

Trauma Matters

Special Edition, Black Maternal Health, Summer 2024

A quarterly publication dedicated to the dissemination of information on trauma and best-practices in trauma-informed care

INSIDE THIS ISSUE:

Page 1-2
Introducing the Perinatal Bill of Rights for Black Families

Page 2-3
Maternal Health Disparities in Connecticut: Addressing Inequities

Page 3
Ask the Experts: An Interview with Dr. Iyanna Liles, MD

Page 6
Improving Black Maternal Health Through Meaningful Engagement in Fairfield County

Page 6
About New Haven Healthy Start

Editor:
Alana Valdez, MA

Editorial Board:

- Alicia Feller, LCSW, MA-IHH
- Carl Bordeaux, CPRP, CARC
- Eva Michelle Bryant, LMSW
- Kimberly Karanda, PhD, LCSW, DMHAS
- Eileen M. Russo, MA, LADC
- Tammy Sneed, DCF
- Laura Williamson, MARC
- Maggie Young, DSW, LADC

A digital version of this publication with a full list of references and resources is available for download at our website: www.womensconsortium.org

Introducing the Perinatal Bill of Rights for Black Families by Earth's Natural Touch: Birth Care and Beyond

Foreword by SciHonor Devotion, Founding Director

The Perinatal Bill of Rights for Black families is a valuable tool that can be used to address systemic disparities and ensure equitable care for families in Connecticut. Black birthing and postpartum families in Connecticut are faced with multiple challenges, including higher rates of adverse birth outcomes, including infant and maternal mortality, compared to other racial groups. Black women in Connecticut experience racism and systemic biases in maternity settings, including inadequate pain management as well as delayed or dismissed medical concerns.

Earth's Natural Touch: Birth Care & Beyond doulas play a crucial role in addressing these disparities by providing trauma-informed and responsive care to our clients, who often encounter healthcare providers who lack cultural humility, leading to suboptimal care and distrust. Having a trauma-informed approach acknowledges the psychological impact of historical and present-day discrimination. Our doulas are trained to understand cultural impacts and work to support Black families to feel respected and understood during their perinatal journey. Our doulas advocate for the rights of Black families to make informed decisions about their care in a variety of settings. This includes supporting their autonomy in birth choices, ensuring that their voices are heard and respected by healthcare providers, and supporting equitable laws and policies.

Doulas can help mitigate the effects of systemic racism in healthcare by addressing implicit biases and advocating for appropriate, and respectful care. This is imperative for improving perinatal health outcomes and building trust between Black families and the medical community. In using a trauma-informed lens, our doulas work to provide emotional support, helping to alleviate stress and anxiety by creating buffers to protect our clients. We also connect our clients to other

community buffers, which can positively influence their pregnancies, births, and postpartum experiences.

Our doulas emphasize anti-racism, empathy, and cultural humility, and encourage integrating trauma-informed care because we believe that by doing so, it is possible to improve maternal and neonatal outcomes, improving overall well-being for Black families.

The Perinatal Bill of Rights for Black Families

1. *Respect and Dignity*

Black families have the right to be treated with respect, dignity, and cultural sensitivity during pregnancy and childbirth.

2. *The Rights of Fathers/Partners*

Black Fathers/partners have the right to inclusive support and involvement throughout the perinatal process, including participation in prenatal appointments, childbirth education classes, and the option to be present during labor and birth.

3. *Freedom from Discrimination*

Black families have the right to health care without discrimination, bias, or mistreatment based on factors such as race, ethnicity, socioeconomic status, gender, sexual orientation, or other protected characteristics.

4. *Listened to, Timely Evaluation and Treatment*

Black families have the right to be listened to and evaluated and not ignored when concerns have been addressed.

5. *Pregnancy Management*

Black people have the fundamental right to manage their pregnancies and make decisions for themselves, including the option of abortion.

6. *Supportive and Inclusive Birth*

Environment

Black families have the right to a supportive and inclusive birthing environment that honors cultural traditions, various family structures, and individual birthing preferences. This includes the freedom to choose the preferred birth setting, whether it be at home, in a hospital, or at a birth center.

7. Immediate Postpartum Support

The postpartum period is a critical time, and therefore, Black families have the right to dedicated time for bonding and attachment, and evidence-based immediate postpartum care practices in a supportive environment.

8. Comprehensive Postpartum Care and Continuity

Black families have the right to comprehensive prenatal and postpartum care that specifically addresses their unique health needs. This encompasses the right to complete, appropriate, and evidence-based postpartum care.

9. Adoption Planning

Pregnant people considering adoption retain their fundamental rights that ensure their autonomy and well-being throughout the process. They have the right to be treated with respect, dignity, and cultural sensitivity during the perinatal period irrespective of their circumstances or decisions.

10. Grief and Loss Support

Black families have the right to receive compassionate support and consideration following fertility challenges, a challenging or unexpected pregnancy or birth outcome, a pregnancy loss, or infant loss.

11. Perinatal Community Support

Black families have the right to live in a community that supports health and well-being during pregnancy and postpartum.

12. Transparent Information and Competent Providers

Black families have the right to transparency in healthcare, including knowing our providers' education, qualifications, credentials, and experience. Additionally, providers trained in all variations of normal birth, including breech delivery, are affirmed.

13. Changes in Racist Medical Spaces

Black families have a right to medical providers who undergo extensive training to comprehend the distinctive cultural needs and experiences of Black people during the perinatal year, which should include awareness of historical trauma, systemic racism, and disparities that may influence their health outcomes.

14. Racial Alignment and Protection

Black families have the right to access Black midwives, OBGYNs, lactation professionals, doulas, and other medical providers throughout the entire pregnancy journey that work to dismantle the institutional racism of the medical system to provide necessary, often life-saving care to Black families.

15. Inclusive and Culturally Humble and Responsive Care

Black families have the right to inclusive and culturally sensitive healthcare that respects our background, beliefs, and values.

16. Informed Decision Making

Black families have the right to receive clear, culturally responsive, and unbiased information about our healthcare options to make informed decisions regarding fertility, pregnancy, childbirth, and the postpartum period. This includes the right to accept or decline any option, with the ability to revoke consent at any time.

17. Autonomy and Consent

Black parents have the right to autonomy and control over our bodies and birthing experiences, free from coercion, discrimination, and judgment.

18. Gaslighting and Mother Blaming

Black families deserve not to be blamed or gaslit for our circumstances. The “mother blame” narrative refers to the societal tendency to attribute negative outcomes or difficulties during pregnancy to the actions or choices of the mother. On the other hand, being “gaslit” during pregnancy means experiencing manipulation or psychological tactics that make the person experiencing it doubt their own perceptions, emotions, or experiences.

19. Equitable and Affordable Access to Quality Care

We have the right to equitable and affordable access to quality healthcare, regardless of socioeconomic status, geographic location, or insurance coverage.

20. Structural and Historical Humility and Responsiveness

Black families have the right to medical providers who practice structural and historical humility, responsiveness, and demonstrate anti-racist attitudes. Providers should acknowledge that race itself is not a risk factor, but racism is, and actively be working towards changing that.

21. Right to Privacy and Accurate Records

Black families have the right to privacy during medical examinations and procedures and to have our personal information

handled confidentially.

22. Transparent Billing and Financial Information

Black families have the right to clear and transparent information about the costs associated with any medications, processes, or procedures, including billing and payment expectations. We have a right to be educated on any potential financial assistance options that may be available.

23. File Grievances

Black families have the right to voice concerns or file grievances without fear of retaliation. Additionally, we have the right to take legal action in cases where harm has been inflicted upon us or our babies.

24. Personal Storytelling and Advocacy

Black families have the right to share our stories of the perinatal year, which is a personal choice that affirms our autonomy in communicating our journey.

25. Right to Thrive

Addressing maternal health disparities in Black communities requires sustained effort, collaboration, and a commitment to dismantling systemic barriers. By combining grassroots initiatives, policy advocacy, and community support, it is possible to create an environment where Black families not only survive childbirth but also thrive in all aspects of life.

To read the full Bill of Rights and learn more about Earth's Natural Touch: Birth Care and Beyond, visit www.earthsnaturaltouch.com/birth-justice.

Maternal Health Disparities in Connecticut: Addressing Inequities

By The Connecticut Health Foundation

Maternal health serves as a key indicator of a nation's overall health, reflecting the effectiveness of its health care system and highlighting existing disparities and weaknesses. The United States has the highest level of maternal mortality in the developed world.¹ The rate is especially high for Black women.

Black women are three times more likely to die from a pregnancy-related cause than white women in the U.S., according to the Centers for Disease Control and Prevention (CDC)². Black women are also twice as likely as white women to be affected by potentially life-threatening conditions or complications, known as severe maternal morbidity.³

Connecticut, despite its reputation as one

of the healthiest states, has significant maternal health disparities. The state's Maternal Mortality Review Committee looked at data from 2015 to 2019 and found 62 deaths occurring during a pregnancy or the first year after birth. While Black people made up only 13% of live births, they made up 27% of all pregnancy-associated deaths.⁴ Babies born to Black women in Connecticut are twice as likely to be born with low birthweight than babies born to white women (12.5% vs. 6.3%).⁵ Infants born to Black women are four times more likely than those born to white women to die before their first birthday.⁶

Health disparities are found at every step of the journey to parenthood. Nationally, Black women are nearly twice as likely than white women to have a birth with late or no prenatal care (9% vs. 5%). Women of color are at a higher risk of being uninsured before their pregnancy.⁷ Black women are also more likely to experience reproductive health disorders such as fibroids and are at higher risk of pregnancy-related complications such as preeclampsia. Across all racial groups, more than half of pregnancy-related deaths happen up to one year after delivery,⁸ underscoring the need for comprehensive postpartum care.

While socioeconomic differences are contributing factors in some instances of maternal mortality, they do not fully explain racial differences in maternal and infant health. A study found that Black women with a college degree or higher were 1.6 times more likely to die from pregnancy-related causes than white women without a high school diploma. Among those with a college education or higher, Black women were 5.2 times more likely to die from pregnancy-related causes than white women.⁹

These inequities are deeply rooted in racism and discrimination. Research indicates that racism and chronic stress adversely affect maternal and infant health outcomes. A recent survey revealed that many U.S. mothers reported experiencing mistreatment and discrimination during pregnancy and childbirth. About 20% of mothers overall reported mistreatment, with the rate climbing to nearly 30% for Black, Hispanic, and multiracial mothers. This mistreatment included being ignored by healthcare providers and having requests for help refused. Among Black mothers, 40.1% reported experiencing discrimination related to factors such as language barriers, lack of health insurance, and involvement with the justice system.¹⁰

[Healthy Connecticut 2025: A State Health Assessment](#) identifies focus areas to improve these outcomes. It involves preconception health, which includes improving the health

of people who could become pregnant and preventing chronic disease, prenatal health to improve outcomes, and medical care improvement including hospital protocol and care.

This year, the Connecticut Health Foundation will be commissioning a blueprint for maternal health equity for people of color in Connecticut, informed by those with lived experience, decision makers, and those who work in the field. We are eager to join those working on these critical issues and to share the findings of this process in 2025.

Ask the Experts: An Interview with Dr. Iyanna Liles, MD

By Alana Valdez, Editor



Dr. Iyanna Liles, FACOG, graduated from Duke University in 2010 and completed her Obstetrics & Gynecology residency at the University of Connecticut in 2018. She specializes in gynecologic care and minimally invasive surgery at Comprehensive GYN of CT and provides obstetric services at Saint Francis Hospital and Medical Center. Dr. Liles is also an Assistant Clinical Professor in Obstetrics & Gynecology at Quinnipiac University and Yale University School of Medicine, and is actively involved in advocacy and volunteer work, particularly with the Connecticut Maternal Mortality Review Committee.

ALANA VALDEZ: You specialize in routine gynecologic care and minimally invasive surgery and your special interests are family planning, adolescent health advocacy and health equity. How [does your work] contribute to healthcare outcomes and improving them for Black women in the community?

DR. IYANNA LILES: For me, this all goes back to my interest in becoming an OBGYN. I learned about reproductive health in col-

lege—and especially the disparity amongst Black women and the forced sterilization amongst Black women—I remember that I refused to let anybody tell me anything about my body that I wouldn't be able to figure out on my own. That's what led me to become a doctor and to become an OBGYN.

So, to that point, I specialize in all these things because in my mind, if I can be an honest and knowledgeable clinician to my patients, I can help them make informed healthcare decisions about their bodies. To me, doing that, also can help improve health outcomes because as people [participate more] in their healthcare, it helps them to feel better and to get better when they're active participants and someone's not just telling them what to do; I think by being knowledgeable and being honest about it as well.

There are certainly times where I meet patients and they want to do something and I may not feel like it's the best for them, but I still want to honor what they think is important. I think being honest and building that rapport with patients has helped me to be able to help people make a decision they're comfortable with, to go with them on a journey to the place where they're ready to do certain treatments or procedures they may not have considered.

The other thing about the work that I do is that I really like to give patients autonomy. I think being active in your own care and making your own decisions is important. I love to tell people, "You're going to go home with your body. I'm not going to take it home with me." So, you have to feel comfortable with your decision—if you're okay with it, I'm okay with it as well. Having that autonomy and that empowerment to make decisions I think is really what's going to turn the tide for Black women—for anyone—to have the appropriate health outcome that they need.

The last thing is listening to patients. I think there's a lot of value in spending time. Sometimes patients have been to different clinicians and may feel that they haven't been listened to or heard. [It's important to give] them the space to be able to talk about whatever's going on or whatever they're concerned about, I think is therapeutic and [helps] to improve their outcomes in the long run.

ALANA: You also do some activism and advocacy work—I saw you in the Reproductive Justice Alliance meeting recently—and then you're involved with the American College of Obstetrics and Gynecology. So, how do you think advocacy plays a role in this—in addressing those disparities? And how is advocacy part of your practice?

DR. LILES: There's a saying that, "If you're not at the table, you're on the menu," and I am a firm believer of that. People are making decisions about a person's healthcare without any input from someone who's knowledgeable about that decision. So for me, it has been a lifelong goal [and] dream to be at the table when it comes to reproductive healthcare, especially because I'm a woman; I'm a Black woman and I don't want anyone making decisions regarding my body that I didn't get [a] say in.

I think of my advocacy work as my way of getting to the table and creating a voice for my patients, for my profession and for myself and my loved ones. Through that, I've been able, as you mentioned, through the various organizations, have had the opportunity to do different advocacy outlets.

The way I incorporated that into my practice is number one, in my exam room, I try to make all my patients advocates. I love to tell doctors, "Even if you don't go to the Capitol, you are an advocate by providing excellent care to the patient and speaking up for them." So, that may mean I call insurance [companies] and I have to yell at them or do the prior authorization. I'll sometimes get patients involved and say, "Hey, you need to talk to your legislator in your town or your federal legislator. They actually want to hear what every patient has to say."

I think if someone's going through something, I'm like, "That didn't cover it? You need to let your senator know because I bet you they will make the hospital move mountains." That's how I like to get patients involved and how I try to do it in the practice.

Now, outside of my actual clinical work, I go to the Hill, I lobby, I will write to legislators, I will use social media outlets. I've gone to DC, I've been down in Hartford, and I will bring stories of patients, de-identified. I will bring my patient stories—the concerns people are telling me—and then I'll hear them say, "Wow, I didn't know that's happening." And I hear it all the time.

To that point, I think that the way that we are going to be able to address maternal mortality, the morbidity, any health outcomes, is that we have to let the people who are in power know what's going on and we have to then fight for it. They are hearing a lot of other noise and a lot of other things pulling them in different directions, and if the people who are significantly impacted by their decisions don't speak up, it's going to continue to happen. I think that's how we've kind of gotten to this place right now is, the squeaky wheel gets oiled, and a lot of other squeaky wheels were louder

than us. I think only now are people starting to get louder in their squeak so that they can be oiled.

ALANA: I really admire your tenacity. I think that's so admirable because a lot of patients, with their own providers, feel like they don't really have a voice or that they don't know enough to talk, [much less] a statewide or a national scale. If you don't feel like you have power in that siloed situation, how are you going to be brave enough to speak to the general public?

DR. LILES: Correct. Having an MD behind my name gives me that sort of legitimacy to be able to say, "No, these are the people who come and speak to me and countless times throughout the week are telling me they're scared, that this is happening, that the insurance is doing this denial. What are we going to do about it? If this were your daughter, mom, loved one, how would you feel and what would you want done?" I think we bring perspectives that way when we ask physicians to go and bring the stories.

But, I also tell patients hearing it directly from [them], as much as they love to hear from me, if they can put a face to a name, a person who's brave enough to put it out there, that is how legislation gets started, because of one person [who] spoke up, made enough noise and made it significant. [Then] it gets to someone's attention to the point where they [are] able to make a law or bring it to attention.

ALANA: Speaking of legislative activity, you also are one of the physicians who provides feedback to the Connecticut Maternal Mortality Review Committee. What suggestions have you made to them and also what initiatives is the state up to right now—what state actions have they taken?

DR. LILES: The Connecticut Maternal Mortality Review Committee (MMRC) is a multidisciplinary group of individuals, so there are physicians of different backgrounds, not just OBGYNs, there's nurses, we have mental health clinicians. There are also state agencies—there's [DMHAS], DCF, DPH—and different community health organizations.

What we do is, [review the deaths of] any person who dies during pregnancy or at postpartum (up to a year) and make recommendations. I can't say all the things I've done [due to confidentiality], but, in particular, what I like to focus on from the physician side of things is where could we, as a physician, have intervened in that person's care and prevented that death from occurring. I think that's very valuable information because sometimes it doesn't seem like anything, as a physician, I could have

done, but maybe we could have incorporated more screening, more checkpoints, etc. The other area that's been interesting over the last couple of years is we've incorporated a lot more screening for discrimination or interpersonal racism and how that might have impacted the death.

Our deaths are much higher in the African American and Hispanic populations than they are in the white population in Connecticut. A lot of times, as we're reviewing the deaths, you're able to see clearly, this person may have experienced some type of racism or discrimination, either during their care or afterward, or even bias, and that potentially led to their death.

[It's] causal at this point, because you can't completely find that, but there is [some evidence], like this person came to the ER a million times and no one picked up on the drug use, or no one screened them, or someone dismissed them.

I think that that's been one of the areas I've been able to help a lot is to say, "Hey, this person meets all of these criteria for discrimination, for implicit bias, for racism." The nurse or the doctor may have written in the chart language that seems that they were maybe passing some judgment. That's been valuable because we can then look at how we address [that] on a societal level so that we can make patients feel more comfortable; we can address their concerns in a compassionate manner.

We make a lot of recommendations concerning ways that we can impact the community. The MMRC, after reviewing all the deaths, we make recommendations, and a lot of the recommendations will then be sent to the state. Because of it, they've increased awareness and [provided] education to the different birthing hospitals in the state, which has been important. We've talked a lot about doulas and having doula care and access to doula care; there was legislation that's passed and we're working on implementing coverage for doulas in the insurance realm.

Partially from work from the MMRC, there's now a maternal mental health hotline. A lot of deaths in Connecticut were around mental health conditions, so we now have a hotline that any clinician who has a pregnant or postpartum individual can call for free and get advice on therapy or medication to help a person who's experiencing some type of mental health issue. A lot of that work has come from what we are seeing in deaths and ways that [the MMRC] feels that we can make an impact on our pregnant and postpartum population.

ALANA: That's all incredible, especially the implicit bias screenings and racism screenings. I know most people think of racism as being potentially deadly, but I feel like we don't think of it in that context and instead think of things like whether someone got the wrong diagnosis or medication as factors in their deaths.

DR. LILES: [Say] this person got the right medication, but [experienced] years of discrimination or felt like the doctor wasn't listening to them. Maybe they didn't take the medication or nobody screened them to see that they would even need that medication because [the prescriber] didn't feel like they would need it. The language that we're using there, it's a lot of colloquialisms and that's actually damaging to patients in the long run.

That's a lot of what we are looking at and there are some cases that look cut and dry until you go through with a fine-toothed comb and you go, "No, I can give you 4 instances where this probably didn't need to happen that way," and then we can think about how do we change the language? How do we change the attitudes and behaviors so that people are treated appropriately?

ALANA: One of the things that I thought was interesting about your bio was your interest in treatment for uterine fibroids and the new minimally invasive method you're trained in. I read that fibroids are more common in Black women, is that true? How do fibroids impact your patients and Black patients particularly?

DR. LILES: Yes, fibroids are [more common in Black women]. They're a huge burden to patients because they just cause a lot of symptoms between heavy periods, sometimes painful periods. They can be disruptive to life for people and we didn't have a lot of great treatments for it: it was either hormone therapy or surgeries where you either take the fibroids out or you do a hysterectomy. A lot of people didn't like those options, patients wanted more options, especially if they wanted to keep their uterus.

The reason I started to get interested in it, especially with this procedure is because I encountered so many people who had fibroids and they [say], "I want to keep my uterus, but I don't want to feel like this." I felt like my hands were almost tied and then I heard about this newer procedure. It's actually been out for at least a decade or more, but it was newer to Connecticut, where we can do minimally invasive surgery to burn the fibroids. By burning the fibroids, it helps to shrink them a little bit and it can help to decrease the symptoms people have, but they also get to keep their

uterus. I think that has been revolutionary for patients.

So, what I love about this new option is that it allows me to really talk with patients about goal setting and try to hammer in what is important to them, because there are going to be people who are like, "I just don't want it anymore, get rid of everything." And I think that that's okay, but for the person who says, "I would like to keep it if possible. Can this help?" I can then have an honest conversation; we can bring in the data, we can individualize it to them, and then help to decrease the burden that these fibroids are having on their life, allowing people to be able to go back to enjoying it, not having heavy periods or painful periods and maybe impact their fertility in a great way.

Ultimately, it's always about health outcome, but within the realm of what their goal is, because for some people the health outcome maybe not having fibroids at all, it's a different procedure. For some people, it is just to feel better and to get back to their normal life. After I started performing these procedures, I've been able to help people in their life and I think it's wonderful. I also do the other ones; don't get me wrong, it's not like I've stopped them, but for the appropriate person. It allows them autonomy, the ability to be involved in their decision and to really be comfortable with the decision that they're making.

ALANA: That just makes me feel hopeful because it feels almost like women's health is done [evolving] sometimes, like there's only a certain amount of options, and it's only these things that we know have horrible side effects or impact your fertility dramatically. It's wonderful that there are options and that you are a person that people can come to and say, "What options do I have before committing to something that's potentially very life-changing?"

DR. LILES: You're right, there's hope. I think the last two years we have not felt hopeful in women's health because so much has happened, it feels like out of our control, and then we get these little pockets of hope which is what I can offer people at least in this realm, especially with fibroids. There is hope and I think it's only going to get better in the future.

ALANA: Obviously, you're involved in a lot of things outside of the scope of your regular practice. How do you deal with compassion fatigue and how do you maintain passion for the work?

DR. LILES: I have a great support system. My husband and my family allow me the space to be able to do all my passion projects, but

also the boundaries to know when I might be crossing the line, and I think that has been able to help keep me grounded. If I get requests to do certain things, I actually do run it through my husband because he's like my master scheduler and he's able to say, "Hey, you have all these other things planned. Can this realistically work in?"

That has been helpful, but I always have to go back to "why did I start this" whenever I get to the point where I'm feeling exhausted or drained. I have to remember that gynecologic organs are my favorite thing on the Earth, and I could talk about them until I turn blue in the face, and I will probably die doing this job. I think that is what's kept this passion going and I have to recognize that there are certain seasons of life that I may not be as active as I normally am. Like when I had my children, I had to take a step back and focus on my kids, and then as they've gotten older, I'm able to branch out and do a little bit more.

So, it's grounding myself in why I do this work, and then, of course, I surround myself with people who love what they do also. It's helpful when you come to work, and everybody is excited about doing things about the uterus or the cervix or the fibroids or ovaries. It makes me excited because I love what I do, it's fun. I think that's what keeps me excited.

For my self-care routine, I have a day off every week. I love my practice, they have allowed me to do tremendous, great work for the community. They have allowed me to have time with the patients to really get to know them. But, I also have a day off work just for me and if I choose to work on it I will do that. If I don't, then I will do my own self-care, which may be lunch with a friend and then doctor's appointments or sitting in a park or picking my kids up early and hanging out with them. I hoard that day like it's nobody's business because that's what's been important. Like you said, I not only work, I'm a mom, I'm a wife, I do a lot of community things. It's the one day that I get to decide what I want to do, and I think that has been a game changer in keeping my fatigue level down because I have a day that I can escape.

ALANA: One of the things that was lauded about your International Women's Day presentation [at the Consortium] was that you ended with a call to action about going out to vote. I love how you speak about enabling patients to be their own advocates; so in your opinion, what are some things that people who are outside of healthcare can do to support efforts to improve Black maternal health outcomes?

DR. LILES: Number one, educate yourself. Read what I read. The same information I

have is not a secret anymore like it used to be, so I advise everyone read all the papers. Come to the appointments with the percentages, that allows a fuller discussion. Encourage events in the community to educate those around you. If we get community partners, and loved ones involved that then speak to patients, it just empowers them more because there's a community loving on them and not just one person.

Especially if you're not the person going through a healthcare issue, advocate for your loved ones. I love when support people come to appointments and, not necessarily speak up for a person, but go well, "What she isn't telling you is..." See what needs they may have, talk to them about their goals so that you can help them achieve your goals. I think that's how we're going to address this issue. If someone doesn't know that there's a problem and no one speaks out for them, I can't help them. Ask if they need help. The pregnancy and postpartum is a very interesting time frame and if someone needs help or you're noticing behaviors or symptoms that seem odd, ask them, or even bring it to the attention of their clinician so that they can ask them discreetly.

The other [thing] I tell everyone: become a clinician. Medical school is hard and long, but there are so many other ways to help in the maternal health space, not just a doctor. There are people who become doulas, you can become a midwife, you can become a birth educator, you can become a nurse, you can become a mental health specialist. Just like we say, it takes a community to raise a baby, it takes a community to support a pregnant person. It shouldn't just rely solely on the pregnant person and their doctor or their midwife or their whomever: it takes a large group. I challenge everyone to get involved in healthcare in some way, shape, or form. You don't have to be a holistic expert in everything, but if you are an expert in your one little thing, you're going to do more for that person than I probably will. I know obstetrics and gynecology like the back of my hand.

Do I know anything about social work? No. I could try, but I'm not going to be good at it. If someone else brings that expertise to the forefront, we can move mountains for patients. That's what's going to move mountains, is everyone with their little silos finally coming together to round that support that pregnant person and help turn the tide in their outcomes.

I think we've proven that we can be better, and



that's what I'm excited for.

Listen to the full interview, "Ask the Experts: Black Maternal Health with Dr. Iyanna Liles" on our podcast, Realizing Resilience on [Spotify](#) or at our [website](#).

Improving Black Maternal Health Through Meaningful Engagement in Fairfield County

By Mary Grace Pagaduan, MPH

Black maternal health in the United States remains a significant public health concern, with Black women experiencing disproportionately high rates of maternal morbidity and mortality compared to their white counterparts.¹¹ In Fairfield County, CT, overall infant mortality rates are 3.96 deaths per 1,000 live births. However, for Black babies, infant mortality rates stand at 9.2 deaths per 1,000 live births, compared to just 2.7 for white babies. Low-weight births in Fairfield County also reflect significant disparities, with 13% of Black babies being born with low birth weight compared to 6% of white babies. The share of births with late or no prenatal care in Fairfield County is 3.1% overall, but it is twice as high for Black mothers (6.7%) than white mothers (3.1%).¹²

Recognizing the urgent need to address these disparities, the [Fund for Women & Girls \(FWG\)](#) at [Fairfield County's Community Foundation \(FCCF\)](#) launched the [Black Maternal Health Initiative \(BMHI\)](#) in November 2022. This initiative aims to improve Black maternal health outcomes through a comprehensive approach outlined in a developed Blueprint.¹³ Strategies include expanding doula services, increasing access to doula support services through education and awareness, community-led initiatives, anti-implicit bias training for hospital staff, policy advocacy, patient-centered care practices, integrated care models tailored to community needs, and monitoring and evaluation.

By engaging the community, centering Black birthing people and Black doulas, and addressing systemic barriers, we can create a more equitable and supportive maternal healthcare system that ensures all Black women have the opportunity for safe and healthy pregnancies and births. Through these concerted efforts, Fairfield County can serve as a model for other regions striving to improve Black maternal health outcomes.

The initiative aims to mitigate racial inequities in maternal health outcomes by embedding doula services within the continuum of care for Black women experiencing disproportionate burdens of maternal morbidity and mortality in Fairfield County. The goals are to improve birth outcomes for Black women in Fairfield County and address structural racism and implicit bias in healthcare access and delivery. Objectives include scaling the community-based Black doula workforce, increasing demand for doula services among Black birthing people, and implementing a rigorous evaluation framework to assess the impact of doula services on reducing racial disparities in maternal health.

Utilizing the [Social Support Theory](#) and the [Health Belief Model](#), the initiative posits that the augmentation of the doula workforce will significantly influence maternal health behaviors and outcomes through enhanced social support mechanisms. This component seeks to empirically substantiate the efficacy of doula interventions in bridging racial disparities in maternal health, thereby informing policy and practice. Guided by the [Socio-Ecological Model](#), this strategy advocates for multi-level societal changes, ranging from individual healthcare practices to wide-reaching systemic and policy reforms, to support the successful integration of doula services into standard maternal healthcare.

Recognizing implicit and explicit bias as foundational contributors to disparities in maternal healthcare, this training is aimed at reducing bias within clinical encounters, thereby advancing health equity. Doulas are poised to directly confront the systemic injustices, including structural racism and healthcare biases that underpin maternal health disparities. This model of care emphasizes personalized, culturally sensitive support, empowering expectant mothers and improving Black maternal health outcomes. Positioned at the intersection of healthcare and community support, doulas address critical gaps in the maternal care continuum, confronting the root causes of health disparities through direct, personalized care, patient advocacy, and improved health literacy.

The Black Maternal Health Initiative employs a local community-centric strategy to tackle the structural and social drivers of health, leveraging local cultural knowledge and networks to improve access to maternal health services in Fairfield County. The projected impacts include decreased racial disparities in rates of maternal mortality and morbidity, increased maternal care satisfaction and birthing experience among Black women, elevated policy recognition of doula services as integral to maternal healthcare delivery, and

reduced healthcare provider biases, fostering an environment of respect, dignity, and equity in Black maternal healthcare interactions.

This initiative seeks to foster systemic change in the maternal healthcare landscape, advocating for a universal, equitable approach to care that supports all women, particularly Black women, in achieving optimal health outcomes during pregnancy, childbirth, and the postpartum period.

Fairfield County's Community Foundation's Black Maternal Health Initiative Community Partners are:

- Bridgeport Prosper
- Community Health Workers Association of CT
- Doulas 4 CT
- UConn Health Disparities Institute
- Primary Care Clinic at Bridgeport Hospital
- Southwest Health Center
- Ministerial Health Fellowship
- Stamford Maternal Health Project
- Health Equity Solutions
- Hospital Association of Connecticut

Mary Grace Pagaduan, MPH is the Director of the Fairfield County's Community Foundation's Fund for Women & Girls. She can be reached via email at mpagaduan@fccfoundation.org.

About New Haven Healthy Start

Summarized by Alana Valdez, Editor

New Haven Healthy Start (NHHS) is a federally funded program that works with local partners to improve birth outcomes and eliminate health disparities. The program aims to eliminate racial and ethnic healthcare disparities and reduce infant mortality. NHHS offers a full spectrum of services for pregnant women and mothers through pregnancy, birth, and the first 18 months of their babies lives. Through a care coordination model, NHHS connects families to referral services to social and medical services, a provider network, parent education, fatherhood support, health insurance enrollment, lactation consulting, and more.

NHHS involves the community in its decision making: the NHHS Consortium serves as a platform for community members to learn about conditions that impact family health, and participate in discussions and

activities to improve those conditions and the services they receive. NHHS also hosts a Men's Consortium as a support network for men and fathers in the Greater New Haven area.

Executive Director Natasha Ray, in partnership with physician researchers from the Yale Robert Wood Johnson Clinical Scholars Program, has conducted a series of research projects to address maternal health issues in New Haven. This partnership resulted in the creation of a guidebook for best practices in community partner research.

Since NHHS' founding in 1997, infant mortality rates (IMR) in New Haven have dropped by more than half. In 2022, the IMR dropped to 7 deaths per 1,000 live births from more than 20 deaths in 1997. For babies of families who receive NHHS services, the IMR drops further to 4.5 deaths per 1,000 live births. The program has served nearly 20,000 pregnant women since its inception.

In early June 2024, U.S. Senator Richard Blumenthal (D-CT) and U.S. Representative Rosa DeLauro (D-CT), along with Healthy Start participant Robert Farrow Jr. and his daughter Harmony, announced \$1 million in federal funding for NHHS. The award is part of a five-year, \$5.5 million grant from the Health Resources and Services Administration and will be used to continue addressing racial disparities and health outcomes.

Who's Been Reading Trauma Matters?

DCF Commissioner Jodi Hill-Lilly!



Jodi Hill-Lilly was nominated by Governor Ned Lamont to be the Commissioner of the Department of Children and Families in December 2023. She is a proud social worker with over 35 years of dedicated service to children and families served by the Child Welfare system on both a local and national level. As Commissioner of DCF, she manages an annual operating budget of almost a billion dollars including state and federal funds. The workforce includes approximately 3,200 members across two children's psychiatric facilities, 14 field offices, a Central Office and an adventure based clinically-supported Wilderness School.

She began her career as a caseload carrying social worker providing direct care to CT's most vulnerable populations during the crack and AIDS epidemics. Commissioner Hill-Lilly also has extensive national experience which includes conducting Federal Child and Family Services Reviews where she audited the Child Welfare practice of over 13 jurisdictions. Commissioner Hill-Lilly currently serves as Co-Chair to the National Partnership for Child Safety (NPCS). NPCS is a quality improvement collaborative of 39 jurisdictions including Connecticut, representing nearly 70% of children involved with public Child Protection systems nationwide.

Commissioner Hill-Lilly is most recognized for her work in Connecticut around Racial Justice and Workforce Development. She serves as the Executive Sponsor for the Racial Justice work in CTDCT that has received national recognition and most recently was recognized by the Commission on Racial Equity in Public Health in Connecticut. Workforce Development is at the heart of Commissioner Jodi Hill-Lilly's passion. Her motto is, "Help the people who help the people." Supporting and teaching child welfare staff to do this work is a true passion and a rewarding experience.



The Connecticut Women's Consortium
2321 Whitney Avenue, Suite 401
Hamden, CT 06518
www.womensconsortium.org

References and Resources

Resources

Connecticut Health Foundation: <https://www.cthealth.org/>

Fairfield County's Community Foundation: <https://fccfoundation.org/>

FCCG Fund for Women & Girls: <https://fccfoundation.org/fund-for-women-girls/>

FCCG Black Maternal Health Initiative: <https://fccfoundation.org/fund-for-women-girls/black-maternal-health-initiative/>

Health Belief Model: <https://sphweb.bumc.bu.edu/otlt/MPH-Modules/SB/BehavioralChangeTheories/BehavioralChangeTheories2.html>

Healthy Connecticut 2025: A State Health Assessment: https://portal.ct.gov/-/media/departments-and-agencies/dph/dph/state_health_planning/sha-ship/hct2025/sha-chapters/3_mich-chapter_ct_sha_report_final060520-3.pdf%3B

New Haven Healthy Start: <https://www.cfgnh.org/leading-on-issues/healthy-families>

New Haven Healthy Start Grant Announcement: <https://www.cfgnh.org/articles/sen-blumenthal-and-rep-de-lauro-announce-5-5-million-for-new-haven-healthy-start>

Perinatal Bill of Rights for Black Families by Earth's Natural Touch: Birth Care and Beyond: www.earthsnaturaltouch.com/birth-justice

Realizing Resilience Podcast: <https://open.spotify.com/show/7dXT5Ezu8MGQz7lXiCpyyV?si=0579032cd82e4540>

Social Support Theory: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5480897/pdf/nihms863739.pdf>

Socio-Ecological Model: https://www.atsdr.cdc.gov/communityengagement/pce_models.html

References

¹ The Commonwealth Fund. (2024, June). Insights into the U.S. maternal mortality crisis: An international comparison. Retrieved from <https://www.commonwealthfund.org/publications/issue-briefs/2024/jun/insights-us-maternal-mortality-crisis-international-comparison>

² Centers for Disease Control and Prevention. (2020). Maternal Mortality Rates in the United States. Retrieved from Maternal Mortality Rates in the United States, 2020 ([cdc.gov](https://www.cdc.gov))

³ JAMA Network Open. (2022). Article Title. Retrieved from <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2794738>

⁴ Connecticut Department of Public Health. (2020). Connecticut's Severe Maternal Morbidity Report: 2010-2020 Connecticut's Severe Maternal Morbidity Report: 2010-2020

⁵ Kaiser Family Foundation. (n.d.). Births of Low Birthweight as a Percent of All Births by Race/Ethnicity. Retrieved from Births of Low Birthweight as a Percent of All Births by Race/Ethnicity | KFF

⁶ Kaiser Family Foundation. (n.d.). Total Infant Deaths by Race/Ethnicity. Retrieved from Total Infant Deaths by Race/Ethnicity | KFF

⁷ Kaiser Family Foundation. (n.d.). Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them. Retrieved from Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them | KFF

⁸ Centers for Disease Control and Prevention. (n.d.). Four in 5 pregnancy-related deaths in the U.S. are preventable. CDC Online Newsroom. Retrieved from Four in 5 pregnancy-related deaths in the U.S. are preventable | CDC Online Newsroom | CDC

⁹ Centers for Disease Control and Prevention. (2020). Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016. MMWR Morbidity and Mortality Weekly Report. Retrieved from Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016 | MMWR ([cdc.gov](https://www.cdc.gov))

¹⁰ Centers for Disease Control and Prevention. (2023). Vital Signs: Maternity Care Experiences — United States, April 2023. MMWR Morbidity and Mortality Weekly Report. Retrieved from Vital Signs: Maternity Care Experiences — United States, April 2023 | MMWR ([cdc.gov](https://www.cdc.gov))

¹¹ Centers for Disease Control retrieved June 8, 2024, <https://www.cdc.gov/healthequity/features/maternal-mortality/index.html>

¹² Abraham, M., Seaberry, C., Davila, K., Carr, A. (2023). Fairfield County Community Wellbeing Index 2023. New Haven, CT: DataHaven. Available at ctdatahaven.org.

¹³ Fairfield County's Community Foundation, retrieved June 1, 2024 https://fccfoundation.wpenginepowered.com/wp-content/uploads/2023/10/FCCF_FWG_MatHlth102523FINAL.pdf