Johnny Tilghman a mom of 6 and welfare rights activist that planted the idea in Dr. King's ear so Dr. King and Malcolm X talked about different forms of guaranteed income. She was thinking about mamas like her who were home raising our future without adequate means to pay the bills and provide child Care Activities.

In 1972 she said the truth is a job doesn't necessarily mean an adequate income. And that feels, to Jeff's point, that as relevant today as it was then. So what does the research say about guaranteed income?

Well, first, I want to talk about what it means to a mom, a family who received a 24 month guaranteed income in Boston. For the first time she was able to catch up on bills and establish an emergency fund and she said maybe the most meaningful part of

this is that I no longer need to work two jobs and I'm able to be home with my kids more. What if everyone lived a life that they love? So now the research. In 2024 it was a landmark year, nine RCTs, 10,000 participants, the data came out guaranteed income really took off in COVID because of a lot of federal funding, and so the findings from the studies show what UpTogether has found in more than a dozen studies we have done. By and large people are using the money for basic needs, paying bills, putting food on the table, housing, but it also creates this opportunity to save money for the first time, and in many cases to pay down debt. It often stabilizes or improves housing and it allows spaciousness for long-term planning that wasn't available before.

I could go back to school now. I can do this job training program. And it creates more time to spend with family and community.

And the media headlines, some of them reported mixed results, and there is some misconceptions that I think are really about this pull yourself up by your boot straps mixed with lots of racists beliefs that we have been indoctrinated with in this country. I will focus on the misconception that guaranteed income is ineffective because it leads to delight in work. I don't know who considered 2.8 hours a decline in work but that's how it was interpreted by some, but also the work data was skewed by two sub groups, single moms, and the qualitative interviews suggested that that extra time was used to spend with their children. And for those under 30, it was because they were using the guaranteed income to pursue higher education. So isn't that a good use of time. Participants were 5.5% more likely than the control group to hold off on taking a job to find one that was interesting or meaningful.

Again, what if everyone could live a life that they love? But there are mixed results. Do the findings show that guaranteed income is a silver bullet, that everyone has the same results, that they last beyond the pilot or have some broad sweeping change in a community? No. They don't show that.

But it's important for all of us to understand and I think the room gets it that there is no silver bullet to ending poverty or to ending racism, and both of those are deeply intertwined in this country.

From my perspective and UpTogether's perspective the evidence is quite clear in the absence of enough decent paying jobs and the ever increasing cost of the goods and inflation guaranteed income is an essential support and more importantly it's pointing us to what is possible when we trust people.

In the words of Lida from the Cambridge rise guaranteed income initiative, people in poverty don't choose to be there.

We should all have the right to live a healthy, normal life in this country.

And there are options. Sharita talked about one family medical leave. What if all of our safety net programs were run with a strength base approach. What if they trusted the people who they were intended to.

(Technical difficulties). The guaranteed income movement shows us hi we with move beyond the framework of supporting the needy to investing in people so they can create a life of sustenance for themselves.

So I invite us all again to consider what if we believe and our policy reflect that everyone deserves to have more than enough at all times and to live a life that they love? What if future studies on guaranteed income or any of the other policies we talked about today, what if this was the framework for how they were constructed and what if this was the framework for which we analyze the data? That's my wish. Thank you all so much.

>> We have 15 minutes, folks. It's not enough, but we will take it, right? We will take it because you all are here with us and you have presented us with a lot in both worlds, I would say. It strikes me. I loved the quote you brought, we live every day one foot in reality and one foot wanting to change that reality. Wanting to change the world. So just very quickly, the birth justice panel, it seems to me you really showed us, again, the Massachusetts example of how local activism, yes, you hit barriers, yes, you do, and yes, it takes ten years Nashira, but how local action, fundraising gets, is getting a job done. And both you, Viveka and Ndidi talked about the Massachusetts State example in making things happen legislatively and Viveka, you were taking it a step further and operationalizing it little by little.

We know in Massachusetts we hope we can keep doing that to forward maternal health equity.

The next panel, you were all so aspirational on one hand, routing us in data of what's possible and I'm so struck by the pioneering innovations that have happened just in the last it seems to me five, eight years, the evidence that is emerging. Other countries have known it for a long time, FMLA, early childhood education, basic income, and similar social policies.

But we are nowhere near there in terms of national progress, even before the current administration., two questions I want to start with, and the first one is picking up where you left off, Jeff. Given what's happening right now, given the aspirations, what we know, we have the knowledge, we have the social strategies, what we don't have is the, well, we haven't had the political will, but now we have, what can states, not

just Massachusetts, take us out to some of our other examples that you know about, Jess, Jeff, Sharita, you work nationally, what can states do without federal government support?

>> The way I look at it it's likely there will be big federal tax cuts. Why don't we reverse those at the state level and solve whatever problem we want to solve. The early education challenge that I talked about to get Massachusetts to a world where every child had a high quality affordable early education, it would cost a lot of money, but not that much money. It's about $1.5 billion. That's like 4% of the state education budget. It's not that much more than a couple of years of inflation adjustments. So if we decided to do it, we could do it, and if we wanted to redirect tax cuts from Washington towards solving one of our problems we could certainly do that.

>> Not just, like I think it's imperative, you talk about early childhood education, head start is under attack next, so it's both a horrifying problem, but also such an opportunity for the states to step in, to step up. With paid family medical leave, it's necessary, and I think even red states that don't want to, like I don't think Alabama sat down and was like, oh, man, I really want to have this social safety net program for folks in our state. That's not how Alabama State government functions, but it wasn't tenable for the state as an employer to lose employees to the private sector where they are getting these benefits. They had to compete. We have got paid leave in Minnesota, we've got Michigan, Wisconsin, Illinois are feeling that pressure because they are losing workers to states with better policies.

In New England, we have got a whole lot of states with paid leave, and so I think we are going to see some of these pressures and points on states where they can do better and the innovations we are seeing are also really exciting. FMLA had a really narrow definition of family. You couldn't use it for a lot of folks that you have care giving needs for. So the other trend we are seeing in states which is really exciting is inclusive family definitions to make sure that you are able to be there or have care provided for you for what your family actually looks like, not just the nuclear family that we have traditionally thought of.

So there are opportunities to take the lead especially as we have kind of lost that assumption that, oh, Congress will say, whoever thought Congress would save us, but definitely not now.

>> Thank you. And, Jess, I know you think a lot about the opportunities in this moment despite how counterintuitive that sounds.

>> What's coming to my mind is that states have driven a lot of our most wonderful federal policy movement over the decades. I think about Gay marriage and the ripple effect that that had across the country and to President Obama.

This is creating an opportunity for states to have to focus and address things that maybe they didn't have to before, and I think it's a reminder for each of us to find, really focus on the opportunities that are there, which is hard to do. Like we are really being tested right now about what we have capacity to handle, but by design they are trying to scare us and immobilize us. And so I think about how do we at the individual level and within our communities channel up what is possible despite the chaos that's being spun around us.

>> Thank you. I don't know where that leaves red states, well, I do know where it leaves them. Although you have, you did, Sharita give good examples of the economic pressures that lead even states that are red to take action, so that's hopeful.

Turning to you all on the birth panel, what do you see now as even in a state sort of counterintuitively like Massachusetts, what do you see as the greatest challenge in this moment? Be it for the federal government shutdowns, disasters, or for more local reasons? What do you see as your biggest challenge right now to achieve, progress in the purpose that you have? Who wants to start?

>> Well, there is a ton of uncertainty as we all know. I think about my situation, I'm recently minted full professor. I represent 2% of black women that are full professors in the academic space. Even more so than that, there is such, even before this current administration principle investigators of color that are managing large grants in this area so when I got my RO1 grants it's a five-year multimillion dollars grant. That's about 1% of people of color that are getting the funding. That is before, so now you add this current administration, it's like where are the resources going to come from? And as an academic based but community-facing center, I think my goal as a leader of a center is to have a lot of liquidity of the resources I have to put it back into the community. If you are facing this uphill battle with funding NIH was the gold standard, now we have to diversify our portfolio of funding. There is a lot of uncertainty, people's jobs and partnerships on the line. The quality of research we are able to produce as a country, nobody here would be surprised about that. What does that mean by the United States globally, what does it mean domestically? What does it mean for evidence-based results, prioritization for funding? All of those things are up in the air. That is a lot of uncertainty. That will translate to lives lost, preventable complications, missed opportunities,

delays in care and the list goes on.

It's a pretty dire time and I think those of us that are scrappy, I call myself a scrappy investigator, we have always looked in the couch cushions and under the coffee table trying to find funding. This is even more so the time to do that, to be able to maintain the research we know is going to absolutely save lives and contribute to better outcomes in the community.

>> LOIS McCLOSKEY: How about you Viveka?

>> VIVEKA PRAKASH-ZAWISZA: I think I would echo a lot of what Dr. Ndidi said too, and also a bit of what Jess said. I worry that the ecosystem is going to shift into a maintenance mode just to hold onto what we have and what we have been able to do and a lot of the amazing innovations and advances and progress and things we are hoping to achieve are going to get tabled. The other concern I have and we sit on the maternal mortality review community and I worry because a lot of the data is handled through the CDC and federal government, what are the kinds of things we are going to be able to analyze with the data? How are we going to be able to translate that? In our discussions we talk about discrimination and bias in these deaths and that's data reported and collected so I do worry about that too, and the data being such an important tool as we saw from almost everyone's presentations today, that's how we know what to work on and where to focus, and so sorry to be bleak, but those are some real issues that I think about a lot.

>> And that very data on discrimination was specifically rooted out from a CDC program prams database before everything was rooted out.

>> LOIS McCLOSKEY: Nashira, same question.

>> NASHIRA BARIL: It was about opportunities.

>> LOIS McCLOSKEY: What's your biggest challenge? What's the opportunity in this moment for you?

>> NASHIRA BARIL: Not to minimize the threats by any means, but I feel like we are always going to be the ones to get ourselves free. So getting hyper local, being in community, the fact that in spite of the zoning board decisions, organizers are going to meet in my living room tomorrow as they have since the beginning of time to figure out ways through oppression and fascism and racism.

So the threats are real, but the love and our political will, I think, are run really deep. And I think that the fear can take us out and is founded, and also I feel, I don't feel optimistic, but I feel resolve, I guess, if there is a difference between the two. I feel resolve that in coalition and in community we will hold each other down.

The numbers are on our side.

>> Thank you. I'm going to --

(Applause).

Our resolve is strong, and, again, I want to reiterate how important it is to be together in person and on Zoom to buoy each other up, to play as Jess recommends, and do I have time to ask them a quick round, one more or not, because one more is a quick round robin, what are you doing to take care of yourselves in this moment? What's working? Just a phrase, yes.

>> Spending lots of time with my kids, planning my son's birthday parties it's going to be all of the vibes on April 18th, my conference coming up, immersing myself in every other part of my life, staying off social media, maintaining self-care, sanity, trying to exercise if I can., and that's it.

>> Organizing community dance parties and dancing with my kid and making sure I put my feet on the ground, like on the actual earth.

>> Two things, one is being grateful that we are all in lines of work where we are actually making a difference every day. Think of the people that are observing what's going on and don't have a way to effect it every day, and the second thing is I will say I discovered in the first Trump term that I don't have to read the newspaper every day. If I read it twice a week I can stay up to date enough to do my job and I don't have to be sad the other five days.

>> I've been taking a lot of strength in talking to my community elders. As a queer woman there is not a whole lot of elders in my community because of the way the AIDS crisis and the federal government's failure to address it allowed it to decimate us, but the ones that, what do you do when you are abandoned, what do you do when your community is being ignored? So I have really found a lot of strength in those elders and learning from those. It's a great reminder because I can't think of anything as bleak as seeing an entire generation of your community die around you, and go from that to marriage equality, to prep, to just all, as we are seeing attacks now and the fight is never over, but it's been a huge source of comfort and strength and a lot of joy and dancing and drinking.

>> I would say for me it's been a lot of meditation, getting outside. Finding community, finding people who are doing the same good work and holding each other up and to your point reminding ourselves that we are all in this together and we will get through it. Yes.

>> I will say hugs, like more than 20 seconds, so co-regulating with another person. My favorite to co-regulate with are my children and watching like puppies on InstaGram with my children. That part, right, it's like, yes, we need the puppies on InstaGram.

>> Puppies, kids, love, dance, music, meditation and

staying away from the newspaper. Thank you. I hope you have all taken heart and ideas from this. Thank you for coming.

You are closing us down.

>> MICHAEL STEIN: Hugs, hugs, hugs. Good. I love that. Thank you to the panelists, thank you professor McCloskey, thank you President Gilliam, come to Talbot, come talk more. We are going there now. Thanks.

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