WOMEN OF COLOR SHOULD HAVE A VOICE & CHOICES IN THEIR PREGNANCY JOURNEY

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MEASURE
Community Led. Data Driven.

ABOUT MEASURE

MEASURE is a research and public education organization led by Black women and dedicated to using data and technology to pursue community goals. Since its founding in 2015, MEASURE has provided over 3,014 hours of free antiracist evaluation support to the community to increase their access to and use of data. In 2021, MEASURE staff and volunteers worked to provide direct support to its community partners through the creation of tools and technology used to maintain their organizations, build consensus, coordinate action, collect data, and publicize their results. MEASURE believes that when used strategically, data provides a common language upon which community members can meet and increase their knowledge about the causes and work together to create equitable changes. MEASURE's efforts are innovative within the ecosystem of social justice as it encourages people of color to be data collectors and storytellers. MEASURE recognizes community engagement as a necessary component to address racial equity, public safety, health, education, economics, and to improve community relations and trust.

ABOUT PARTNERING ORGANIZATION

Healing Hands is a 501c3 organization dedicated to improving birth outcomes in Black women, eliminating birth outcome disparities, and lowering the maternal and infant mortality rate for Black women. Healing Hands was started in 2017. The mission of Healing Hands Community Doula Project (HHCDP) is to eliminate the negative birth outcome disparities (high rates of preterm birth and low birth weight infants) that exist between Texas' Black women and women of other cultures and ethnicities and to eliminate the high rates of maternal and infant mortality in Black women and infants in Texas (1). HHCDP's mission is also to serve their doulas and work towards paying them a living wage for the work that they do. HHCDP serves and supports low-income childbearing Black women in Central Texas with an enhanced perinatal care program utilizing full-spectrum Black doulas from conception through the first year of their child's life (1).

HHCDP is based in Austin, Texas and supports childbearing Black women and their families with a variety of programs, including: pregnancy and labor support, specialization in bedrest and high-risk pregnancy support, postpartum care, breastfeeding support, and childbirth education, community workshops (1). HHCDP helps fill a much-overlooked gap in maternity care for Texas' Black childbearing women. HHCDP is one of four community-based doula organizations in the Maternal Health Equity Collaborative (MHEC) dedicated to improving birth outcomes in Central Texas, specifically among BIPOC childbearing people.

AT 18.5 DEATHS PER 100,000 LIVE BIRTHS, **TEXAS' MATERNAL MORTALITY RATE IS ABOVE THE US AVERAGE** (TUMA, 2021).

NON-TRADITIONAL BIRTHING OPTIONS AND CHOICES

According to the Centers for Disease Control and Prevention, the percentage of out-of-hospital deliveries increased from 1.26 percent of all U.S. births in 2011 to 1.36 percent in 2012 (2). Just over 35,000 of the nearly 54,000 out-of-hospital births in the U.S. happened at home in 2012. Birthing centers served as the setting for around 15,500 of them (2). Despite the evidence for their positive impact of doula support on birth outcomes, doula services remain widely underutilized (3).

Source:
Tuma, M. (2021, May 30). 'It's easy to dismiss Black Women's lives': Texas drags feet on maternal mortality crisis. The Guardian. Retrieved June 28, 2022, from https://www.theguardian.com/us-news/2021/may/30/texas-maternal-mortality-crisis-black-women-medicaid

NON-TRADITIONAL BIRTHING OPTIONS AND CHOICES

In a nationally representative survey of women who delivered a singleton infant in a U.S. hospital in 2011-2012, only 6% of women reported doula care during childbirth. Among those without doula support, 59% were aware of doula care. Among women who were aware of doulas but did not have one, 27% of women reported that they would have wanted a doula. Black women and publicly insured/uninsured women had significantly higher likelihood of desiring, but not having a doula (3). Mothers who most need a doula and who would most benefit are unable to afford and access this support service (3).

ROLE OF MIDWIVES AND DOULAS

Midwives are trained medical professionals who care for women before, during, and after their pregnancies. Midwives tend to be proponents of natural childbirth and they usually try to minimize unnecessary interventions (4). Certified nurse-midwives (CNMs) are registered nurses. CNMs can help with prenatal exams, tests and screenings, diet, nutrition, and exercise advice. In addition, they can help with medications, emotional support, lactation and breastfeeding counseling, or education (5). In Texas, Medicaid recognizes CNMs as primary care providers for women. Per Texas Administrative Code §355.8161, Medicaid reimburses CNMs at 92% of the rate paid to a physician for the same service.

Doulas are professionals trained in childbirth who provide emotional, physical, and educational support to a mother who is expecting, experiencing labor, or has recently given birth. The doula's purpose is to help women have a safe, memorable, and empowering birthing experience. Many doulas are certified, but they do not deliver babies or offer any other kind of medical care (4). The use of a doula may assist pregnant mothers to avoid a Cesarean section (or C-section) delivery, giving birth without needing as many or any pain medications, and spending less time in labor. The presence of a doula throughout pregnancy provides pregnant women with a ready resource of support, information, and assistance (4).

Midwives are providers, just like physicians. Doulas are birthing assistants. Both midwives and doulas are present together only if the midwife is the provider. If there is a transfer, often the midwife will drop back into the doula role. However, if there is a doula during the transfer, the doula frequently goes with the pregnant person, especially if they need a C-section.

ST. DAVID'S FOUNDATION PLANNING GRANT

HHCDP is currently working to help St. David's Foundation to establish a Perinatal Safe Zone and to transform maternity care making a wide array of maternity care options available to all childbearing people. A Perinatal Safe Spot, as defined by Jennie Joseph, centers the needs of childbearing people. A Perinatal Safe Spot is judgment free, and no one is turned away from care. High quality and culturally congruent healthcare is provided freely to everyone who wants and needs it.

Many Black, Indigenous, People of Color (BIPOC) childbearing people in Central Texas have little to no financial means, experience little to no choice, no bodily autonomy, and few if any childbearing options. They often recount their childbearing experiences as hostile, harmful and traumatic, and leave feeling angry and traumatized, both physically and emotionally. HHCDP is working with St. David's Foundation to promote radical change in maternity care by establishing a Perinatal Safe Zone and implementing the JJ Way® Model of Maternity Care in Central Texas. The JJ Way® Model of Maternity Care will center the childbearing person, can be implemented in any care setting, and improves birth outcomes for BIPOC. HHCDP intends to make quality maternity care, which includes compassionate obstetrical care, midwifery care, doula support, lactation support, the choice and ability to birth at home, at a birthing center or a hospital, with whatever family or support the childbearing person chooses, available to all childbearing people, regardless race, ethnicity, gender, sexual orientation, or ability to pay.

MATERNAL HEALTH EQUITY PROJECT

Healing Hands Community Doula Project, as part of the Maternal Health Equity Collaborative (MHEC), and MEASURE previously designed, implemented, analyzed, and disseminated survey data from clients to inform reimagining what childbirth could be like for BIPOC childbearing people in Central Texas. A few of the survey takeaways in 2020 included: BIPOC respondents reported feeling isolated, and that their concerns were overlooked or ignored; Even when BIPOC childbearing people have the financial means, they are still not afforded the same comprehensive compassionate care as White childbearing mothers (6). When COVID-19 first hit, doulas were not welcomed in the hospital for pregnant mothers. MHEC and Community Resilience Trust (CRT) challenged the hospital about not allowing doulas to support pregnant mothers. In March of 2020, at the start of the COVID-19 Pandemic, MHEC and CRT addressed hospitals and doulas were granted admission to support pregnant clients.

HISTORICAL TIMELINE

A visual timeline depicting how historical racism contributes to the high rates of poor maternal healthcare outcomes and the disproportionate maternal mortality rates. The timeline shows childbearing mothers who are Black, Indigenous, People of Color more likely to experience barriers in receiving quality healthcare.

Please click the link to view the timeline: https://tinyurl.com/measurehhcdp. The sources for the historical timeline are listed in Works Cited page of this report, sources 7-19.

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WORKS CITED
SEE PAGE 2

HISTORY OF INJUSTICE FOR PROVISION OF MATERNAL HEALTH CARE

1845 — UNETHICAL EXPERIMENTATION

1845 James Sims began unethical surgical experimentation on enslaved Black women without consent or anesthesia. He was referred to as the "Father of Gynecology", and gained fame and wealth from these experiments (1).

The early **1900s** brought a rapid move toward medicalization of healthcare with a sharp increase in hospital births, especially outside of rural communities (2).

1920 — THE SHEPPARD-TOWNER ACT

1921 The Sheppard-Towner Act provided federal funds for states to create regulatory programs for midwives. Over the next decade, most states passed mandatory registration and certification laws in a campaign against Black Grand Midwives (3). The new laws were designed to ensure that midwives, who provided essential healthcare services to both black and white communities, were unable to practice (3).

1930-1970 — MEDICALIZATION OF HEALTHCARE

In **1938** fewer than 55% of births occurred in hospitals. but by 1960, that number had increased to over 90% of births (2).

Ina May Gaskin launched her career as a midwife and eventually became known as the "Grandmother of Modern Midwifery". She is credited with the practice of midwifery regaining popularity throughout the **1970s** (4).

1980-2014 — CDC MORTAILITY RATES RISE

Mortality rates began to climb in the late **1980s** (5). The Centers for Disease Control (CDC) and Prevention reported that the US pregnancy-related mortality ratio increased from 7.2 deaths per 100,000 live births in 1987 to 18.0 deaths per 100,000 live births in 2014 (6).

In a study of pregnancy-related deaths from 2011–2013 in the US, approximately 30% of those deaths occurred before birth, 17% during birth, 18% in the 1–6 days after birth, and 34% more than 6 days after birth (5).

2014-2016 — INSURANCE CHOICE IMPACTS BIRTH OUTCOMES

In **2014**, Affordable Care Act (Obamacare) listed maternity care as one of the ten essential health benefits that must be included in all new individual and small group policies (7).

In **2016**, although most births occured without adverse outcomes, women with Medicaid coverage were more likely to have preterm births and low-birthweight infants, both key indicators of birth outcomes, compared to privately insured women (8).

2017-2018 — JJ WAY MATERNAL HEALTH MODEL

The JJ Way, created by midwife Jennie Joseph, is a patient-centered model of care that seeks to address disparities in maternal health (9). A **2017** evaluation of the JJ model showed that women who received maternity care had lower preterm birth rates and better low birth weight outcomes (10).

In **2017**, Healing Hands Community Doula Project was started to serve and support childbearing black women in Central Texas creating a program utilizing full-spectrum black doulas from conception through the first year of their child's life (11).

2018-2021 — MATERNAL HEALTH LAW AND COVID-19

H.R. 1318 was approved on December 21, 2018 as Public Law 115 - 344 - Preventing Maternal Deaths Act of 2018 (12).

In **2018**, Black women in Texas were 3 times more likely to die from complications of childbirth than white women. A 2018 report found that nearly 80% of pregnancy-related deaths in Texas could have been prevented (13).

In **2019**, The social and economic impact of COVID-19 on maternal health was evident. A high frequency of maternal mental health problems, such as clinically relevant anxiety and depression, during the epidemic was reported (14).

2021-2022 — BIRTHING OPTIONS IN CENTRAL TEXAS

COVID-19, overwhelmed hospitals and the renewed interest in providing alternative ways to give birth was sparked by advocates like the Congressional Black Maternal Health Caucus, which has succeeded in pushing legislation to improve maternal health (14).

In Spring **2021**, Congress voted to allow states to extend Medicaid coverage for mothers up to one year after birth (16). In 2021, President Joe Biden signed the first bill that would invest in studying and addressing racial disparities in maternal care (15).

Historical timeline citation:
Jennings, E., & Miller, S. (2022, June 28). History of Injustice for Provision of Maternal Health Care. Retrieved from https://www.canva.com/design/DAFDBN-U-Io/1ArOogbyYgygzUS3ehXfhA/view?utm_content=DAFDBN-U-Io&utm_campaign=designshare&utm_medium=link&utm_source=publishsharelink

METHODOLOGY

The MEASURE Certified Educators used focus groups to better understand the experiences of the pregnancy and birthing process that took place within the last five years of low-income women and women of color to identify solutions on how to improve the overall pregnancy, birth, and postpartum journey in Central Texas. Insights from the focus groups informed recommendations on how to implement the JJ Way Midwives Model in Central Texas and create a perinatal safe zone that allows for low-income women and women of color to receive culturally congruent comprehensive maternity care.

FOCUS GROUPS

A MEASURE Equity Focus Group Tool® approach allows those who are historically and systematically impacted by disparate social outcomes to make up the majority of the focus group and leads to an elevation of rich data, showcasing the lived-experience of focus group participants. Three remote focus groups were conducted with community members who identified as being a low-income and/or woman of color that had a baby within the last five years in one of the following five counties of Central Texas: including Travis, Hays, Caldwell, Bastrop and Williamson counties. The focus groups took place in May and June 2022 using a web-based video conferencing tool called Zoom. We requested that all participants use their camera if possible. Each session lasted 105 minutes and covered the following activities: Core Values & Biases Assessment, Defining the Problem from Community Perspective, Historical Timeline, Equity-Focused Questions, and Wrap Up & Closing Remarks. The first focus group was used to co-define and evaluate questions that would be used in the protocol for the two remaining focus groups. In the second and third focus groups a Canva presentation template was used to guide the activities of the focus group. Participants were able to see each of the 12 questions discussed.

The participants were recruited by Healing Hands and their community partner Maternity Health Equity Collaborative through social media and email correspondence. The first focus group included 5 participants. The second focus group included 12 participants and the third focus group included 9 participants. Focus groups were conducted during the early evening on Saturday and Sunday to accommodate the community availability. All focus group participants spoke English. Approximately 65% of the participants resided in Austin proper. There were a total of 26 focus group participants. Described here is the demographic mix of the focus groups participants. Majority (24) of the focus group participants self-identified as Black/ African-American, 1 participant self-identified as Native American/Alaska Native, and 1 participant self-identified as both Black/African-American and Native American/Alaska Native. From an age perspective, 8% of the participants were between the ages 18-24, 69% of the participants were between the ages of 25-34, and 23% of the participants were 35-44 years old. In terms of gender, 88% of the participants identified as cisgender female. One participant self-identified as transgender female and two participants did not prefer to answer the gender related demographic question. 81% of the participants are working full-time, 11% are working part-time, and 8% are self-employed.

Most participants were in a relationship: 81% identified as married or in a domestic partnership and 19% identified as single (never married), divorced, or separated. More than half of the participants had private health insurance (54%), 11% had medicare, medicaid, or an Affordable Care Act Plan, 4% had multiple sources of health insurance, and 4% did not have any insurance during their last birthing experience. Health insurance information was not available for 27% of the participants. Income and education distribution can be found in the Figures 1 and 2 displayed below.

The focus group included participants who experienced their last birth in different settings: 73% in a hospital, 15% at home, and 12% in a birthing center. A significant number of participants experienced their last birth within the last two years in the midst of COVID-19. The timing of the last birthing experience across participants is displayed in Figure 3. There were participants with various perceptions of their pregnancy experience ranging from negative to positive as indicated in Figure 4.

FIGURE 1. PARTICIPANT INCOMES

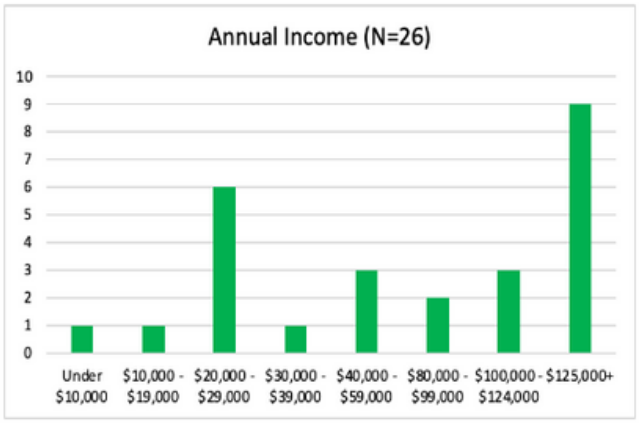


FIGURE 2. PARTICIPANT EDUCATION

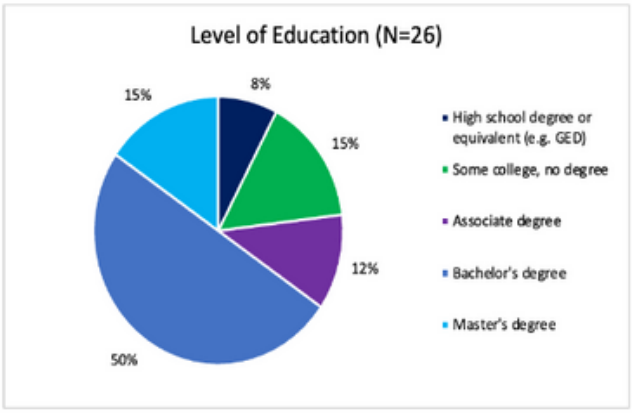


FIGURE 3. TIME SINCE LAST BIRTHING EXPERIENCE

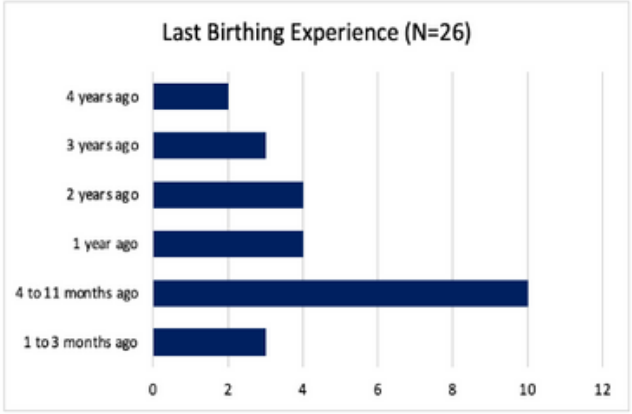
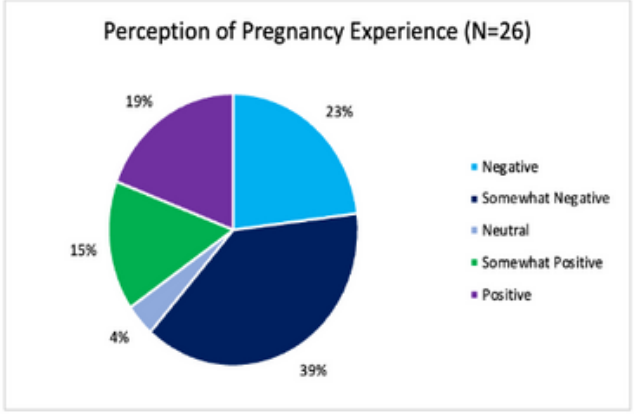


FIGURE 4. PREGNANCY EXPERIENCE PERCEPTION



THEMATIC ANALYSIS & FOCUS GROUP INSIGHTS

The focus groups help to identify solutions on how to improve the overall pregnancy, birth, and postpartum journey of low-income and Black, Indigenous, and People of Color (BIPOC) childbearing people in Central Texas. The transcripts and notes from focus groups were reviewed to identify patterns. Then an initial set of codes that represented the patterns identified in the data were created. The codes were grouped into themes. The following themes emerged from the three focused groups are: 1) need for more BIPOC & cultural competent non-BIPOC maternity care professionals, 2) benefits of having a doula, 3) partners need resources and support, 4) therapy & support groups during prenatal & postpartum care, 5) financial support, 6) importance of education and self-advocacy, 7) need for safety in maternal care team, and 8) resources needed for a healthy pregnancy journey.

NEED FOR BIPOC AND CULTURAL COMPETENT NON-BIPOC MATERNITY CARE PROFESSIONALS

Many focus group participants expressed that they had a hard time finding a Black doctor for their prenatal and postpartum care within the five counties of Central Texas. Participants who did have access to Black doctors expressed that the doctors had more knowledge of their body, better understood their concerns, and listened to them during their pregnancy journey. There was a feeling of safety just by having a Black doctor. Several focus group participants said they did not feel heard or non-Black maternity care professionals did not believe their pain level. One participant described it as she felt like an experiment, didn't feel non-Black maternity care professionals cared, and that she was blamed when she had to have an emergency c-section. It was the worst first pregnancy experience, especially since her actual doctor could not be there. The experience led the participant to not go back for a follow-up, rather found a new doctor working with Healing Hands and Black Mama ATX. Another participant did not go back for follow-up due to a bad experience with a c-section. Participants express the importance of having a connection with a caring, trustworthy, and compassionate doctor regardless of color.

There was a lot of discussion in the focus groups around the need for non-Black maternity care team members (including physician, nurse, anesthesiologist, & medical assistants involved in the pregnancy process) to do a better job at understanding issues with prior pregnancies and anything that mothers want to stay the same from those experiences. Participants said they think that non-Black maternity care professionals were still learning misinformation that Black bodies have a higher pain tolerance, were not taught how pregnancy looks different across cultures and incomes, and that one size approach does not fit all, which led to biases and misconceptions. Some participants said maternity care professionals needed to be trained in cultural competency to mitigate some of the adverse events that some had experienced in their last pregnancy journey. Focus group participants also conveyed that nurses were more critical to the overall pregnancy journey especially during delivery and their experience was often with a White nurse, and some of them did not receive culturally-appropriate maternity care from the White nurse. It is critical that the maternity care team does not allow their biases to interfere with providing prenatal and postpartum care to BIPOC childbearing people.

BENEFITS OF A DOULA

Focus group participants did not like that the doctor who provided prenatal care was not always available for delivery and felt a disconnect with the on-call doctor. One participant said she requested a Black doctor during her delivery as she wanted a sense of safety given her Black doctor could not be there. Most of the participants who had a birthing assistant, had a doula rather than a midwife. The doulas were often described as being a part of the Black race, which was intentional for most participants who did not have a doctor of color. The focus group participants who had Black doulas said they had a better experience in situations with White nurses or doctors not being available during delivery as the doulas provided familiarity, connection, protection, nurturing (i.e. essential oils, massages, music), and were able to advocate for them and elevate their voice throughout the process. Doulas helped mothers-to-be with developing an extensive birthing plan, providing education on the overall journey, reviewing different options for delivery experience, coaching & supporting partners, leading support groups, and advocating for the mothers' desires.

Participants that did not have doulas or did not have access to their doulas in delivery due to COVID-19 said they felt alone, paranoid, heightened anxiety, not able to have a real pregnancy experience due to shutdown, restrictions, and stressed considering pregnant people were more likely to be hospitalized if they were diagnosed COVID-19. There were no birthing classes, support groups, in-person baby showers, and partners were not able to attend regular check-ups. They wished they had access to a doula during COVID-19. Some participants appreciated COVID-19 because it gave them time to spend with their babies and adjust to their new life given the ability to work from home. Those that did not have a doula, did say they think the birthing experience would have been a better experience with a doula. In fact, a participant, who was a doula, said she regretted not having a doula and knew her voice would have been heard with a doula. A few participants had a doula and midwife during their pregnancy experience. There are limitations of having both midwife and doula with family members in the delivery room, so that is something to take into consideration when deciding to have both types of birthing assistants. There was no strong conclusion on if both a doula and midwife were needed. The decision to have a doula, midwife, or both came down to if the doula or midwife were covered by health insurance or offered through organization at a free or low-cost.

PARTNERS NEED RESOURCES AND SUPPORT

Partners were mentioned frequently as one of the main people that supported the focus group participants during their pregnancy journey. Several focus group participants highlighted the need to better prepare partners in the pregnancy journey. Some participants mentioned asking their doulas to help coach partners and provide resources to them. They felt that some partners did not know how to support them throughout the journey especially during an unexpected C-section or other pregnancy complications. Partners also needed access to resources that helped themselves such as postpartum therapy and additional time off from work. Participants mentioned the importance of making sure their partner was prepared and included in the overall process, especially the delivery and postpartum. They did not want their partners to feel lonely in the process.

> *I was stressed after 18 months of having my baby. I had lots of support from family, spouse, and pandemic made people available and supportive. After 18 months it started to catch-up with me and I started to feel burnout. Support gone and on its own to balance work and childrearing.*
>
> **- Participant with Positive 1st Pregnancy**

THERAPY AND SUPPORT GROUPS DURING PRENATAL AND POSTPARTUM CARE

Therapy was commonly mentioned throughout the focus groups. Participants said they participated in therapy and support groups during pregnancy and postpartum. Some participants had pre-existing mental health issues (i.e. anxiety, depression). Though only a few participants expressed participating in therapy during the pregnancy. Anxiety was the main mental health disorder that some participants expressed having during the pregnancy especially in situations where this was the first pregnancy. Participants suggested having options for attending individual therapy and support groups during pregnancy, so they could discuss the impact of their childhood on parenting style and learn from other childbearing people about the experiences throughout the pregnancy journey. One participant said that when she informed her doctor that she was mentally and emotionally exhausted during her pregnancy, the doctor tried to pressure her into taking medications.

Focus group participants that partook in therapy during postpartum typically had been diagnosed with post-traumatic stress disorder (PTSD), postpartum depression (PPD), and postpartum anxiety (PPA). Participants who went through a postpartum mood or anxiety disorder said they were afraid to take care of a baby or possibly suffocate their baby, so having open discussion and resources on anxiety and fears for taking a baby through the pregnancy journey would be helpful. It's important that the therapist be honest with childbearing people about what they are experiencing postpartum. A participant who did not have a therapist because she had a lot of family support, spoke about feeling burnout 18 months after the baby was born and family support was gone.

Those participants that had traumatic or adverse experiences during pregnancy, also suggested that the maternity professionals involved should also receive therapy and trauma-informed care education. There was a preference for Black therapists or therapists who have been trained to provide culturally congruent therapy. Some participants mentioned participating in support groups either offered by their healthcare provider or doula to manage their mental and emotional health during postpartum. Participants wanted to have multiple therapists to choose from and not rush the searching for the right therapist.

FINANCIAL SUPPORT

Financial limitations were mentioned as barriers to a positive pregnancy experience. A few participants mentioned that their insurance providers had restrictions on what maternity treatments and services they covered, and did not cover “alternative" forms of care. Many of the participants would have preferred to have access to a birthing center, doula, and midwife during their last pregnancy experience, but did not have money or adequate insurance to cover the expenses. The lack of healthcare coverage or money had a high prevalence among the childbearing people who identified as having a low income. Some participants said they could not afford childcare during pregnancy or postpartum, which contributed to stress levels. In addition, those participants who had their last pregnancy during COVID-19 discussed the financial impact they experienced due to losing their jobs or not being able to work during the shutdown. As a result, paying bills was difficult and one participant mentioned having to raise money from friends to cover their prenatal and postpartum care. Lack of funding for services has contributed to the reason why previous efforts in addressing persistent and worsening maternal health outcomes among low-income and childbearing people of color have not worked.

IMPORTANCE OF EDUCATION AND SELF-ADVOCACY

Education and self-advocacy were mentioned in all three focus groups. It is important to provide many options for learning and preparing for the pregnancy journey regardless of education level. There are childbearing people of color with bachelors, masters, and PhDs that don’t know they have choices in the pregnancy process because they typically just do what the doctors say. The participants wanted to know what they will experience, what to do and not to do, and be educated about their choices during the pregnancy journey to be able to speak up for themselves and know that they were heard by the medical team, partners, family, and friends.

A few focus group participants mentioned how they did not know how to tell family, friends, and others when they needed space and needed that type of coaching for when the doula or midwife is not around. Those participants that took a doula certification course, read books, listened to podcasts centered around people of color, and birthing classes felt well prepared and comfortable with the process. They felt they were able to advocate for themselves and set appropriate boundaries with family & friends. Participants wanted free birthing classes that would teach them about the placenta. Some participants wanted to exercise their power and voice in how maternity care was delivered to them. For example, it is important for the medical team to listen to childbearing people of color in their preference for the delivery position, not all women can lay on their back. One participant mentioned that laying on her back triggered memories of being sexually molested. In Central Texas, there is a need to educate to self-advocate and activate good maternity care among BIPOC pregnant people.

NEED FOR SAFETY IN MATERNAL CARE TEAM

"Safe" was a word heard often in all the focus groups regardless of whether the participants had a positive or negative birthing experience. They wanted to feel safe in their medical team's care and not be afraid of having a baby as a BIPOC childbearing person in Central Texas. Safety meant a lot of different things to the participants, and overall, it was about human connection, being treated as a human being, and knowing that they would receive culturally appropriate care throughout the pregnancy journey. Participants described safety as having a transparent, easy, and healthy pregnancy provided through culturally congruent care that includes being heard, regular check-ups, education, therapy, meditation, financial support, family support, eating healthy (essential nutrients), and being properly taken care during the birthing process.

RESOURCES REQUIRED FOR A HEALTHY PREGNANCY JOURNEY

Focus group participants indicated that certain resources were necessities to support healthy pregnancy journeys and achieve better health outcomes. Below is a list (Table 1) of resources that can help create a safe environment and reduce the chances of pregnancy-related complications among childbearing people in Black, Indigenous, and People of Color communities within Central Texas. The resources needed vary across all stages: during pregnancy, delivery, and postpartum. Some of the resources are needed throughout the journey such as therapy and some resources are only needed during pregnancy such as birth classes. These resources can help create the community conditions that support BIPOC pregnant people before, during, and after birth as well as give them the choices they need in the overall pregnancy journey. Affordability, education, availability, accessibility, technology, cultural appropriateness, and awareness were the main barriers to obtaining most of these resources.

TABLE 1. LIST OF RESOURCES FOR A HEALTHY PREGNANCY JOURNEY

BIPOC & Culturally Competent Medical Team Database

- Obstetrics & Gynecology
- Holistic Practitioners
- Pediatricians & Family Physicians
- Therapists & Social Workers

Chiropractic care, Acupuncture, & Massage Services

Culturally Competent Hospitals & Birthing Centers

Culturally Competent Birth Services & Training Programs

- Doula & Midwifery Services

BIPOC Centered Education

- Pre-pregnancy Classes
- Birth Classes (in-person & online)
- Breast-feeding and Lactation
- Books & Podcasts
- Library Membership

Healthy Food Services & Nutritionists

Childcare Services

Housing Resources

Postpartum Care & Post Birth Planning Up to 3 years Partners, Family, & Friends Services

- Therapy
- Education Resources

Diverse Support Groups

- Peer Mentoring/Buddy Database
- Group Prenatal Care
- Mom Groups
- Parenting Groups
- Play Groups

Financial Grants & Services

- Free & Low Cost Services
- Regular Check-ups & Support Stipends
- Childcare Stipends
- Parental Leave Stipends
- Technology Stipends
- Flexible Work Schedule

Physical & Spiritual Wellness Services

- BIPOC Centered Churches
- Parks & Recreation Centers
- BIPOC Centered Fitness Coaches
- Yoga

LIVED-EXPERIENCE DATA & STORYTELLING

> The Edinburgh Postnatal Depression Scale (EPDS) is a checkbox. No one ever addressed my scoring high on it but the pediatrician and my OB both administered it at every appt. It was a dang checkbox not actually used to help me.

- Participant with Somewhat Negative 1st Pregnancy

"Read a lot of books and listened to many podcasts that centered on people of color and evidence based holistic perinatal healthcare. Taking the time to educate myself about pregnancy, birth, and postpartum and including my partner in those initiatives truly contributed to having a successful and healthy pregnancy and home birth."

- Participant with Positive 1st Pregnancy

"After my first birth, I found out that my doula (the one that went to bat for me) was a Trump supporter. I felt violated and I was really upset. I will always have a Black doula because I need someone who I can trust to honestly care about me, my life, and my family's life."

- **Participant with Positive Geriatric & Multiple Pregnancy**

LIVED-EXPERIENCE DATA & STORYTELLING

> I didn't realize the effect my childbirth experience had on my husband. He witnessed a lot and it definitely impacted our marriage following.
>
> **-Participant with Somewhat Negative 1st Pregnancy**

"I was mentally and emotionally exhausted and I would tell one of the doctors I saw at my OB office and she would always push the whole “take this medication” and I felt pressured, but I was able to find a doctor that listened to me and made me understand my emotions and what I was mentally going through, made me feel so much better. I made all my appointments specifically with her and although she didn’t deliver my son, she came the next morning and stayed with me for a while talking and making sure I was comfortable with breastfeeding. See her to this day because I feel so comfortable with her."

- Participant with Positive 1st Pregnancy

our experience makes us EXPERTS

LIVED-EXPERIENCE DATA & STORYTELLING

Had the baby on the 14th epidural wore off on the 15th. Didn't regain movement in my left leg, from my lower left leg to my foot. It's been almost two months. And I am basically paralyzed from that and can't walk unassisted, they don't know what's going on. I have nerve pain. It wasn't a near death experience. I wanna clear that up, but I am not at my normal self as I went into the hospital. And there's a lot of fingers pointing on what happened, but now I'm having a newborn and I can't walk. And that's what I've taken from this childbirth.

-Participant with Negative Geriatric & 1st Pregnancy

"For me, I feel like I'm in the wrong place, but I'm very grateful to have a black doctor. And so that stuck out more because she looked like me. Cause prior to her, I had a white doctor where I felt like I wasn't being heard about the situations that I was dealing with having fibroids, DCOS, all the infertility things. And I was dealing with it prior to going to the black doctor. But once going to my doctor, that doctor, I felt safe."

- Participant with Somewhat Positive 1st Pregnancy

RECOMMENDATIONS FOR PERINATAL SAFE ZONE IN CENTRAL TEXAS

#1 Provide access to a database of BIPOC and culturally competent maternity care professionals: Certified non-BIPOC Maternity Care Professionals serving Central Texas: Focus group participants shared that they preferred and felt safe with BIPOC Maternity Care Professionals. They also acknowledged the need for non-BIPOC Maternity Care Professionals to have been trained to provide culturally congruent care and perinatal safety strategies. Some participants mentioned they had a hard time finding a BIPOC doctor for their last birthing experience. BIPOC childbearing people need a central location for finding and researching BIPOC Maternity Care Professionals and Culturally Competent Certified non-BIPOC Maternity Care Professionals in Central Texas.

#2 Provide access to doulas of color for free or at a low cost: Whether participants had a doula at the beginning, middle, or end of their last pregnancy journey, they all agreed that their experience was better because they had a doula. Doulas provide connection, advocacy on behalf of mothers, an extensive birthing plan, child birthing education, different options for delivery experience, coaching for partners, and support groups. However, health insurance typically does not cover doula or midwife services and mothers who would most benefit are unable to afford doula services. Financial assistance can help support BIPOC pregnant people in obtaining alternative birthing services.

#3 Ensure partners receive specialized training, education, postpartum therapy, and other resources: Partners are an important member of the maternity care team yet are overlooked or ignored during the pregnancy journey. It is essential that resources are centered around partners not only providing information on how to support BIPOC mothers, but also helping partners through the process with free or low-cost specialized education, training, postpartum therapy, and support groups so they are better prepared for BIPOC mothers.

#4 Ensure culturally competent therapist & support group options are available during prenatal & postpartum care: Therapy is often sought during postpartum care. Focus group participants revealed the need to have access to therapy and support groups throughout the pregnancy journey. Anxiety and depression were the most common mental health problems mentioned during the focus groups. The Perinatal Safe Zone should provide free or low-cost individual therapy and support groups options during pregnancy and after birth.

#5 Offer financial assistance to cover prenatal and postpartum care expenses: Affordability is one of the key barriers to accessing resources needed for a healthy pregnancy journey. In order to provide quality maternity care through an array of services including compassionate obstetrical care, midwifery care, doula support, lactation support, the choice and ability to birth at home, at a birthing center or a hospital, childcare services, therapy, support groups, healthy food, partners & family support, and other essential culturally appropriate resources mentioned during the focus groups to BIPOC childbearing people in Central Texas, financial assistance must be provided. Another way to provide financial assistance is by offering some of these services free or low-cost. Provide easy access to financial grants or stipends to assist in covering expenses during pregnancy and postpartum up to 3 years.

RECOMMENDATIONS FOR PERINATAL SAFE ZONE IN CENTRAL TEXAS

#6 Offer on-line and in-person BIPOC centered education series, podcasts, books, and a peer mentoring program. Focus groups participants shared the need to have a voice, choice, and feel heard. Participants mentioned the importance of being educated about what to expect in the pregnancy journey and what choices are available. They said knowledge sharing between the medical team and other peers was essential to creating a healthy pregnancy journey and better health outcomes. One suggestion received during the focus groups is to offer an orientation program and group prenatal care to help educate people and keep them informed. The orientation program could cover topics such as happy and disruptive birth, dos and don'ts of pregnancy, breastfeeding and its complications, know your pregnancy rights, setting boundaries, pediatric CPR, safe sleeping for infants, and how to handle a crying baby. The group prenatal care allows for a group of childbearing people at the same stage to come together over 10-12 weeks to learn skills related to pregnancy, birth, postpartum, and parenting; share information through facilitated discussions; receive routine health assessments; and develop a support network. Another suggestion is to offer a peer mentoring program to help people share knowledge and provide continuous support for each other during pregnancy and after birth. These programs should be led by culturally competent instructors.

#7 Develop a toolkit that provides training on culturally congruent practices, perinatal safety strategies, and trauma-informed practices for all maternity care team members in Central Texas. Focus group participants expressed the need to feel safe with their maternity care team. The toolkit should provide training that emphasizes the importance of collaborative teamwork, transparent communication, cultural awareness, trauma-informed approach, and in situ simulation with the goals of building a connection to enable a partnership with the mother and providing person-centered maternity care that is inclusive of the partner, family, and friends. This toolkit should be made available to all maternity care professionals and facilities that want to serve BIPOC childbearing people in Central Texas.

#8 Offer easy and affordable access to resources needed for a healthy pregnancy journey and improve maternal health outcomes. Ensure to implement equitable eligibility requirements for accessing the resources. The resource providers should be trained in culturally congruent practices, so they are able to provide culturally appropriate services and experiences when working with BIPOC childbearing people. Implement an inclusive marketing approach to how BIPOC childbearing people are made aware of the perinatal safe zone and available resources. Resources should be made available in-person and online as much as possible and across all stages in the pregnancy journey, where it makes sense. Resources should be provided at an affordable cost or able to be covered with various types of health insurances including Medicaid and Medicare. Financial grants or stipends should be available to cover any pregnancy related resources not able to be covered by health insurance or out of pocket. Although technology has been used to improve prenatal care and reduce inequalities, it is important that the resources provided through the perinatal safe zone program are accessible to communities and locations that are less technologically advanced. Ensure that resources are made available within a reasonable time and provide access to alternative sources if resources are not available. Consider including a mobile version of the perinatal safe zone to increase reach and make these resources available to BIPOC childbearing people in rural areas of Central Texas.

CONCLUSION

BIPOC and low-income childbearing people can have a healthy pregnancy journey and good maternal health outcomes. As revealed in this research they need: 1) affordable access to doulas, midwives, birthing centers, and other perinatal resources during pregnancy and after birth, 2) connection and partnership with a culturally competent maternity care team, 3) knowledge provided to the mother, partner, family, and friends on what to expect during the entire process and all available childbearing options, and 4) empowerment to self-advocate and make decisions that activate maternity care that is best for them. This is the “radical change in maternity care” that emerged from listening to the BIPOC and low-income childbearing community and understanding their lived pregnancy experiences in Central Texas. These four requirements align to the core principles of the JJ Way® Model of Maternity Care and further supports the integration of this model in the development of a culturally relevant and accessible Perinatal Safe Zone in Central Texas.

By addressing these needs through a Perinatal Safe Zone, St. David’s Foundation will help eliminate racial and social-economic class disparities in perinatal health and improve birth outcomes for all in Central Texas. In order to create the Perinatal Safe Zone in Central Texas that benefits all, the needs of the BIPOC and the low-income childbearing community should take center stage. It is critical that BIPOC and the low-income childbearing community are leading decision makers in their maternity care and should continue to be involved in the design and development of the Perinatal Safe Zone in Central Texas.

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