# DIVERSE COLORADO VOICES

## COMMUNITY-BASED SOLUTIONS FOR THE PERINATAL PERIOD

*Shelby Irvin, CLC, pictured with her husband, Talos Irvin, and their daughter. Shelby is the only Black Certified Lactation Counselor in El Paso County. She is also a Doula, Childbirth Educator, Midwifery student, and owner of The Soulful Mama, LLC.*


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Clayton EARLY LEARNING

FAMILIES FORWARD RESOURCE CENTER
Strong Families, Strong Communities

Raise COLORADO

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# DEDICATION

We want to acknowledge that this report encompasses input from inhabitants of territories of the Dine, Ute, Pueblo, Hopi, Cheyenne, and Arapaho peoples. Further, we acknowledge that 48 contemporary tribal nations[1] are historically tied to the lands that make up the state of Colorado. We also recognize that land acknowledgment is how we continue to recognize and pay homage to our own rich diverse nations within our own communities, in governance, in celebration, and in ceremony. We acknowledge and dedicate this report to the profound historical role of Indigenous Midwives and other maternal health leaders on these lands. Of those leaders we would like to specifically acknowledge Dr. Justina Ford, Colorado's first Black woman physician, who supported the birth of generations of Black and immigrant Coloradans.[2]

We would like to acknowledge that birth equity and reproductive justice has traditionally been the work in and of the community. This report is a synthesis of community member input from 31 zip codes, 29 of which are in Colorado, one in Wisconsin, and one in central California, on issues and solutions in infant and maternal health in the state. While acknowledging the work that birth equity advocates have done in Colorado, we would be amiss to not recognize Demetra Seriki, Colorado's only Black Certified Professional Midwife, and her extraordinary work to eradicate perinatal racial disparities in her practice, A Mother's Choice Midwifery, in El Paso County. We also recognize and honor the leadership of multiple partner organizations that have been the historical trail blazers in birth equity and reproductive justice in Colorado, including Elephant Circle, Heather Thompson, Indra Lusero, the Colorado Organization for Latina Opportunity and Reproductive Rights (COLOR), and Soul2Soul Sisters. Without their work we would not have a path forward to advance birth justice and equity in Colorado.

1 Colorado Commission of Indian Affairs and History, Colorado. (2019). Colorado Tribal Contacts List. *Colorado Commission of Indian Affairs and History Colorado.* https://www.colorado.gov/pacific/sites/default/files/atoms/files/Tribal%20contact%20list%20July2019%20%281%29.pdf

2 Jones, K. (2020). For People of Colorado, Could Homes Births Be Safer? Colorado Trust. https://www.coloradotrust.org/content/story/people-color-could-home-births-be-safer-hospitals

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## OTHER CONTRIBUTORS

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# KEY TERMS AND DEFINITIONS

## ANTI-RACISM

Anti-racism is a focus on transforming and disrupting white supremacy culture, racist policies and power structures, and racial inequalities that shape interactions on a personal, institutional, and systemic level.

## COMMUNITY

In relation to activism, community implies the involvement of individuals and groups directly impacted by specific issues or conditions that are the focus of change. For the purpose of this report, community is defined as individuals who are not affiliated with an institution or agency but rather represent groups of people and families who have historically been left out of the decision-making table in light of policy development.

## HEALTH EQUITY

Health Equity is the vision that everyone has a fair opportunity to be as healthy as possible. This vision must be operationalized to remove obstacles to health, like racism, poverty, discrimination, and its consequences, including powerlessness and lack of access to decision making, safe environments, education, housing, and health care. Health Equity reduces and ultimately eliminates disparities in health.[3]

## INSTITUTIONAL RACISM

Institutional racism refers to the ways in which institutional policies and practices create different outcomes for different racial groups. The institutional policies may never mention any racial group, but its effect is to create advantages for whites and oppression and disadvantage for people of color. Examples:

- Government policies that explicitly restricted the ability of people to get loans to buy or improve their homes in neighborhoods with high concentrations of African Americans (also known as "red-lining").
- City sanitation department policies that concentrate trash transfer stations and other environmental hazards disproportionately in communities of color.[4]

## MATERNAL DEATHS (MATERNAL MORTALITY)

Individual deaths that occur during pregnancy and up to 42 days postpartum. **Late Maternal Deaths** are extended to deaths occurring more than 42 days but less than one year postpartum.[5]

## MATERNAL MORBIDITY

Maternal Morbidity is an overarching term that refers to any physical or mental illness or disability directly related to pregnancy and/or childbirth. These are not necessarily life-threatening but can have a significant impact on the quality of life.[6]

3 Braveman, P. (2017). A New Definition of Health Equity to Guide Future Efforts and Measure Progress. https://www.healthaffairs.org/do/10.1377/hblog20170622.060710/full/

4 Potapchuk, M., Leiderman, S., Bivens, D., Major, B. (2005). Flipping the Script: White Privilege and Community Building

5 Maternal deaths. (n.d). https://www.who.int/data/gho/indicator-metadata-registry/imr-details/4622

6 Koblinsky, M., Chowdhury, M. E., Moran, A., & Ronsmans, C. (2012). Maternal morbidity and disability and their consequences: neglected agenda in maternal health. Journal of health, population, and nutrition, 30(2), 124–130. https://doi.org/10.3329/jhpn.v30i2.11294

## PERINATAL PERIOD

The perinatal period commences at 22 completed weeks (154 days) of pregnancy and ends seven completed days after birth. Perinatal and maternal health are closely linked as defined by the World Health Organization.[7]

## PREECLAMPSIA

Preeclampsia is a pregnancy complication characterized by high blood pressure and signs of damage to another organ, most often the liver and kidneys. Preeclampsia usually presents after 20 weeks of pregnancy and can lead to serious, even fatal, complications for both the birthing parent and the baby. The most effective treatment of advanced preeclampsia is delivery. Postpartum preeclampsia is a rare condition in which preeclampsia occurs after delivery, rather during the prenatal period.[8]

## RACIAL EQUITY

Race is no longer a predictor of outcomes, leading to more just outcomes in policies, practices, attitudes, and cultural messages.[9]

## RACISM

Racism is the systematic subjugation of members of targeted racial groups, who hold less socio-political power and/or are racialized as non-white, as means to uphold White supremacy. Racism differs from prejudice, hatred, or discrimination. It requires one racial group to have systematic power and superiority over other groups in society. Racism is implicitly and explicitly supported and maintained by institutional structures and policies, cultural norms and values, and individual behaviors.[10]

## RACIST POLICY

A racist policy is any measure that produces or sustains racial inequity among racial groups. Policies are written and unwritten laws, rules, procedures, processes, regulations and guidelines that govern people. Racist policies are also expressed through other terms such as "structural racism" or "systemic racism". Racism itself is institutional, structural, and systemic.[11]

## WHITE SUPREMACY

White supremacy is the idea (ideology) that white people and their ideas, thoughts, beliefs, and actions are superior to that of People of Color. White supremacy is an artificial and historically constructed culture that justifies and binds together white-controlled institutions into systems, such as the United States system, and white-controlled systems into the global white supremacy system.[12]

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7 Maternal and perinatal health. (n.d) *World Health Organization.* https://www.who.int/maternal_child_adolescent/topics/maternal/maternal_perinatal/en/

8 Preeclampsia. *Mayo Clinic*. https://www.mayoclinic.org/diseases-conditions/preeclampsia/symptoms-causes/syc-20355745

9 CCSSP (2019). Key Equity Terms and Concepts: A Glossary for Shared Understanding. Washington, DC: Center for the Study of Social Policy. https://cssp.org/wp-content/uploads/2019/09/Key-Equity-Terms-and-Concepts-vol1.pdf

10 Ibid.

11 Kendi, I. (2019). How to be an Antiracist, Random House

12 White Supremacy Culture. SURJ Workshop. https://www.showingupforracialjustice.org/white-supremacy-culture.htm

# EXECUTIVE SUMMARY

Issues in maternal health in Colorado are as unique as the state's geographical landscape. Maternal and infant mortality are often used as measurements of overall infant and maternal health. Infant and maternal health are also indicators of societal health. The well-being of mothers, parents, infants, and children determine the health of the next generation, and healthy birth outcomes enable children to reach their full potential.[13] It is hard to compare maternal health and maternal mortality (defined as deaths during pregnancy to 365 days postpartum) with that of other states; nationally, women are dying from pregnancy-complications more than in any other developed country in the world. In Colorado, maternal mortality is (relatively) low; 35 women die each year. However, nearly 80% of their deaths are preventable.[14] Racial perinatal disparity rates have been long documented, but there is significant lack of transparent perinatal (defined as time, usually a number of weeks, immediately before and after birth) racial disparity data in Colorado. There is an opportunity to clarify and quantify the benefit of community birth, open access clinic models, and the model of Midwifery care in the state of Colorado to achieve better birth outcomes. There is also an opportunity to improve maternity care in Colorado overall.

13 Maternal, Infant, and Child Health. Office of Disease Prevention and Health Promotion https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Maternal-Infant-and-Child-Health

14 Navarro. N, (2019) The Maternal Mortality Rate in the US is Hight. Colorado is Spending to Try to Stop it. CPR News. https://www.cpr.org/2019/06/18/the-maternal-mortality-rate-in-the-us-is-high-colorado-is-spending-to-try-to-stop-it/

## EXECUTIVE SUMMARY (CONTINUED)

In July 2020 the Maternal Mortality Review Committee released their report titled Maternal Mortality in Colorado, 2014 - 2016 which examines all cases of maternal death. The team reviews an array of deidentified records and materials on each case organized by the Colorado Department of Public Health and Environment to determine the cause of death, designate if the death was preventable, indicate if the death was pregnancy-related, and outline the contributing factors. The committee described one of the next steps in the process as identifying community-led solutions to maternal mortality. The report acknowledges that "grassroots community-based perinatal and birth providers and activists all play a unique and necessary role and will be a part of community-led solutions."

Ultimately 66 community members participated in the five virtual listening sessions, resulting in three overarching themes impacting perinatal outcomes: systemic racism, lack of postpartum support, and systems-level inadequacies. Community members shared that the result of systemic racism ranges from distrust in the system and specific institutions to cases of preventable morbidity and mortality. Examples of implicit and explicit racism were shared by community members, culminating in the recommendation that individuals interacting with perinatal populations desperately need universal, ongoing, and comprehensive anti-racism training. Community members communicated experiencing extremely inadequate postpartum support, ranging from a lack of mental health support to non-universal and/or minimal lactation consulting support. Finally, community members described systems-level inadequacies including receipt of low-quality medical care with an insufficient focus on prevention, issues regarding insurance coverage, limited family medical leave, and geographic disparities across the state. This report provides an in-depth understanding of each of these themes and identifies barriers and solutions through case studies representative of community member experience within each theme.

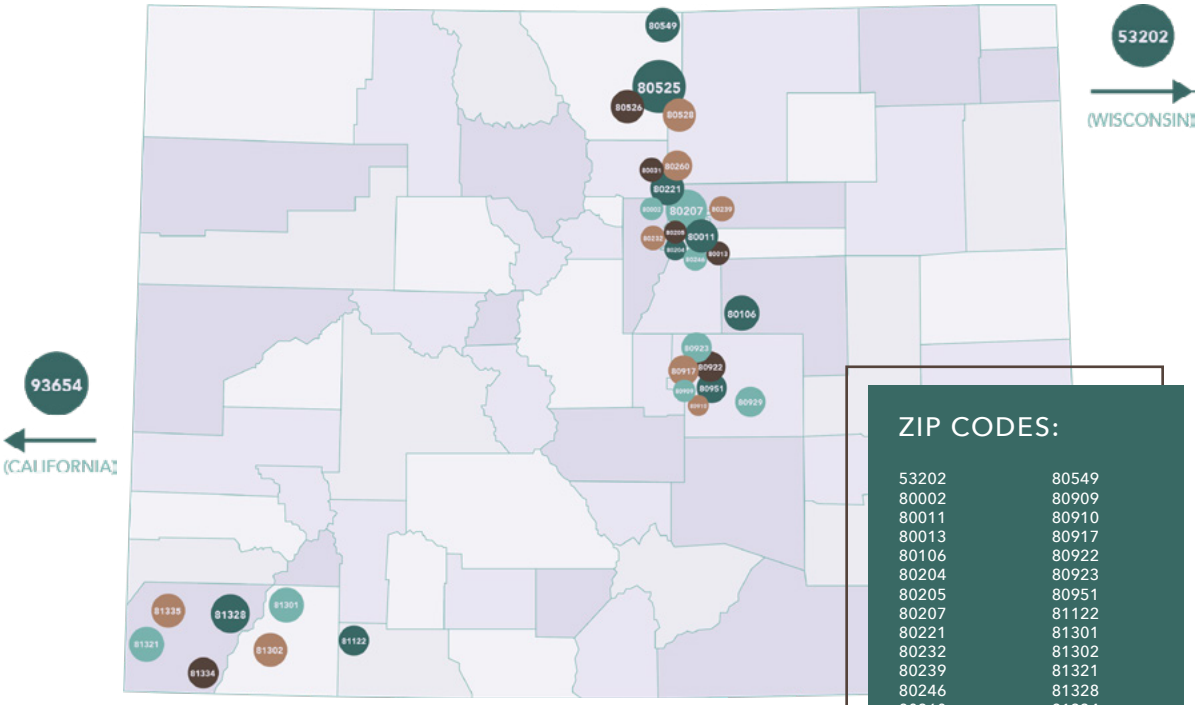
Following the findings of the report, four categories of opportunity for systemic change and 24 possible policy recommendations are identified to aid various stakeholders in supporting anti-racist policies, practices, and programing to optimize over-all improvements in maternal health in Colorado. It is imperative that all efforts aiming to improve maternal health outcomes consider the interconnected systems that impact both an individual's and families' ability to thrive, including, but not limited to, the systems of healthcare, education, criminal justice, and housing. Therefore it will take an intentionally collaborative movement to minimize the number of cases of maternal mortality and morbidity (defined as any physical or mental illness or disability directly related to pregnancy and/or childbirth) and achieve health equity.[15]

**This report implores us all to approach these efforts with a collaborative, anti-racist mindset in partnership and allyship with community members most impacted by health disparities.**

15 Koblinsky, M., Chowdhury, M. E., Moran, A., & Ronsmans, C. (2012). Maternal morbidity and disability and their consequences: neglected agenda in maternal health. Journal of health, population, and nutrition, 30(2), 124–130. https://doi.org/10.3329/jhpn.v30i2.11294

## HOW TO USE THIS REPORT

This report is intended to highlight community voices while aligning advocacy efforts amongst partner organizations committed to birth equity in Colorado. As a community member, as a legislator, and an advocate, you are able to use this report to reflect on a few of the lived experiences of our community members, inform your work, and to push to optimize health equity in maternal and infant care with a particular focus on perinatal disparities. The data provided represent a sample of community members from 44 of the 66 participants, from 29 Colorado zip codes. While participants shared their experiences and recommendations, this report is not intended to completely describe the vast array of experiences across the state. Therefore, while this report is intended to inform, it is also intended to encourage you to immerse yourself in equity and justice work in allyship with communities most impacted by inequity. Communities that experience disparities know what is best for their community and should be supported to achieve these solutions. Achieving equity often means allocating resources that have historically been intentionally unavailable to these exact communities. Further, this report is intended to highlight the leadership of community members, birthing parents, perinatal professionals of color, and their invaluable work to address birth equity in Colorado.

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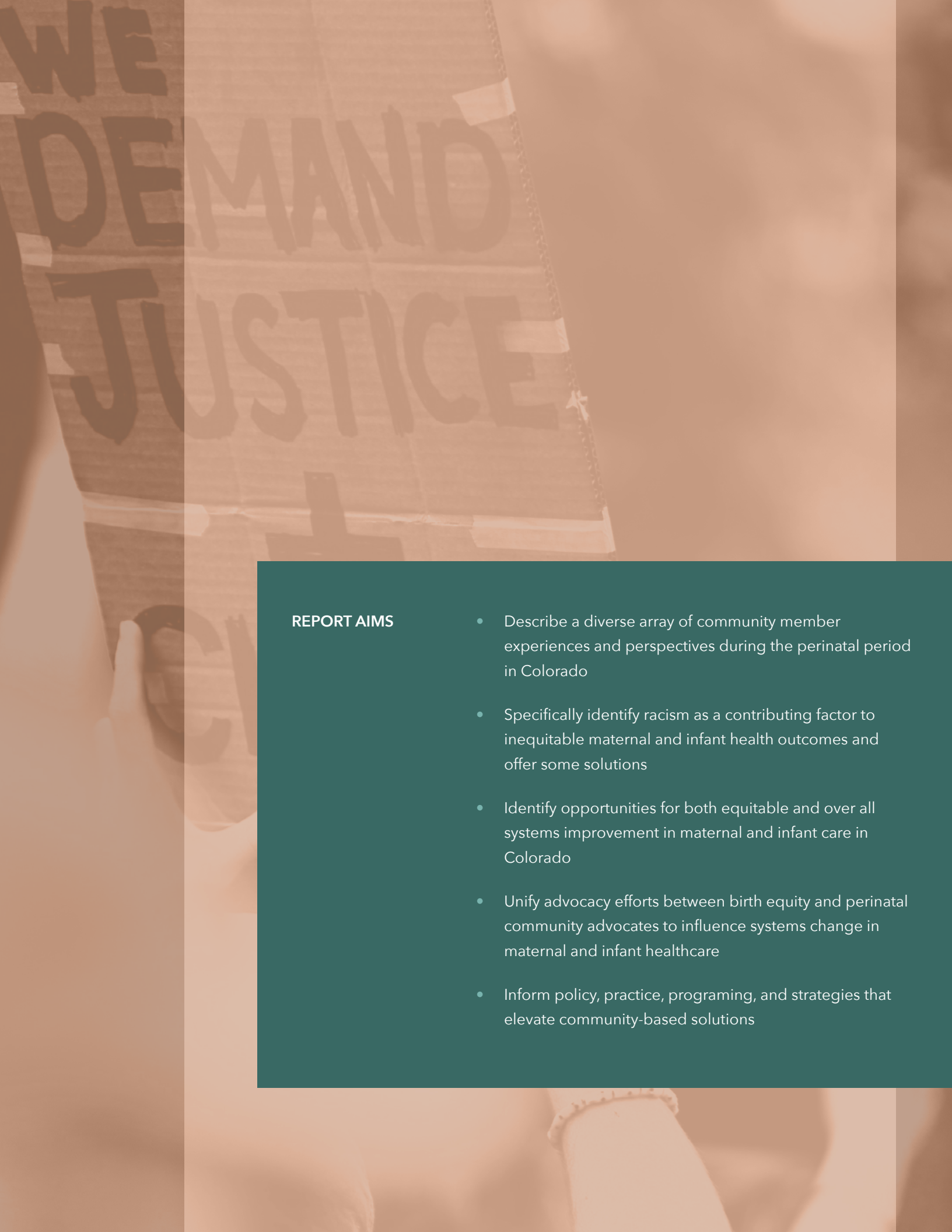



**REPORT AIMS**

- Describe a diverse array of community member experiences and perspectives during the perinatal period in Colorado
- Specifically identify racism as a contributing factor to inequitable maternal and infant health outcomes and offer some solutions
- Identify opportunities for both equitable and over all systems improvement in maternal and infant care in Colorado
- Unify advocacy efforts between birth equity and perinatal community advocates to influence systems change in maternal and infant healthcare
- Inform policy, practice, programing, and strategies that elevate community-based solutions

# INTRODUCTION

Maternal health outcomes have been a topic of conversation amongst community members, birth equity leaders, public health specialists, and law makers for decades, though these discussions tend to rarely overlap. In 2019 the Colorado Maternal Mortality Review Committee (MMRC) was formally authorized and funded to support its review of maternal deaths, provide recommendations to the legislature, and to ultimately keep pregnant and postpartum people safe.[16] The committee launched the Maternal Mortality Review Committee report in July 2020, acknowledging that community should be a part of driving solutions to issues in infant and maternal health. The listening sessions presented in this report serve as a complementary to the MMRC report, highlighting the personal and professional expertise of community members.

There is a critical opportunity to engage community stakeholders to better contextualize maternal and infant health across the state, with a focus on perinatal racial disparities. It is understood that experiencing structural racism and individual-level racism impacts maternal and infant outcomes. For instance, evidence suggests that geographical proximity to communities experiencing systemic racism in the form of police brutality is associated with higher rates of maternal depressive symptoms among Black birthing women.[17] ZIP codes that are home to increased proportions of residents of color have fewer Obstetrics and Gynecological healthcare providers, resulting in reduced access to care for Black, Indigenious, and People of Color (BIPOC) birthing people.[18, 19] Housing has been identified as a correlated determinant of health in maternity care. Pregnancy actually increases a woman's likelihood of experiencing homelessness, and redlining has been associated with residential segregation among pregnant women.[20, 21] Language access, culturally responsive care, availability of diverse providers, and choice all play vital factors in achieving optimal maternal and infant health.[22]
The United States is poised at a critical juncture in our history. Racial inequities have been on full display in the United States as racism, white supremacy, and political turmoil persist. The COVID-19 pandemic has exacerbated the barriers to optimal care for many

16 https://leg.colorado.gov/bills/hb19-1122

17 Premkumar, A. , Nseyo, O. & Jackson, A. V. (2017). Connecting Police Violence With Reproductive Health. Obstetrics & Gynecology, 129(1), 153–156. doi: 10.1097/AOG.0000000000001731.

18 Yimgang, D. P., Wang, Y., Paik, G., Hager, E. R., & Black, M. M. (2017). Civil Unrest in the Context of Chronic Community Violence: Impact on Maternal Depressive Symptoms. American journal of public health, 107(9), 1455–1462. https://doi.org/10.2105/AJPH.2017.303876

19 Premkumar, A. , Nseyo, O. & Jackson, A. V. (2017). Connecting Police Violence With Reproductive Health. Obstetrics & Gynecology, 129(1), 153–156. doi: 10.1097/AOG.0000000000001731.

20 Robin, E. Clark, L.W., Julie M. F., Robert W. S. (2019). Pregnant and Homeless: How Unstable Housing Affects Maternal Health Outcomes. Health Affairs. https://doi.org/10.1377/hlthaff.2018.05156

21 Mendez, D. D., Hogan, V. K., & Culhane, J. (2011). Institutional racism and pregnancy health: using Home Mortgage Disclosure act data to develop an index for Mortgage discrimination at the community level. Public health reports (Washington, D.C. : 1974), 126 Suppl 3(Suppl 3), 102–114. discrimination at the community level. Public health reports (Washington, D.C. : 1974), 126 Suppl 3(Suppl 3), 102–114.

22 E., Lattof, S. R., & Coast, E. (2017). Interventions to provide culturally-appropriate maternity care services: factors affecting implementation. BMC pregnancy and childbirth, 17(1), 267. https://doi.org/10.1186/s12884-017-1449-7

## INTRODUCTION (CONTINUED)

communities, including those in the perinatal period. The pandemic has only further revealed the need for anti-racist policies, practices, programing, and care during the perinatal period, and in a pandemic.

Advocates and leaders are turning to community voices to inform their work in reviewing policies, practice, programming, and budgeting. Community members and families directly impacted by policies are often the most valuable stakeholders in the development of policy, and their community voices, perspectives, and lived-experiences are critical for the success of sound, equitable policy. This report, comprising five listening sessions with community members, birth advocates, Midwives, Doulas, early childhood education advocates, mental health professionals, and birth workers, highlights the issues that have persisted in maternity and infant care in Colorado. Individuals who are most impacted by issues around perinatal care often have the most thoughtful and innovative solutions to systems change. This report proposes community driven solutions to address the issues in maternal and infant care for Colorado families.

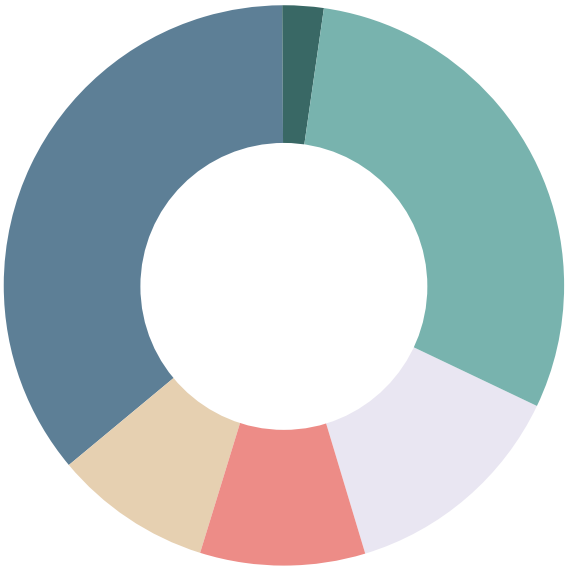
**Community members and families directly impacted by policies are often the most valuable stakeholders in the development of policy.**

# METHODOLOGY

The data in this report were collected from five virtual listening sessions, involving 44 of the 66 total participants, and 12 one-on-one story collections with listening session participants. Four of the listening sessions were held in English and the fifth was attended by bilingual (Heritage Spanish/English) speakers, such that the listening session continuously switched between Spanish and English. Listening sessions were facilitated by community leaders dedicated to optimizing equity in reproductive health, birthing practices, maternal health, and infant health. Community leaders were identified through previous work and relationships with Raise Colorado and the listening session project manager, with focus dedicated to identifying community members and birth workers who are traditionally overlooked by the system. It was critical to recruit a diverse population for input on matters that affect birthing people.

> **Sixty-four percent of participants racially/ ethnically self-identified as other than white or caucasian.**
>
> *(30% Black/ African American/ Pan Afrikan, 14% Hispanic/Chicana/Latinx, 9% Native American/ American Indian/Indigenous, 9% multiracial, and 2% Asian).*

Many individuals living in rural areas participated to elevate these experiences and perspectives regarding maternal health. Thirty-one zip codes were represented in the listening sessions. Almost half of the participants were parents or someone who has given birth. Alongside those, participants were predominantly people who work with new parents, birthworkers, Doulas, caregivers, and educators in the early childhood field, including infant mental health.



RACIAL & ETHNICAL SELF-IDENTIFICATION OF SURVEY PARTICIPANTS

- Asian - **2%**
- Black/African American/ Pan Afrikan - **30%**
- Hispanic/Latino/Chicano - **14%**
- Multiracial - **9%**
- Native American/American Indian/Indigenous - **9%**
- White/Caucasian - **36%**

## METHODOLOGY (CONTINUED)

Listening session facilitators, co-hosts, and note takers collaborated to recruit participants within their communities, with the support of the listening session project manager. Collaboration between facilitators and co-hosts ensured consistency between listening sessions. Facilitators and co-hosts were compensated for their time dedicated to the listening sessions. Their own work in birth equity in Colorado was also highlighted through social media, newsletters, and networking channels. Mental health consultants and a Spanish heritage speaking note taker were also incorporated into the listening sessions to provide support to individuals sharing traumatic experiences. A listening session guide was developed in collaboration with facilitators and was designed for a two-hour session. Notes were taken during each of the sessions by dedicated notetaker(s), and the virtual sessions were recorded for data analysis purposes. All participants were asked to complete a follow-up survey identifying the top three barriers/issues in the perinatal period and three solutions to remedy these issues. This survey also asked individuals if they were willing to share more about their experiences in a one-on-one conversation. Participants were provided with a $50 stipend incentive as a token of appreciation for their time and sharing their lived expertise and stories with us.

Collected data were analyzed in several ways. Survey data were examined to identify the top barriers identified by community members in the perinatal period. These barriers then served to guide a deductive thematic analysis of listening sessions and follow-up one-on-one interview data. Individual case studies reflective of these barriers were identified in the data, with participant follow-up conducted as necessary. The top three barriers and issues most commonly raised by community members in the listening sessions and one-on-ones are described. Findings were reviewed by all participants to ensure the results were reflective of their lived experiences.

**Community members also served as report contributors as it is their stories that are told here.**

# FINDINGS

Community members identified **the three top issues** faced in the perinatal period as systemic racism, lack of postpartum support, and systems-level inadequacies - resulting in poor quality of care. Each of these broad issues and the challenges within can contribute to cases of maternal mortality, morbidity,near misses," and/or low quality of care.

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## SYSTEMIC RACISM

Community members discussed example after example of racism and racist practices that they or their loved ones experienced in the healthcare system during the perinatal period. These ranged  from off-the-cuff comments from providers to violations against their bodies and non-consensual procedures. Community members shared that the result of systemic racism ranges from distrust in the system and specific institutions to cases of preventable morbidity and mortality. Examples of implicit and explicit racism can be seen in stories shared by community members and include ignoring pain complaints or concerns that birthing parents communicate to staff, witnessing providers give different kind of care to clients of color, inadequate attempts to provide language access to non-English speakers, and community members agreeing that certain hospitals, known as 'battlegrounds' for birthing women of color, should be avoided if possible. Further, systemic racism impacts a family's ability to obtain safe and adequate housing, income and economic security, wealth building potential, academic opportunities and achievement, etc. For this reason, we heard community members talk about multiple problems when discussing issues in maternity care. Housing was highlighted in all listening sessions, and the bilingual listening session spent a significant amount of time discussing the needs for tenant rights, limitations on raising rent, and the importance of permanent housing during the vulnerable perinatal period.

## IMPLICIT AND EXPLICIT RACISM: THE PROBLEM

Community members described experiencing both implicit and explicit racism during the perinatal period. One community member shared that many providers do not believe, or take Black patients seriously, when they communicate issues.

> **When you show up at your OB's office and you tell your OB 'I am swelling, and this is new,' and they tell you 'Okay, drink water.' This is problematic because this is an early warning sign of preeclampsia [a life threatening condition that requires specific management]. Then later they are intervening to save your baby because you are in crisis, because they didn't intervene sooner when it could have been prevented.**

Community members described the profound inequities experienced by many non-English-speaking families. When one community member was providing Doula services in Cortez to her monolingual Spanish speaking mother during delivery, *"There were no translators on staff. The doctor had tiny bits of Spanish and was speaking to her at that level. Stuff was not translating to her. The husband started translating, but [the doctor] wouldn't slow down, so he stopped. There wasn't translation and the mother had no idea what was going on."* Birthing individuals in this situation often do not have an opportunity to give clear, verbal, informed consent for different procedures commonly used in labor and birth. Therefore, non-English, monolingual speakers often experience many more non-consensual interventions and procedures during labor and delivery.

> **The issue in maternity care and racial disparities - It isn't just a language barrier, it is a cultural difference - it is white dominant cultural supremacy negatively impacting our families…** when my sister had her son, she was dismissed. She raised questions about how the baby was doing, but it wasn't 'till things got worse that she was heard - it turned out that her baby's kidneys were not developing. It [the developing kidneys] was a sac of fluid. She knew something was off but her concerns were ignored.

**MARIA LIMON //**
BAYFIELD, COLORADO

“**The medical providers are explicit and implicit…** An Ethiopian woman was bleeding out - [her] Doula was a Muslim doula - brand new - there is not only the physical pain, but also **[she] heard from the nurse, ‘Why are we celebrating [redacted derogatory remark] Floyd?’** This woman had a postpartum hemorrhage and bled out. **How do we create training so that folks are aware of their biases and prejudices - systemic racism has impacted all of us.** We need to know how to not impede someone’s care so quickly.”

**PIA LONG //** DENVER, COLORADO

“**I have witnessed and heard providers treating our Latinx families with a lack of respect and disbelieving or minimizing their symptoms/ experiences. We are in need of more multicultural, Spanish speaking therapists who accept Medicaid.**”

**LIA CLOSSON //** FORT COLLINS, COLORADO

## IMPLICIT AND EXPLICIT RACISM: THE SOLUTIONS

### EDUCATION OF PROVIDERS

Several community members recommended specific anti-racist training for all individuals interacting with pregnant people during the perinatal period. One community member shared that there is vast variation in actions and communication amongst staff, and therefore both administrative and direct care providers interacting with individuals in the perinatal period should be required to receive universal and ongoing anti-racist training. "I don't know how best to tackle it but there is a huge amount of potential with more anti-racism training, not cultural competency training, not box checking – but **really, deep rooted, hits you in your gut – anti-racism training, so that providers can take black women more seriously, so that maternal mortality rate stops skyrocketing."** Ideas from connecting training to certifications, and licensure were discussed, including changing internal hospital policy to involve on-going anti-bias training for all staff.

> [For my first birth] **I wanted a new nurse and wasn't sure if I could ask for one...For my second child, I knew how I wanted to birth,** so I wasn't necessarily fearful, I just knew more what I wanted. **I told the nurse that I wanted a tub - and her response was kinda like, 'Oh you're high maintenance'.**
>
> **V. MALAMA //** NORTHGLEEN, COLORADO

### PROVIDER ACCOUNTABILITY AND DISAGGREGATING DATA BY RACE

Even with anti-racism training for providers, transparent data that shows families how well providers do with clients of color is lacking. Therefore, it has become vital to disaggregate data by race in birth outcomes, prenatal care, and postpartum quality measurements. Listening session participants expressed that supporting families in their decision making process when choosing a provider is likely to result in improved birth outcomes.

Community members agreed that client choice of provider alleviates stress, promotes client centered care, and can decrease fear among pregnant individuals of color. Further, client provider choice can often ensure that the selected provider relates to the client's life experience.

## LACK OF REPRESENTATION: THE PROBLEM

The birthing process, and all aspects of pregnancy, can be overwhelming. While many community members expressed their ability to proudly advocate for themselves, they recognized that they often needed additional support from others to have a healthy experience. They expressed mistrust in the system and hesitancy to believe that providers that do not share their race, culture, and/or lived experience would be acting in their best interest. Many community members shared that they aimed to fill in this gap by working with a Doula or Midwife that shared their lived experiences, but finding racially congruent providers of all professions was very difficult. For instance, community members communicated that there is only one Black Internationally Board Certified Lactation Consultant (IBCLC), one Black Certified Lactation Counselor (CLC), and three Black Doulas actively practicing in all of Colorado Springs.

Birthing people need to be not only listened to, but to be understood from their cultural history of birthing practices, and therefore superficial cultural competency training will not create an equitable experience for people of color. One community member stated a need for "cultural sensitivities" in healthcare providers. Community members shared that healthcare provider staff often treated their families with disrespect and dismissed their lived experiences. Community members shared that providers would refer to their husbands as "boyfriends" or "baby daddy", asking about "why they were not at work" and generally alienating and demeaning their husband. One community member brought up the "baby daddy" comment to the clinic manager, and was told "Well, maybe she [the phlebotomist that made the comment] was just trying to relate to you."

CASE STUDY

"During my first delivery...my water broke, but nothing was progressing. After a couple hours of nothing happening. I asked if I could have something to eat. I had not eaten anything all day, and it was about 9 p.m. at this time. I can remember the nurse having this look of disapproval on her face. She did not really tell me I could not, but she did not encourage it either. Out of frustration and not really caring what the nurse thought, I had a 12 inch sandwich. **After a couple hours, the nurse came into my room and said my baby was "sleepy" and advised that I drink some juice. I was not informed what this meant or even why this was a concern. For the most part, I felt that I was not being informed of anything about the laboring process and wasn't sure how things should be going because I had never given birth before... I felt I was being watched and did not feel genuinely supported by this nurse.** I also could tell by her comments and body language that she was either new to birth, never had given birth, or both.

**...I felt like I was being judged by this nurse and resolved in my mind that I wanted a different nurse, but I was not confident in asking for one.** After my delivery, I had a hemorrhage. **I did not have anyone go back to the operating room with me.**

I ended up receiving two [blood] transfusions. A few years later I later learned that my body had created a K antibody - that my husband had to receive a K cell test to ensure my second pregnancy was not in danger. This too also caused a bit of anxiety as I was not even certain about how my body created the antibody until I started questioning the test and was asked if I had a blood transfusion. When I asked how this happened, **I was told that when my transfusion was given, it was not fully screened and that in the future if I needed another transfusion I would have to request the blood to be fully screened.** This was quite disturbing since as a patient, I trusted my medical providers to ensure I would be taken care of. **I understand the emergency at the time, but how is a patient supposed to know to ask for blood to be fully screened?"**

**V. MALAMA //** NORTHGLEEN, COLORADO

## LACK OF REPRESENTATION: THE SOLUTION

Community members self-identifying as BIPOC strongly communicated that they would benefit from having providers with **similar lived experiences**. They wanted to receive care from providers that would better understand their unique challenges during the perinatal period, and could serve as an ally for them during the birthing process. Community members shared that they would like to see a better pipeline, with intentional recruitment and financial support, for BIPOC individuals to become Doulas, Midwives, lactation consultants, physicians, nurses, and other essential healthcare providers.

Additionally, the difficulty of securing a trainer to train individuals from communities of color to become Doulas and Midwives was identified as a barrier to the creation of a more diverse workforce of birth workers. As one community member said, "We have Black women ready to be Doulas but we don't have a trainer in our area - so we continue to serve our communities, [Black families] without the benefit of being trained or certified."

> "There needs to be access to becoming a Doula and certification. **There are boundaries and barriers that have been created, specifically for people of color who want to help their community,** who want to be there in the realm of birth working, and they are not able to. **We've been doing this for centuries,** and now we cannot go into hospitals with these women because we are not certified... There are traumatic events that are happening in regards to them [women] not being informed. Something needs to happen so that women should have to give a verbal, okay, 'yes' to everything, and anything that they are doing to us."
>
> **SHELBY IRVIN, CLC //** COLORADO SPRINGS, COLORADO

> "**El Paso county in general does not want to discuss racism. They were not willing to accept the fact that there are instances in our make-up – differently – an example is heart disease: for many years heart disease was treated the same [to all clients regardless of racial identity] across the board, but why aren't we acknowledging that our bodies are exposed to different chemicals, and perinatal disorder like pre-eclampsia.**"
>
> **DEMETRA SERIKI //** COLORADO SPRINGS, COLORADO
> **A MOTHER'S CHOICE MIDWIFERY, CPM**

"We need more and Lactation Consultants [of color]... I work with many providers as a Doula – I just see many things that are very unacceptable. There has to be a change with having accessible care – we need to take down boundaries and barriers to get [more] birth workers of color...there needs to be access to becoming a Doula and certification. There are boundaries and barriers that have been created, specifically for people of color who want to help their community, who want to be there in the realm of birth working, and they are not able to. **We've been doing this for centuries, and now we cannot go into hospitals with these women because we Doulas are not certified.**"

**SHELBY IRVIN //** COLORADO SPRINGS, COLORADO


"We are truly not allowing birth to be a physiological process...**I couldn't figure out how to navigate and support people in the system [as a Doula of color]** – and instead of complaining about the system I wanted to disrupt the system [becoming a nurse] – **and disrupting bias is so much of the work I now do as a nursing student...** They are trying to have us view birth as a medical condition. So, from a pathological perspective, there can be more and more interventions. **We are truly not allowing birth to be the physiological process that it is, particularly for families of color.**"

**ELIZABETH BUENO //** EL PASO COUNTY, COLORADO

CASE STUDY

Our breastfeeding experience was completely horrible. We were seeing a lactation consultant at the hospital. I remember we were at the hospital for two days and they kept telling me that my son was cluster feeding. Later on I found out my son had a tongue tie. We would go back to the same nurse and have visits and my husband had taken time off from work, of course, and this was our first baby, we were super excited, we did all the classes, everything.

You know, sometimes mothers just dismiss things. I just thought it was my experience – my nurse [nursing consultant at my provider's office], but **she would always call my husband my boyfriend, and she would ask him why he didn't have a job and why he was not at work.**

The last visit we went into, she asked him about his job, asked if he had to work today, and called him my boyfriend. I was sitting there with my baby, he was tiny and little, he just had a surgery on his tongue. His tongue was completely swollen, he couldn't latch to a bottle, we were feeding him, so with a support system, finger feeding him, I was pumping my breast milk because I was determined to breastfeed. **She looked at me and she told me, 'You're just lazy. People like you are lazy.' And I said 'People like me?' and she said, 'Black people are lazy and do not want to breastfeed.'** Those were her exact words. … I couldn't move. She was standing above me as my lactation consultant, I am nude from the waist up. My baby is in his diaper and he is sitting there screaming and crying. And he has lost so much weight. He was 5 pounds. I remember my husband putting my son in his carrier, and he walked me out. I was in tears. I didn't even say anything. I hadn't had any sleep. I was lethargic, my baby doesn't know what to do, my baby is starving, and you're going to tell me that I am not having a successful breastfeeding journey because 'I'm lazy?!' Because I am Black?! My husband told me, we are going to find somebody that works for us and we are going to breastfeed our baby and I was going to have the journey that I wanted to. **These are the experiences that we have. When we see these things, this is why it is important that we have representation; an ally that is giving us the tools that we need to serve our own community.**

**SHELBY IRVIN //** EL PASO COUNTY, COLORADO

02

# LACK OF POSTPARTUM SUPPORT

Community members described an abundance of postpartum issues that impacted their personal health and well-being in addition to their partners and infants, including inadequate mental health support, inadequate lactation support, lack of general care in their postpartum, including family planning services, and lack of attention to their symptoms' warning signs before it was too late. It is common practice for mothers who deliver via a vaginal birth to see their Obstetrician six weeks postpartum, which leaves a considerable gap in care during a critical transitional period for both the birthing person and baby. While presenting issues could be addressed at this standard appointment, a lack in care following discharge from the hospital can compound issues around mental health and lactation support. Further, this suboptimal arrangement leaves the onus on often sleep-deprived mothers to identify and arrange for support on issues such as mental health and lactation. Even at the six week appointment, these issues are not uniformly discussed nor are resources universally available to birthing people. Lack of continuity of care from the same provider through the postpartum period continues to be a complaint that reflects national opinion. It is a major missed opportunity to create a trusted and ongoing relationship with patients such that birthing individuals can discuss and process their birth experience.[23]

23 Martin, A., Horowitz, C., Balbierz, A., & Howell, E. A. (2014). Views of women and clinicians on postpartum preparation and recovery. Maternal and child health journal, 18(3), 707–713. https://doi.org/10.1007/s10995-013-1297-7

## INADEQUATE MENTAL HEALTH SUPPORT: THE PROBLEM

Community members shared that stigma plays a critical role in birthing persons who experience symptoms of depression not reaching out for help. One community member emphasized that the mental health of parents impacts infant mental health and that "We cannot separate the two." Even if offered screening for depression, community members shared that the stigma can be too overwhelming. "When I was screened for postpartum depression, which I was experiencing, the nurse said 'You are not depressed, are you?' and I felt judged and too ashamed to say yes. I held back my tears and continued to suffer in silence." Another community member was told that "most therapists don't like working with depressed people" when searching for a therapist for her postpartum depression.

Community members shared that the mental health system places the responsibility for mental health challenges on the individual experiencing mental health needs and not on the systemic oppression that has contributed to poor mental health issues. Mental health is therefore further stigmatized. Community members expressed fear of having their baby taken away if they admitted being depressed, or when searching for mental health support, they were met with barriers to care, including lack of providers who take their insurance, lapse of insurance, lack of providers who they can relate to (racially, ethnically, or culturally), or interruptions in their care and limits to how many appointments they could have. Historical and systemic racism have also created insurmountable barriers to achieving community trust, an overlapping indicator in all postpartum care issues.

"**I went to get behavioral supports and I had suicide ideation - they couldn't help me, I waited 6 weeks for an intake. I am a suicide attempt survivor.** I was struggling so much with being a parent and a single mom and I know I needed help and would get access in a certain way. You can't see a psychiatrist until you see a therapist. Some folks can only see therapists bi-weekly. Now that I have a good job I get these experiences but there are so many people that don't have the care quality I have now. **Not having insurance or receiving good counseling when you need it – in a timely manner – is make-it or break-it [life threatening].**"

**EMMA HARMON //**
DURANGO, COLORADO

My biggest challenge was postpartum. **When my son was under 1 year old, I was covered for three sessions with a counselor, but once my kiddo turned one, the options to see a mental health provider fell out.** The ability to be supported is so minimal. **I wanted help but I couldn't afford it.** I don't know the solution, but there needs to be more support for a longer period.

**TONILYN SALETTA //**
MANCOS, COLORADO

## INADEQUATE MENTAL HEALTH SUPPORT: THE PROBLEM (CONTINUED)

Many participants shared that the devaluing of birthing people, women, and specifically women of color due to systematic racism, has a vital impact on mental, emotional, and behavioral health. Gender inequity predisposes risk factors to depression and other mood disorders.[24] Many participants described that in immediate postpartum they had more concern for the safety and well-being of their newborn or other children.

> **...Moms are willing to go to therapy for their child and not for themselves.**

**LIA CLOSSON //** FORT COLLINS, COLORADO

## INADEQUATE LACTATION SUPPORT: THE PROBLEM

Many community members shared that they experienced severe inadequacy in lactation support despite their clear and consistent desire to initiate and continue breastfeeding. Problems ranged from never receiving support in the hospital to receiving support from a culturally unresponsive provider which did more harm than good. Issues in breastfeeding were often blamed on the mother. Adequate lactation support positions families to give their children the best head start to a life of good health. Breastfeeding also decreases the odds of chronic diseases associated with poverty and other determinants of health like racism. Breastfeeding can decrease the likelihood of childhood diabetes and obesity, asthma, maternal breast and uterine cancer, maternal high blood pressure later in life, and maternal cardiovascular disease.[25] Both the child and the birthing individual receive many lifetime health benefits from breastfeeding, and lack of adequate, culturally-humble lactation services actively increases perinatal racial and health disparities throughout the lifespan.

24 Mayo Clinic. (n.d). Depression in women: Understanding the gender gap. https://www.mayoclinic.org/diseases-conditions/depression/in-depth/depression/art-20047725

25 The Benefits of Breastfeeding for Baby & for Mom. (2018). Cleveland Clinic. https://my.clevelandclinic.org/health/articles/15274-the-benefits-of-breastfeeding-for-baby--for-mom

CASE STUDY

> There is such a lack of help when it comes to lactation, for sure. My son is 3 months, and I am thankfully still breastfeeding, with the help of [Lactation Consultant] and a couple of friends. It is interesting - when I talk to people who do not breastfeed, and why they didn't breastfeed, and a lot of it comes down to they didn't have time from work or they just didn't know about their body and what was supposed to happen and getting that help, or even the encouragement, of getting them through that initial phase. For me, my milk didn't come in until day four or five, and I was super nervous about it. [My Lactation Consultant] let me know that it was completely normal. But a lot of people don't have those resources that I had, to encourage them to continue on whatever journey that they want to take.

**ANONYMOUS //** COLORADO

**INADEQUATE MENTAL HEALTH & LACTATION SUPPORT: THE SOLUTION**

Community members shared that they would like to see postpartum home visits universally provided to all birthing individuals with focused attention on issues including mental health, lactation support, and sleep support. Community members strongly communicated that these services should be covered by insurance and revolve around the evolving needs of the family.

The second biggest issue discussed as a barrier to optimal postpartum care was the lack of mental health support. Community members stated that the stigma around mental healthcare in general was impeding many birthing people from accessing care they need for their livelihoods. Some suggested changes to promote options for birthing people to receive mental healthcare, especially during the postpartum period when depression rates are at their highest. Prevention and intervention measures need to also be taken to ensure that no one slips through the support beams with respect to their mental well-being. Incentivizing OB/GYN's to relocate to areas who need perinatal care was offered as a potential solution as access to specialized care is a building block to maternal and infant mental health. Robust health care programs like Healthy Start or the Nurse Family Partnership, where mothers and infants receive care up to two years postpartum, should be considered the gold standard for postpartum maternity care.

# 03 SYSTEMS-LEVEL INADEQUACIES

Community members identified several systems-level inadequacies that resulted in low quality of care and, including inadequate maternity care, that then, resulted in poor outcomes for the family. Community members also identified lack of preventative care and providers within the same hospital system being unfamiliar with patient records or providers ignoring red flags (often client reported) during prenatal care.

> **"The OB is responsible for letting women know that they need and can request information about epidural before labor starts. OBs can't talk about epidurals [ie. cannot consent for the procedure or discuss the benefits/risks], so the risks and consent waits for an anesthesiologist."**
>
> **DEMETRA SERIKI //** EL PASO COUNTY, COLORADO

### RECEIPT OF SUBSTANDARD MEDICAL CARE WITH AN INSUFFICIENT FOCUS ON PREVENTION: THE PROBLEM

The issue of lack of adequate management of preeclampsia, high blood pressure, and HELLP syndrome (H - Hemolysis, EL - Elevated Liver enzymes, LP - Low Platelet count, often seen as a variant of preeclampsia) was discussed in almost every listening session. Over and over participants shared experiences where their concerns with symptoms of preeclampsia were not heard by their providers until they or their babies became "near misses". This lack of prevention nearly ended community members' lives. This inadequacy is reflected in national data and shows that preventative care models are lacking in our current hospital maternity care system.[26]

26 World Health Organization. (2016). Pregnant women must be able to access the right care at the right time, says WHO. World Health Organization. https://www.who.int/news/item/07-11-2016-pregnant-women-must-be-able-to-access-the-right-care-at-the-right-time-says-who

## RECEIPT OF SUBSTANDARD MEDICAL CARE WITH AN INSUFFICIENT FOCUS ON PREVENTION: THE SOLUTIONS

In every listening session, access to Midwifery was discussed among community members as a solution to provide comprehensive preventative care. The overall feedback was that Midwifery care (defined as care provided by a Certified Professional Midwife) offers longer appointments, is relationship-based, and often incorporates improved provider choices amongst clients. Community members expressed that Midwifery care often provides more thorough postpartum care than traditional OB/GYN care. Traditionally, Midwifery care offers five to six postpartum visits with direct communication with the same provider on an on-call basis, which is drastically different from the traditional one to three average visits in the postpartum period with a OB/GYN/physician model of care. Midwifery care offers a model of care that has an emphasis on prevention, rather than intervention later on.

Additionally, the quality of care provided in hospitals and by OB/GYNs needs to be improved for families who may not prefer Midwifery care and or have a high-risk pregnancy. While emergency department (ED) visits are high for pregnant individuals, it is imperative that departments within hospitals streamline care for individuals during the perinatal period. For individuals who are between 23 weeks pregnant and the postpartum period, it is recommended that staff specializing in labor and delivery or postpartum come to the ED to help monitor fetal heart rate and maternal vitals, or postpartum vitals. For individuals who are less than 23 weeks pregnant, ED staff can assist and consult with labor and delivery nurses or OB-GYN on call. This gives providers the opportunity to respond to signs and symptoms outside of normal variation in a timely manner.[27]

There is an opportunity to explore more data regarding solutions related to treatment and intervention of pre-eclampsia (PE). While the majority of PE cases are unpreventable, there are secondary prevention options based on the interruption of known pathophysiological mechanisms of the condition before it is established and worsens.[28] Screening protocols also need to be followed rigorously to ensure that the condition is caught as early as possible. There have been efforts that focused heavily on selecting families considered pre-disposed or high risk and proposing an effective intervention early on in pregnancy to avoid severe complications.[29] While low-dose aspirin initiated before 16 weeks in high-risk groups, along with calcium intake, show promise in the prevention of PE, further research needs to be done to standardize best practices for PE prevention strategies across the board and to design specific strategies to address PE in most at-risk or predisposed individuals.[30]

27 Care Process Model. (2014). Intermountain Health. https://intermountainhealthcare.org/ckr-ext/Dcmnt?ncid=521396209

28 Bezerra Maia e Holanda Moura, S., Marques Lopes, L., Murthi, P., & da Silva Costa, F. (2012). Prevention of Preeclampsia. Journal of pregnancy, 2012, 435090. https://doi.org/10.1155/2012/435090

29 Sibai BM. (2005) Diagnosis, Prevention, and Management of Eclampsia. Obstetrics & Gynecology. 2005, 105(2):402-410

30 Bezerra Maia E Holanda Moura, S., et al. (2012). Prevention of Preeclampsia.

CASE STUDY

"I applied for additional life insurance coverage when I was in my third trimester with my first child, and I was denied coverage because my blood pressure was so high. I was immediately worried and called my doctor, and I did a couple of preeclampsia screens – my blood pressure was high, but I didn't have protein in my urine (which is what they were looking for for a preeclampsia diagnosis).

Days before I gave birth I was swollen -- like, extra swollen, and things felt weird, so I called my doctor again and asked them to read through my notes, and they did. I told them my symptoms. I was working and had a full day of meetings that day. I asked, "Do I need to come in?" and they said, 'No.' I went into labor a couple of days later – labored at home, my water broke at home, and I got to the hospital – they didn't screen my urine for protein, even though my blood pressure was high throughout my third trimester and severely high in labor.

I was in the hospital for less than two hours before my son was born – the nurse wasn't great. They did an unconsented episiotomy, and I had a baby. My blood pressure stayed high postpartum, and they sent me home. I said, 'I don't want to go home if I am not ready and if this blood pressure is questionable.' They were like, 'No you're fine,' I said, 'I don't feel very good'. They kept ignoring me.

A few days later, I was standing in the kitchen and I told my husband, 'I have to go to the emergency room right now' – and we went. I waited for seven hours in the ER before I was evaluated, then they did blood work, and I was emergency transferred to be admitted for severe postpartum preeclampsia. It took them seven hours to see in my medical records – in the same hospital where I had my baby – that I needed immediate care... **As a white person, to have the system just barely keep you alive, to have so many people doubt you, no wonder there are so many terrible outcomes for people of color. Why is the system broken?**"

**ERIN MILLER //** DENVER, COLORADO

## CHALLENGES WITH INSURANCE AND CHOICE OF PROVIDER: THE PROBLEM

Community members identified that public and private insurance programs often do not cover support outside of the hospital setting that mothers and families need including home birthing options, Midwives, Doulas, mental health support, and other support services. Insurance providers need to comprehensively consider the family's needs during the perinatal period.

One community member shared that her biggest challenge was her mental health postpartum:

> **"I was covered [by insurance] for three [mental health] sessions but once my kiddo turned 1, the options to see a mental health provider fell out. I wanted help but I couldn't afford it."**

Certain health care delivery systems, or insurance providers, only cover specific providers to consumers for maternity care. This often results in a lack of client autonomy in choosing their provider, or limits transfer of care options for pregnant individuals when they may no longer feel supported or satisfied by the care they are receiving. Families with less input on their provider have a decreased likelihood of attaining optimal outcomes.[31]

## CHALLENGES WITH INSURANCE AND CHOICE OF PROVIDER: THE SOLUTION

Community members shared how they would like to see Medicaid reimbursement for Doulas and Certified Professional Midwives (CPMs), but only if it serves as a livable wage. Community members indicated the importance of having diverse providers that accept Medicaid was linked to the importance provider choice. As the number of providers that accept Medicaid increase, so do families' options when choosing a provider during the prenatal period. This solution provides more client autonomy and expands transfer of care options for pregnant individuals to make their own decisions about who provides them care. Expanding the scope of Midwifery care in Colorado to allow CPMs to work in birth centers is another low cost, proven solution to diversify providers for families to choose from and remedy the lack of access to OB/GYNs in rural areas.[32] According to the study performed by the Center for Medicare & Medicaid Services, individuals who received prenatal care in birth centers where CPMs have been employed experienced better birth outcomes when compared to the rest of the country.[33]

31 Gruber, K. J., Cupito, S. H., & Dobson, C. F. (2013). Impact of doulas on healthy birth outcomes. The Journal of perinatal education, 22(1), 49–58. https://doi.org/10.1891/1058-1243.22.1.49

32 Midwife Center. (2020). Groundbreaking CMS study shows better outcomes and lower costs at birth centers. Midwife Center. https://midwifecenter.org/news/groundbreaking-cms-study-shows-better-outcomes-and-lower-costs-at-birth-centers

33 Ibid.

## GEOGRAPHICAL INEQUITIES: THE PROBLEM

Colorado experiences extreme geographical inequities in access to quality, comprehensive care. Community members in rural areas described situations where they were required to travel to Denver due to lack of services in their area, especially for rare conditions, or care management for high risk pregnancies that required intervention of sub-specialists. For those experiencing high risk pregnancies (accounting for 6-8% of all pregnancies), clients are often expected to meet with their provider twice a week in the third trimester.[34] This scenario puts stress on a family's work opportunities and their overall economic security.

The geographical inequalities also exist in urban areas of Colorado. For instance, there are neighborhoods that have an abundance of access to OB/GYN care while nearby neighborhoods do not have access within their communities. Many community members rely on public transportation to attend clinic visits, therefore geographical proximity is critical to reducing barriers to care. This inequity in physical access to obstetrical care is compounded when considering the multitude of factors that drive selecting a provider. For instance, pregnant individuals not only have to identify a provider that is accepting new patients, accepts their insurance type (or lack thereof), but also is a provider from whom the pregnant individual is comfortable receiving care, and all within a short time period to allow the pregnant individual to receive timely prenatal care.

> "I had severe preeclampsia, which wasn't caught. So I ended up having an emergency C-section. While that was happening we learned that our son had tracheoesophageal fistula, or TEF, so he was fighting for his life. **We spent that first year going back and forth to Denver, which is about seven hours away. He had to have six or seven procedures in the first 18 months of his life,** since aside from the esophagus, TEF can also affect the spine, the heart, and anything that is along the midline of his body. Being down in Southwest Colorado, if anything happens you have to go to Denver. **We actually thought we were pretty well supported medically, but emotionally, mental health-wise, we could have used a lot of help. It was very stressful.** My partner and I were just trying to survive that first year."
>
> **KELLIE PETTYJOHN** // MANCOS, COLORADO

34 UCSF Health: Obstetrics and Gynecology. (2020). High Risk Pregnancy. UCSF Health. https://www.ucsfhealth.org/conditions/high-risk-pregnancy

## GEOGRAPHICAL INEQUITIES: THE SOLUTION

Mitigating the geographical disparities in maternal and infant care can be solved through improved access, with focused and intentional consideration of improving diversity in the workforce such that patients are able to find providers that reflect their lived experiences. In the short term, incentives could be offered to practicing healthcare providers to locate practices in underserved areas, including both rural areas and in lower socioeconomic urban neighborhoods, much like the National Health Service Corps, but focused on disparities in the perinatal time period that are specific to Colorado.[35] Incentives could be financial, such as loan forgiveness, but could also include appointments at Academic Medical Centers located in urban areas such that rural providers are more easily connected with resources like continuing education, a vast network of colleagues, and collaboration and research opportunities.

In the long term, pipeline programs need to intentionally prepare a healthcare workforce with diverse lived experiences to fill the gaps in our system. This includes expanding financial support and scholarship opportunities for those who want to become birthworkers in their communities. Expanding Midwifery and home birth care (currently provided by Certified Professional Midwives in Colorado) is one solution to the lack of providers in rural areas in other states, according to the National Conference of State Legislatures.[36]

## INADEQUATE UNIVERSAL FAMILY MEDICAL LEAVE: THE PROBLEM

Family medical leave varies greatly between occupations. While the Family and Medical Leave Act (FMLA) can be paid out through short term disability, it is only a fraction of a new parent's paycheck. Many community members expressed an inadequacy in family medical leave as it is not seen as inclusive; many community members discussed that this lack of inclusion leads to barriers for the non-birthing parent to take leave. In addition, many community members shared that the protection offered by three months leave does not provide the family adequate time to heal and bond.

## INADEQUATE UNIVERSAL FAMILY MEDICAL LEAVE: THE SOLUTION

The 'one size fits all' standard for parental leave needs to be more flexible, assessed on a case-by-case basis, normalized for both parents, and paid out at an equitable, livable wage. In the Fall of 2020, Coloradan voters passed the state's first Paid Family Medical Leave Program through a ballot initiative. *[See p. 39 for more details on current Colorado policies.]*

35 NHSC. (2020). About NHSC. HRSA: National Health Services Corps. https://nhsc.hrsa.gov/about-us

36 Mairin, Rivett, Erik S. (2019). Boosting Maternity Care in Rural America. NCSL. Vol. 27, No. 39.

# DATA INTERPRETATION

Findings from these listening sessions largely mirror the state of perinatal care and concerns at the national level, especially as related to systemic racism, postpartum care, and systems-level inadequacies.

### SYSTEMIC RACISM

Black women in the United States are three to four times more likely to die as a result of pregnancy-related complications than their white counterparts, and evidence suggests that a weathering effect of racism is a significant contributor to birth outcome inequities.[37, 38, 39] While racism has been identified as a contributor to poor birth outcomes for Black mothers, the nation has not shifted from acknowledgment to accepting responsibility and making the necessary changes such that Black communities experience equitable health and wellness outcomes. Leading experts have identified various solutions to move towards equity and justice, including pipeline programs aiming to improve diversity in the healthcare workforce such that patients can receive care from providers with similar lived experiences, often in the form of shared race, ethnicity, culture, or language.[40, 41] Recent research echoes community members' concerns, including a 2020 study on the care of Black and white babies by white or Black pediatricians. Black babies were three times more likely than white babies to die when they were cared for by white doctors. Additionally, mortality rates of Black newborns decreased by 39-58% when Black physicians managed their birth.[42] Developing specific care plans for BIPOC patients that are considerate of the impact of racism and bias has not universally been implemented through policy and systems change.

37 Creanga, A. A., Syverson, C., Seed, K., & Callaghan, W. M. (2017). Pregnancy-related mortality in the United States, 2011–2013. Obstetrics and gynecology, 130(2), 366. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5744583/

38 Wallace, M. E., Mendola, P., Liu, D., & Grantz, K. L. (2015). Joint effects of structural racism and income inequality on small-for-gestational-age birth. American journal of public health, 105(8), 1681-1688. https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2015.302613

39 Dominguez, T. P., Dunkel-Schetter, C., Glynn, L. M., Hobel, C., & Sandman, C. A. (2008). Racial differences in birth outcomes: the role of general, pregnancy, and racism stress. Health psychology, 27(2), 194. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2868586/

40 Black Caucus Health Braintrust. 2015 Kelly Report: Health Disparities in America. Washington, D.C: Congressional Black Caucus Health Braintrust; 2015. https://robinkelly.house.gov/sites/robinkelly.house.gov/files/2015%20Kelly%20Report.pdf

41 U.S. Department of Health and Human Services. (2011). HHS action plan to reduce racial and ethnic disparities: A nation free of disparities in health and health care. Washington, D.C: U.S. Department of Health and Human Services. https://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

42 Picheta, R. (2020). Black Newborns more likely to die when looked after by White Doctors. CNN. https://www.cnn.com/2020/08/18/health/black-babies-mortality-rate-doctors-study-wellness-sc-li-intl/index.html

## POSTPARTUM CARE

Restructuring postpartum care needs to be addressed in order to lower the mortality rates in the postpartum period. The model of Midwifery care is a gold standard example for adapting to more sophisticated and thorough postpartum care planning (providing home visits, standardizing five to six postpartum care visits within six weeks, and being on call for clients in those six weeks postpartum). The overwhelming need to reimagine the postpartum experience has been heeded by the American College of Obstetricians and Gynecologists (ACOG). In 2018 ACOG redesigned postpartum care recommendations, pivoting from a standard postpartum visit within six weeks of delivery (traditional OB/GYN/physician practice), to considering postpartum care as an ongoing process with special attention to mood and emotional well-being, infant care and feeding, sleep and fatigue, physical recovery from birth, chronic disease management, and health maintenance.[43] However, these recommendations have not yet universally reached all Colorado providers, as community members delivering their babies as recently as 2020 did not experience physician-based postpartum care as re-envisioned by the organization.

## SYSTEMS-LEVEL INADEQUACIES

The healthcare system often functions in piecemeal fashion, such that patients are responsible for navigating complex systems often during times of heightened stress. Postpartum women are often vulnerable to losing health insurance coverage due to their changed eligibility status such as the 60-day postpartum termination from Medicaid if they no longer meet outstanding enrollment criteria.[44] Even if they remain insured, postpartum women often are not seamlessly transitioned into the primary care setting, which remains a major missed opportunity for comprehensive and coordinated care, especially amongst high-risk women who experienced pregnancy complications such as hypertensive disorders.[45, 46] Women who experienced preeclampsia are known to be three to four times more likely to have high blood pressure later on in life and have double the risk for heart disease and stroke.[47] Echoing the research published in the Colorado Maternal Mortality

43 American College of Obstetricians and Gynecologists. (2018). ACOG Redesigns Postpartum Care. ACOG. https://www.acog.org/news/news-releases/2018/04/acog-redesigns-postpartum-care

44 Molina, R. L., & Pace, L. E. (2017). A Renewed Focus on Maternal Health in the United States. The New England journal of medicine. 377, no. 18: 1705. https://pubmed.ncbi.nlm.nih.gov/29091560/

45 Essien, U. R., Molina, R. L., & Lasser, K. E. (2019). Strengthening the postpartum transition of care to address racial disparities in maternal health. : 349-351.

46 Lewey, J., Levine, L. D., Yang, L., Triebwasser, J. E., & Groeneveld, P. W. (2020) Patterns of Postpartum Ambulatory Care Follow-up Care Among Women With Hypertensive Disorders of Pregnancy. Journal of the American Heart Association 9, no. 17: e016357.

47 Thilaganathan, B., & Kalafat, E. (2019). Cardiovascular system in preeclampsia and beyond. Hypertension (Dallas, Tex. 1979), 73(3), 522-531. doi:10.1161/hypertensionaha.118.11191

48 Colorado Department of Public Health & Environment. (2020). Maternal Mortality Review Committee Report. CDPHE. https://drive.google.com/file/d/11sB0qnM1DmfCA-Z87el3KMHN6oBy5t2y/view

### SYSTEMS-LEVEL INADEQUACIES (CONTINUED)

Review Committee Report, cardiac conditions were one of the top five reasons for all maternal deaths during 2014-2016.[48] Therefore, it is critical that women with pregnancy complications are intentionally, seamlessly, and comprehensively transitioned into a primary care setting. Further, pregnant and postpartum mothers with opioid-use disorder (OUD) are also overlooked by the system, such that less than one fifth of all addiction-treatment facilities have dedicated and specific services for pregnant and postpartum women.[49] Quality and choices of care and provider continues to be tied to type of insurance, lack thereof, and incentivizes providers differently in the sector.

## LIMITATIONS

Like all data collection endeavors, this report is not without limitations. Listening session participants were recruited through social media and word-of-mouth by session facilitators. It is likely that many interested individuals were not aware of the data collection efforts if not previously connected to the organizations and individuals serving to facilitate the sessions. While virtual sessions can improve session attendance and reduce barriers in transportation and selecting a central location, this session format does not offer the same environment that often creates a sense of comfort and trust amongst participants. Many of the subjects discussed during the sessions are deeply sensitive, so while facilitators did their best to provide a welcoming and warm environment, it is likely that many participants were not yet ready to share such personal information around their lived perinatal experiences. Finally, while listening session participants represented a diverse array of community members, not all marginalized groups were represented. Future efforts will recruit an increased sample size and focus to intentionally include community members that were underrepresented in the reported efforts.

49 Terplan, M., Longinaker, N., & Appel, L. (2015). Women-centered drug treatment services and need in the United States, 2002–2009. American journal of public health, 105(11), e50-e54. https://pubmed.ncbi.nlm.nih.gov/26378825/

# POLICY IMPLICATIONS & RECOMMENDATIONS

## CURRENT POLICIES IN COLORADO

Colorado has intentionally tried to improve the lives of those in the perinatal period and identify opportunities for impactful solutions. Several policies and practices edge the state toward a better understanding of the causes of maternal mortality and morbidity, and optimal health for birthing individuals and their infants. Three policies and/or practices that support Colorado's success to maximize equity include the Maternal Mortality Review Committee, Baby Friendly Hospitals, and the Paid Family and Medical Leave ballot measure.

**The Maternal Mortality Review Committee** was introduced and passed in 2019 to appoint at least 11 individuals to review maternal deaths and provide recommendations to the legislature to keep pregnant and postpartum people safe.[50] While this critical legislation has been put into practice, vast disparities remain between outcomes of safety and care of Colorado's perinatal population and optimal outcomes of safety and care. The state needs to accelerate systems' change efforts to ensure that policies, practices, and programs continuously address racial inequities that result from experiencing racism. Some Maternal Mortality Committees across the nation have found that they are better able to identify causes of death by expanding their membership to include representatives from the community while others have found that authentic community collaboration is necessary to implement impactful solutions.[51, 52] This report is intended to supplement the MMRC report [2020], to begin to incorporate community voice and experience, and to provide on-the-

50 Colorado Department Of Public Health And Environment Maternal Mortality Review Committee. (2019). Colorado General Assembly. https://leg.colorado.gov/bills/hb19-1122

51 St Pierre, A., Zaharatos, J., Goodman, D., & Callaghan, W. M. (2018). Challenges and Opportunities in Identifying, Reviewing, and Preventing Maternal Deaths. Obstetrics and gynecology, 131(1), 138–142. https://doi.org/10.1097/AOG.0000000000002417

52 Foretia, A. (2020). Maternal Mortality Review Committees: A Decade of Challenge and Growth. AMCHP.http://www.amchp.org/AboutAMCHP/Newsletters/Pulse/Pages/Maternal-Mortality-Review-Committees-A-Decade-of-Challenge-and-Growth.aspx

ground contextualization for the MMRC report findings.[53] Shivani Bhatia, the Maternal Health Manager with CDPHE, described the holistic role that MMRC can serve:

> **The ethic of the maternal mortality review is one of reflection, respect, grief, and improvement. It is an opportunity for us as a society to reflect on how we can do better by pregnant and postpartum people and our communities, and to grieve for the person who has died, to recognize and honor the trauma experienced by their children, their families, their provider care teams, and their communities. It is also an opportunity to grieve that these are inequities that exist in our society, and to build a fire for change—not just to ensure that we prevent deaths, but also to ensure that we support health and well-being.[54]**

**SHIVANI BHATIA, M.P.H.** // COLORADO

Colorado is home to 14 hospitals participating in the **Baby-Friendly Hospitals Initiative**, the only "report card" grading-like system. Baby-Friendly Hospitals receive accreditation from Baby Friendly USA if they meet the accreditation criteria to support education on the importance of breastfeeding, facilitating breastfeeding, and encouraging bonding in the first few days between parents and baby while keeping out commercial interests.[55] The WHO and UNICEF started the Baby-Friendly Hospital Initiative in 1991 in order to increase the quantity of hospitals that focus on the health of babies.[56] It requires all staff that provides direct care during labor, birth, and postpartum to have attended a minimum lactation training requirement (which includes supplemental feeding consultation). However, there are minimal current incentives for hospitals to seek accreditation from the program, and lactation courses are not an overall requirement for OB/GYNs, labor and delivery staff, pediatricians, and postpartum staff. State incentives (financial or otherwise) to hospitals that work to improve breastfeeding initiation and duration through other routes in addition to hospital-based, lactation-support resources in hospitals with minimal or no lactation support could move the state towards equity in breastfeeding initiation and duration, which is known to impact an infant's health throughout their lifespan.

**Lessons learned from the baby-friendly hospital initiatives should be considered when constructing a state-level recognition system that better serves birthing individuals and their families.**

53 CDPHE. (2020). Maternal Mortality in Colorado 2014-2016. CDPHE. https://drive.google.com/file/d/11sB0qnM1DmfCA-Z87el3KMHN6oBy5t2y/view

54 Foretia, A. (2020). Maternal Mortality Review Committees

55 CDPHE (2020). Baby-Friendly Hospital Initiative. CDPHE. https://www.colorado.gov/pacific/cdphe/baby-friendly-hospital-initiative

56 Baby-Friendly USA. (2020). The Baby-Friendly Hospital Initiative. Baby-Friendly USA. https://www.babyfriendlyusa.org/

## CURRENT POLICIES IN COLORADO (CONTINUED)

In Fall 2020, Colorado passed the **Paid Family and Medical Leave** ballot measure, which is now the ninth paid leave measure of its kind in the nation. This measure is a major step forward in the path to fully paid leave for applicable family members and circumstances. While there is still major work ahead in implementation, a majority of the state's voting population agrees that it is time to provide paid time off to give birth or care for a sick family member, regardless of employer.[57]

### CURRENT FEDERAL POLICIES

As of 2020, nine Federal bills, termed Momnibus, aim to optimize equity in Black maternal health outcomes. These nine bills work together to support comprehensive Black maternal health from prenatal to 12-months postpartum. The Momnibus was developed by the Black Maternal Caucus, endorsed by members of the Black Maternal Health Caucus and over 120 organizations, and sponsored by Congresswoman Lauren Underwood, Congresswoman Alma Adams, and Madame Vice President-elect, Kamala Harris. Many perceive these nine bills as critical investments in the social determinants of health (ex. housing, transportation and nutrition), as they provide funding to community-based organizations, invest in Veterans Affairs maternity care coordination, diversify the perinatal workforce, improve data collection and quality measures, invest in maternal mental health, improve care for incarcerated women, invest in digital tools, promote innovative payment models, and expand care for up to one year postpartum.[58] The Momnibus lays a strong foundation for Black maternal care and can serve as a guide for similar and additional state-specific plans to support equitable maternal and infant health outcomes.

57 Kuwik, A. (2020). Proposition 118 is a Major win for Colorado Families. Bell Policy Center. https://www.bellpolicy.org/2020/11/05/prop-118-major-win/

58 Black Maternal Health Caucus. (2020). Momnibus. U.S. House of Representatives: Black Maternal Health Caucus. https://blackmaternalhealthcaucus-underwood.house.gov/Momnibus

## GLOBAL INITIATIVES IN MATERNITY CARE

Approaching maternal health with a human rights framework has been an initiative by Black Mamas Matter Alliance (BMMA), which reflects global initiatives in maternity care. BMMA has led the Black Maternal Health Week campaign, joining dozens of other global organizations that are fighting to end maternal mortality, and advocating for the United Nations to recognize April 11 as the International Day for Maternal Health Rights.[59] Other campaigns such as Hear Her by the Center for Disease and Control have also been effective in educating families and providers on the warning signs in pregnancy, the importance of client-centered care, and trusting pregnant and birthing individuals to identify warning signs, and know when something isn't right. State-wide public campaigns are vital to educate both birthing families and providers and have been successful in multiple states.[60]

## RECOMMENDATIONS

Findings from this report include input from 66 community members, and yield an array of policy recommendations that can advance equitable infant and maternal health and well-being. It is imperative to recognize, however, that maternal health outcomes are deeply interconnected to factors often seen as outside the realm of healthcare, such as housing, education, and the legal system, and therefore all efforts should consider an interdisciplinary approach to begin to dismantle the years of systematic and systemic racism designed to oppress and marginalized communities of color.

### SUPPORT THE DESIGN AND IMPLEMENTATION OF ANTI-RACIST POLICIES

- Support and invest in ongoing anti-racist training for all healthcare workers that interact with birthing individuals
- Create committees dedicated to identifying and dismantling racist practices in all new legislation
- Encourage stakeholders to normalize disaggregating data by race and ethnicity in maternity care
- Support innovative solutions to address intersectional issues, like housing for pregnant people, substance use disorder services for pregnant individuals, and expanding child care for infants and toddlers
- Provide prenatal insurance coverage to all Coloradans, regardless of documentation status

59 Black Maternal Health Week. (n.d). Black Mamas Matter Alliance. https://blackmamasmatter.org/bmhw/

60 Merck for Mothers. Making Pregnancy and Childbirth Safer. (n.d). Association of Maternal and Child Health Programs. https://www.merckformothers.com/docs/States-Insights.pdf

RECOMMENDATIONS (CONTIUED)

## INVEST IN PREVENTION-FOCUSED CARE, COMMUNITY BIRTH, & THE PERINATAL WORKFORCE

- Expand Midwifery care in the state of Colorado including the allowance of Certified Professional Midwives to work in birth centers
- Build internal Doula programs that pay Doulas a livable wage
- Require that licensed facilities allow for every birthing person to have a client identified support person and or Doula to support them in the birth room or operating room, in addition to a partner or spouse
- Explore reimbursement options for Midwives and Doulas to accept Medicaid and private insurance
- Diversify the perinatal workforce, including recruiting and incentivizing Spanish heritage speakers
- Fund scholarships for education, training, and certifications for BIPOC birthworkers to streamline entrance into the workforce
- Incentivize diverse perinatal professionals to join practices that serve communities with whom they share a ethnic or racial identity and or are in rural areas & incentivize practices to recruit, retain, and expand a diversified workforce
- Standardize lactation training for all medical professionals interacting with families during the perinatal period, including pediatricians and OB/GYNs
- Create universal best practices for preventing, recognizing, and managing preeclampsia
- Standardize early comprehensive sex-education and access to reproductive health and family planning services

RECOMMENDATIONS (CONTIUED)

## REIMAGINE AND REDESIGN POSTPARTUM CARE

- Expand Medicaid eligibility for pregnant individuals to a minimum of one year postpartum
- Expand care during the postpartum period[61]
- Streamline communication with birthing individuals and their provider in the postpartum period
- Support transitions to primary care
- Prioritize and incentivize providers to offer perinatal mental and behavioral health services, that include programming designed for communities that experience racism
- Replicate and invest in home-visiting care models for the postpartum period
- Universally and routinely provide screening during prenatal and postpartum care for birthing individuals who are at higher risk for cardiovascular conditions, including high blood pressure, preeclampsia, etc.

## ADDRESS SYSTEMS-LEVEL INADEQUACIES

- Create and maintain directories for families to identify healthcare providers that share their lived experience
- Utilize data to create public dashboards that can inform family choices around provider selection including outcomes of care for families from diverse racial and ethnic backgrounds
- Require desegregation of data by race and ethnicity for all providers[62]
- Improve grievance processes, and incorporate consumer and family feedback into systems change whenever possible
- Create advisory committees comprised of community members that hold power to enact systems-level change

61 Optimizing postpartum care. ACOG Committee Opinion No. 736. American College of Obstetricians and Gynecologists. Obstet Gynecol 2018;131:e140–50. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care

62 Glance, Laurent G., et al. (2014). Rates of Major Obstetrical Complications Vary Five-Fold Among US Hospitals. Health Affairs, Vol. 33 No. 8. https://www.healthaffairs.org/doi/10.1377/hlthaff.2013.1359

# CONCLUSION

The authentic and intentional incorporation of community voice and lived experiences into policy, practice, and programing has the profound potential to optimize equitable health outcomes for those in the perinatal period. Data gathered during community member listening sessions identified three overarching issues faced in the perinatal period: systemic racism, lack of postpartum support, and systems-level inadequacies. Policy implementations and recommendations to optimize perinatal care are drawn from community member input, and emphasize the need to examine issues as interconnected and inextricably linked to the social determinants of health. Critically, all policies should be viewed through an anti-racist lens such that Colorado strives to attain health equity for all. Implementation, design, and development of these recommendations need to be done with the consultation of the lived expertise of families that experience these challenges and personally experience perinatal racial inequities.

**Questions and presentation inquiries?**
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# DIVERSE COLORADO VOICES:

## COMMUNITY-BASED SOLUTIONS FOR THE PERINATAL PERIOD

**Report edited & designed by: Cassie Li** // Cassandra Classics Freelance Creative

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