BIRTH JUSTICE COLLABORATIVE

LITERATURE SYNTHESIS REGARDING BLACK AND AMERICAN INDIAN MATERNAL HEALTH AND BIRTH JUSTICE STRATEGIES

> *Our communities have not yet had the chance to ideate, cultivate, or collaborate to heal from historical trauma. To do this, we must reconnect to birth as ceremony.*
>
> LISA SKJEFTE, MINNESOTA INDIAN WOMEN'S RESOURCE CENTER
> (WITH ATTRIBUTION TO HER ELDER, DORENE "WAUBANEWQUAY" DAY, BOIS FORTE ANISHINAABE)

BIRTH JUSTICE COLLABORATION

Literature Review and Synthesis Updated 2-2023

This document is submitted by the Birth Justice Collaborative (BJC), which consists of four Black and American Indian led organizations—Liberty Northside Healing Space, Minnesota Indian Women's Resource Center, Native American Community Clinic, and the University of Minnesota Robert J. Jones Urban Research and Outreach-Engagement Center (UROC)—and a coordinating organization, Collective Action Lab.[a] The BJC is under contract with Hennepin County to offer strategies for birth justice that have been evaluated and published in literature and/or drawn from community member input. This document discusses strategies drawn from peer-reviewed literature and from community-based birth justice coalitions across the US that have been evaluated in some manner.

> ***For purposes of this work, the term birth justice[b] broadly encompasses any policy, practice, mindset, behavior, or ceremony found in community, institutional, spiritual, family, and/or other system or construct that positively impacts maternal health and well-being from pre-conception through post-partum, reduces exposure to adverse experiences, and/or fosters trauma healing among American Indian and Black people.***[c]

The BJC will also engage community members in Hennepin County to share their strategies for birth justice and will convene a leadership coalition to review the literature and community guidance to co-create and vet with community members a plan for implementing recommended strategies for which County funds are designated.

Our confidence lies in American Indian and Black community members to identify and help realize strategies that reflect the future we wish to live into through re-connection with cultural strengths and wisdom, while concurrently addressing structural racism and other barriers to maternal health and well-being.

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[a] The bulk of research and analysis captured in this report was conducted by Nicollette Moore, University of Minnesota School of Public Health Master's student. The BJC is grateful for Ms. Moore's knowledge, expertise, and commitment to maternal health and birth justice for Black and American Indian people and communities as she has so evidenced in this report.

[b] Reproductive justice (RJ) was originally defined in 1994 by SisterSong, the largest national, multi-ethnic Reproductive Justice collective. RJ includes the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities. Birth justice is a mandate that birthing rights and care options from pre-conception through post-partum recognize and address the history and life circumstances of oppressed groups.

[c] Gender inclusive language will be used throughout this report because not all people who get pregnant identify as women. Terminology such as "women" might be used to accurately describe study findings that used gendered terminology.

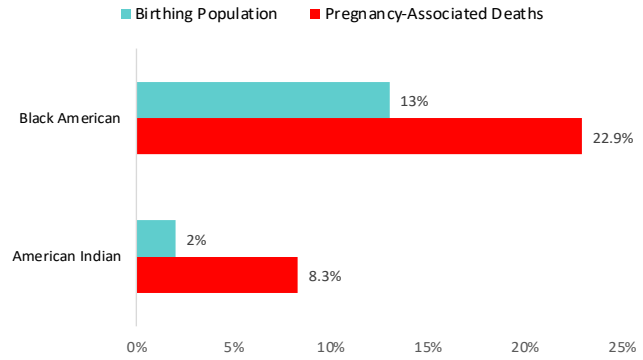
FOCUS: CENTERING BLACK AND AMERICAN INDIAN PEOPLE AND COMMUNITIES

This report centers Black and American Indian communities when examining root cause inequities and responsive strategies because that is where the greatest past and current harm, injustice, and impediments to maternal health exist. We know that any reparative and responsive strategies will have universal benefit. American Indian and Black communities within Minnesota are not monolithic and the rich diversity within and across them influences maternal health needs, experiences, and outcomes. In Minnesota, there are 11 federally recognized American Indian tribes: 7 are Anishinaabe (Ojibwe, Chippewa) and 4 are Dakota (Sioux).[1] In addition, there are people from the Latinx community in Minnesota who also identify as American Indian and/or Alaska Native.[2] Minnesotans who identify as Black include those born within the US—with a further critical distinction of US born African Americans who are descendants of slavery, and those born outside the US. The largest population of Somali Americans live in Minnesota with a majority living in the Twin Cities,[3] and other Minnesota Black immigrants and refugees include but are not limited to those born in Kenya, Liberia, Nigeria, Eritrea, South Africa, Uganda, Togo, Ghana, Ethiopia, and Sierra Leone.[4]

FRAMING: SURFACING ROOT CAUSES OF DISPARITIES AND RESPONSIVE STRATEGIES

To emphasize the breadth and the scope of the issues we face in maternal health, most national, state, and county level literature centers Black and American Indian ***disparities***.

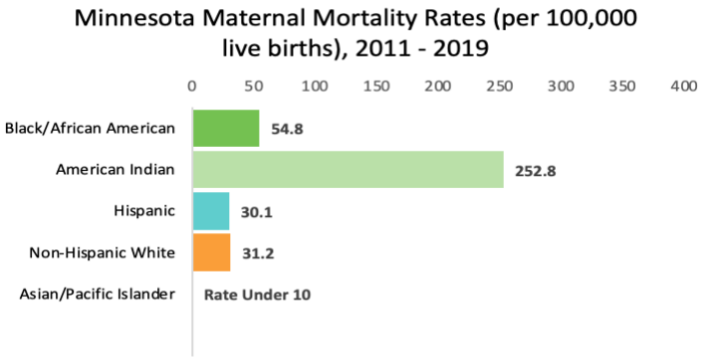
These resources establish that despite Minnesota's comparatively overall low pregnancy-related mortality rates –which reflect death during pregnancy, or within one year of pregnancy due to pregnancy-related complications—Black and American Indian people respectively comprise 22.9% and 8.3% of pregnancy associated deaths even though they comprise only 13% and 2% of the birthing population in Minnesota.[5]



Source: Minnesota Department of Health, Office of Vital Records

Additionally, in the 2016-2020 timeframe:

- US born Black/African Americans were 2.8 times and American Indians are 8.1 times more likely to experience maternal death than white Minnesotans.[6]
- Only 45% of American Indian pregnant people and 64% of U.S born Black pregnant people receive adequate prenatal care in Minnesota,[6] which correlates with significantly increased rates of low-birth-weight infants.[7]



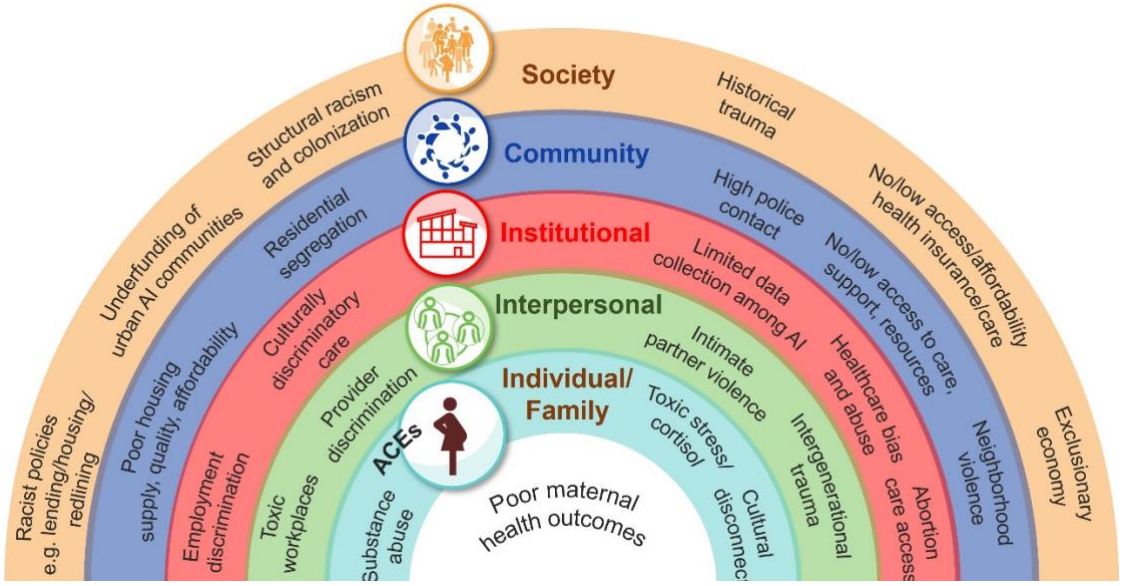
Data Source: Minnesota Department of Health, Minnesota Resident Maternal Mortality File

These and other disparities for American Indian and Black people are especially well documented in the Minnesota Department of Health's July 2022 Maternal Mortality Report.[8] This synthesis does not aim to reiterate literature on disparities, but instead draws upon it to surface root cause inequities and responsive strategies to advance radically better experiences and outcomes in maternal health and well-being for Black and American Indian people.

BIRTH JUSTICE DEMANDS A MULTI-FACETED CONSTRUCT:

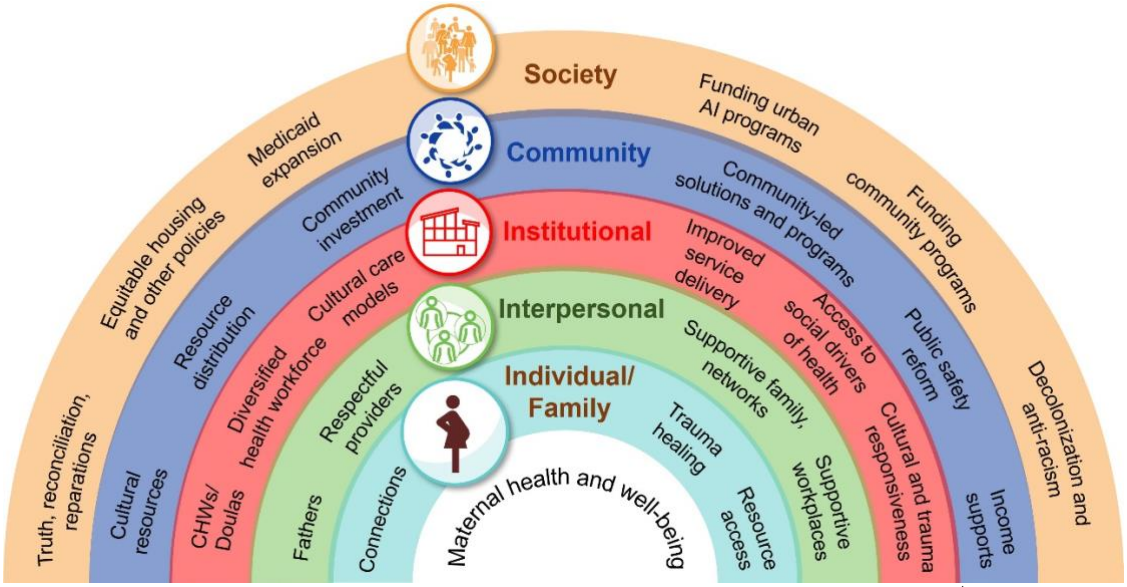
Due to the complexity of issues surrounding maternal health for Black and American Indian people, a socio-ecological model helps to adequately examine the drivers of disparities and responsive strategies to address them. This model provides a comprehensive context and acknowledges that individual health and well-being is linked with past and future generations, strongly intertwined with societal policy and community environments, and highly affected during sensitive periods such as childhood.

ROOT CAUSE DRIVERS OF MATERNAL HEALTH DISPARITIES: While individuals experience maternal health disparities at different rates, the visual below reflects inequities at each level of the socio-ecological model that collectively drive disparities for Black and American Indian people.



Conceptual Source: Bronfenbrenner, U. (1994). Ecological models of human development. In International Encyclopedia of Education, Vol 3, 2nd Ed. Oxford: Elsevier. Reprinted in: Gauvin, M. & Cole, M. (Eds.), Readings on the development of children, 2nd Ed. (1993, p. 37-43). NY: Freeman.

RESPONSIVE STRATEGIES: The diagram below offers responsive strategies[9] to address inequities comprehensively, including those at societal, community, and institutional levels, which can achieve greatest impact. *Tinkering with program shifts at just one level will only perpetuate harm and disparities.*



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ALIGNING ROOT CAUSE DRIVERS OF DISPARITIES AND RESPONSIVE STRATEGIES:

> *"We know Native people are at the top of every disparity; what we do not talk about is the root cause, colonialism.*
>
> **MARISA MIAKONDA CUMMINGS, PRESIDENT/CEO, MINNESOTA INDIAN WOMEN'S RESOURCE CENTER**

SOCIETAL

ROOT CAUSE DRIVERS

Structural racism, colonialism, and resulting historical trauma for American Indian and Black people. American Indian and Black communities have experienced collective and historical trauma for centuries due to mass genocide, broken treaties, forced relocation, cultural erasure, boarding schools, and forced sterilization of American Indians; forced birthing/sterilization, chattel slavery, Jim Crow laws, mass incarceration, and residential segregation of African Americans.[10] This has been linked to multiple psychological and social issues including an increased risk of perinatal mood disorders, substance use disorder, preventable infant deaths,[11] mistrust of government agencies and healthcare systems, and reluctance to seek health care. [12,13]

Racist housing/lending policies. Policies, such as redlining and racial covenants, have contributed to residential segregation, which continues to persist in Hennepin County and Minnesota and across the United States.[16] This has led to decades of community disinvestments, concentrated poverty, and barriers with building generational wealth through home ownership.[17] Minnesota currently has the largest disparity in home ownership rates between Black and white people in the US. Residentially segregated neighborhoods have less access to needed resources which includes limited health care options such as hospital maternity wards & OB-GYNs.[18] Among Black residents who live in highly segregated neighborhoods, the rates of preterm births and infant mortality are disproportionately higher.[19,20]

No/low access to health insurance and health care. In 2021, the percentage of Minnesotans without health insurance hit a historic low at 4%,[21] however, uninsurance rates among Black, American Indian, and communities of color were 10.2%,[22] which contributes to a higher rate of maternal death among those without insurance compared to those with it.[23]

RESPONSIVE STRATEGIES

Acknowledge and address the impact of historical context and colonialism on maternal health and well-being. We must acknowledge and confront the history of colonialism and its impact on Black and American Indian people through the following actions, all of which have been shown to have a positive impact on maternal health and well-being. [14,15]

- Cultivating knowledge of historical trauma and fostering cultural humility through open dialogue and education
- Reparations including transfers of land and money to those impacted by past injustices
- Supporting and reclaiming traditional community birthing practices
- Incorporating trauma-informed practices into all care and support

Adopt a racial-equity-in-all-policies standard. Policy reform[24,25,26,27,28] is the first step in addressing the root cause drivers of disparity for Black and American Indian people and should minimally include:

- Addressing the legacy of residentially segregated neighborhoods via better resource distribution and investments in policy that generates cleaner air, green spaces, retail, and grocery stores
- Public safety reforms that consider community needs
- Establishing and enforcing employment equity standards for all sectors to reduce discriminatory workplaces
- Advancing housing equity, affordability, and access
- Ensuring that everyone has health insurance
- Expanding Medicaid coverage to include culturally meaningful care and support
- Promoting doula care models grounded in cultural practices
- Covering and providing livable wage reimbursement rates for doulas services via Medicaid and private insurance
- Expanding coverage for and access to abortion care
- Removing restrictions on abortion access
- Reducing unconscious bias among system providers
- Historical reparative policy such as Truth and Healing Commission on Indian Boarding School legislation[29]

Root Cause Drivers

Exclusionary economy. Access to money and longer-term, generational wealth is a fundamental resource that influences maternal health.[30, 31] Black and American Indian women are disproportionately represented in lower paying and more precarious occupations, which puts them at risk for poor health outcomes, including maternal health. Among full-time, year-round workers, for every dollar earned by white men, Native women earn 57 cents, and Black women earn 62 cents.[32] The average white family has roughly 10 times the amount of wealth as the average Black family and white college graduates have over seven times more wealth than Black college graduates. [33] Home ownership disparities resulting from racist policy also prevent Black and American Indian people from building and transferring wealth over time and generations. [34] The most recent Home Mortgage Disclosure Act (HMDA) data shows that 16.1% of all mortgage applications in 2020 were denied. Of those denials, Black borrowers had the highest denial rate (27.1 percent), whereas white borrowers had the lowest (13.6 percent).[35]

Underfunding of Urban Indian Health Organizations (UIOs), which provide opportunities for American Indian people to receive culturally meaningful care, are underfunded and as a result, a majority of UIOs do not provide obstetric care.[43]

Insufficient data collection. Limited data, data suppression, and being grouped with other racial groups or categorized as "other," leads to erasure of American Indian people and could threaten development of and access to responsive care and resources. Additionally, data collection on the diversity within the Black community is overlooked. This creates barriers when identifying the specific needs between US born and foreign-born Black people. It also overshadows how generational exposure to racism impacts health outcomes among US born Black people. Without more meaningful data on American Indian and Black people, effective maternal health strategies and their impacts will elude us.

Responsive Strategies

Provide income, education, housing, business, and other wealth building supports. Investments in basic resources including income supports such as direct tax credit payments[36] and guaranteed income[3738] has been shown repeatedly to improve maternal and birth outcomes for Black and other mothers of color. For example in one guaranteed income pilot, Magnolia Mother's Trust, Black women served by the pilot showed higher resilience through COVID 19 in that their ability to pay all their bills on time increased from 27% to 83%; those who had money saved for emergencies increased from 40% to 88%; and mothers reported an increase from 64% to 81% in their ability to have enough money for food.[39] Likewise, housing reparations including down payment grants, housing revitalization grants, or access to government subsidized mortgages with very low interest rates and low or no down payments has the capacity to help address wealth gaps, lower stress, and improve overall health and well-being.[40] Other reparative supports in practice[41,42] include baby bonds, college tuition, business grants, and purchasing property for descendants of enslaved Black people and American Indians.

Increase funding for UIOs. Funding of urban American Indian programs with designation for maternal and obstetric care is critical for American Indian birthing people to have access to culturally meaningful care and support. [44]

Improve data collection and analysis. Government entities must collaborate with urban Indian organizations to improve data collection as well as support tribal data sovereignty and research capacity. Government entities should also better distinguish data relating to US born versus foreign born Black people to better understand their different needs and how generational exposure to racism impacts health outcomes among US born Black people.

COMMUNITY

ROOT CAUSE DRIVERS OF DISPARITIES

Residential segregation and resulting disinvestments. There has been minimal change in residential segregation in Minneapolis since the banning of racial covenants in the 1960s.[45] Historical disinvestment in residentially segregated communities has resulted in fewer resources that positively impact maternal health and care. This includes limited or no access to grocery stores and primary clinics.[46] The Indian Health Service only distributes 1% of funding towards urban Indian organizations which inherently limits investments in American Indian communities. [47]

Lack of investments in physical environment Racially segregated communities typically have fewer trees and parks, which increases the risk of heat exposures and elevates exposure to environmental hazards. [50,51] This increases the risk and rates of preterm births, low birth weights, and still births.[52]

High police contact and neighborhood violence. Black people are more likely to live in neighborhoods with higher exposure to poverty, violence, and crime. This has led to higher police presence due to racially motivated ideologies on criminality.[53] Living in high-policed neighborhoods increases the risk of preterm births. A Minneapolis-based study found that in areas with high police contact the odds of preterm birth were higher for all populations, but highest for US-born Black individuals (100%), compared to 90% higher for white people, and 10% higher for Black individuals born outside the US. [54]

Poor abortion care access. A nationwide ban on abortion is estimated to increase maternal mortality by 21% overall and by 33% among Black birthing people.[57] Additionally, American Indian birthing people are 2.5 times more likely to experience sexual assault compared to their racial counterparts and being unable to receive needed abortion care can cause an increase in maternal mortality.[58, 59] Minnesota could become an island for abortion care in the Upper Midwest due to neighboring states restricting access to abortion.[60] Planned Parenthood North Central States, the largest abortion provider in Minnesota, is anticipating a 10-25% increase in abortion. Limited providers to support increased demand will lower access to reproductive health services for Black and American Indian people.

RESPONSIVE STRATEGIES

Invest in American Indian and Black community assets, resources, and physical environments. Living in a healthy environment with access to needed resources positively correlates with improved maternal health outcomes. For example, being surrounded by green spaces decreases the risk of low infant birth weight and small gestational age[48] and living in walkable neighborhoods and having access to grocery and retail resources decreases the risk of postpartum depression.[49]

Make investments in partnership with American Indian and Black Communities. Community investments must be guided and led by community members as they carry the wisdom and knowledge on how to effectively care for and improve outcomes in their communities.[55] To accomplish this, government and other partners must adopt a "community-engaging-community" approach in place of other engagement models; and listen to, invest in, and implement community recommendations that flow from the process.

Public safety reform. Adopt the American Public Health Association's recommendations for addressing over policing and police violence, including eliminating policies that contribute to the facilitation of police violence among special populations such as people of color; implementing law enforcement accountability measures; investing in the promotion of racial and economic equity; supporting community-based alternatives that seek to reduce harm and trauma; and working with public health professionals to document cases of police contact, violence, and injuries. [56]

Incorporate abortion care in reproductive justice and remove access barriers.

- Invest in expansion of preconception and abortion care, including efficient abortion referral systems.
- Require abortion care in all insurance coverage, remove legal restrictions to access, increase, train, and support abortion care providers, especially those most trusted by Black and American Indian people.

INSTITUTIONAL

ROOT CAUSE DRIVERS OF DISPARITIES

Healthcare bias and abuse. There is a long-standing history within the healthcare system of racism and medical abuse against Black and American Indian people which negatively influences their current care and support[61] and contributes to ongoing and growing mistrust of health institutions. [62,63] For example 22% of Black people and 15% of American Indian people avoid going to a doctor or seeking out health care services due to fear of discrimination or being treated poorly because of their race.[64,65]

Health care underrepresentation. Severe under-representation of American Indian and Black people in the care workforce,[66] paired with implicit bias and lack of cultural humility of existing care systems, exacerbates health inequities and resulting disparities among Black and American Indian people. This is deeply traumatizing and contributes to ongoing and growing mistrust of health institutions.

RESPONSIVE STRATEGIES

Workforce education and training: Educate and train current and future health and social sector professionals on culturally meaningful care, trauma-informed care, unconscious bias, and the legacy of medical racism. Specifically include:

- Current impacts of historical trauma generally and the specific history of medical mistreatment and abuse.[68]
- How unconscious bias can be triggering for birthing people and the ways healthcare teams deliver inequitable care.[69]
- Non-dominant cultural values and birthing traditions, especially those that differ from Western practices.
- Secondary trauma and compassion fatigue education, tools, and support so that providers support themselves and address how they can mirror the symptoms of post-traumatic stress disorder of those they serve and further traumatize them.[70]
- Resource and referral mechanisms for local, culturally meaningful programs and other community-based assets.

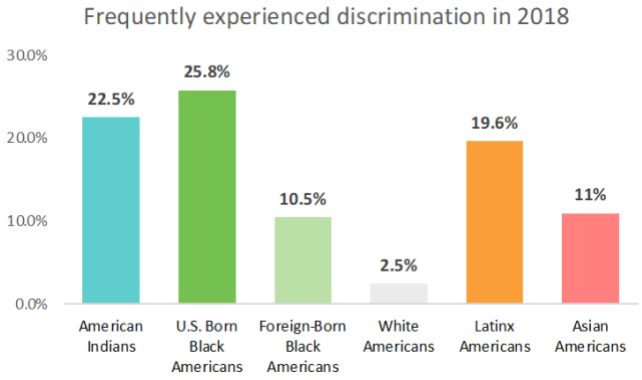
Diversify the health and social care workforce. Racial concordance improves interpersonal provider-patient relationships, increases positive patient experiences, adherence to medical recommendations, and preventative screenings.[71] People of color who enter the healthcare workforce are also more likely to serve marginalized communities. A study on midwives of color in Minneapolis found that motivations to enter this field were based on a desire to implement racial justice, offer racially concordant care, and provide physical and emotional safe care.[72]

We must adopt a Reproductive Justice Framework in maternal care. This framework incorporates eight ethical competencies into providing care and support: (1) Listening to Black and American Indian birthing people; (2) Recognizing the historical context and expertise of American Indian and Black birthing people and their families; (3) Using the reproductive justice framework while providing perinatal care—which includes the right to have a child, the right to not have a child, and the right to parent a child or children in safe and healthy environments; (4) Addressing prevalent racist beliefs in modern medicine; (5) Replacing white supremacy, patriarchy, and other systems of oppression with a new care model; (6) Educating patients on health literacy and autonomy; (7) Investing in paraprofessionals; and (8) Understanding that access to care is not equivalent to quality care.

> *We know what keeps us safe. Devastating pregnancy outcomes for American Indian and Black relatives isn't a choice we have to keep making.*
>
> **CORENIA SMITH, COLLECTIVE ACTION LAB**

Root Cause Drivers of Disparities

Culturally insensitive care. Bias and discrimination and underrepresentation results in culturally insensitive care which is deeply traumatizing and contributes to ongoing and growing mistrust of health institutions. Within Hennepin County, 22.5% of American Indian people, 25.8% of U.S born Black people, and 10.5% of foreign-born Black people reported frequent discrimination due to their race, culture, religion, or immigration status compared to 2.5% of white people in 2018.[67] Among those who reported frequent discrimination, 32% felt stress most or all the time and 40.1% experienced frequent mental distress.



Responsive Strategies

Decolonize birthing practices by funding and ensuring meaningful access to cultural models of care. Different and responsive models of care must be widely available to meet each pregnant person's needs and align with their cultural practices and traditions. These include interventions proven to enhance perinatal health among Black and American Indian birthing people and their infants such as community and hospital-based doulas, group prenatal care, kangaroo maternal care, Nurse-Family Partnership, midwifery continuity of care, and other community-informed models.[73,74,75,76,77,78]

Support community-based care models: Engaging communities in public health initiatives has a positive effect on a range of health outcomes across various conditions[79] and needs to be at the center of developing clinical models, holistic treatment plans, and other supportive services and programs. American Indian and Black community-informed models that advance birth justice include midwifery-led community care, doulas, and home visiting programs.[80] Rooted in team-based care, these evidence-based models utilize the reproductive justice framework, are person-centered, value racially concordant care, and integrate clinical and social services. They improve racial health equity by decreasing preterm births, low infant birth weight, and neonatal intensive care unit admissions. [81] For instance, many doula care organizations train doulas on trauma-informed care principles and doulas can provide culturally meaningful care by incorporating traditional birthing practices into their work.[82,83]Cumulatively, this increases the chance for respectful care, self-efficacy, and improves birth outcomes.[58,59,84]

> *I was taught by my elders that there is little more sacred and vital to Indigenous people than our women and children. Women create life, are the carriers of our future generations, and the transmitters of our lifeways and cultural knowledge. All that we are and all that we will become springs forth from our women. Our children are sacred gifts from the Creator, who breathes life into all things. There is a Cheyenne proverb that says: "A nation is not defeated until the hearts of its women are on the ground." The well-being of our women and their children is imperative to the survival of our Nations. We must, and we will, do all we can to ensure that they survive and thrive!*
>
> **Antony Stately, Ph.D. (Oneida/Ojibwe), President and Executive Officer, Native American Community Clinic**

INTERPERSONAL

ROOT CAUSE DRIVERS OF DISPARITIES

Interpersonal racism and discrimination in toxic health and social care settings. Provider discrimination and mistreatment contributes to poor health outcomes, medical mistrust, reluctance to seek health services, and is traumatizing. In one study, 33% of American Indian women and 22.5% of Black women experienced mistreatment by a health care provider.[85] Black and American Indian women were twice as likely to report that a health provider ignored them, refused their request for help, or failed to respond to requests for help in a reasonable time. Among people who reported frequent discrimination due to their race, culture, religion, or immigration status, 16.6% were not always treated with respect by their health care provider in Hennepin County.[86] Among those who reported frequent discrimination, 32% felt stress most or all the time and 40.1% experienced frequent mental distress. [87]

Intimate partner/domestic violence. Intimate partner violence is defined as any behavior within an intimate relationship that causes physical, psychological, or sexual harm to those in the relationship. [94] Physical, sexual, and psychological intimate partner violence during pregnancy is associated with low birth weight, pre-term labor/delivery, insufficient weight gain, obstetric complications, STIs/HIV, miscarriage, and unsafe abortion. It is also associated with higher levels of depression, anxiety, and stress, as well as suicide attempts, lack of attachment to the child, and lower rates of breastfeeding.[95]

Father stigma and lack of recognition of non-dominant culture parenting. Even though fathers are increasingly involved in their children's lives,[97] fathers are often stigmatized as being absent or not capable of contributing to family well-being. This is especially true for Black fathers who are less likely than white fathers to marry their child's mother, but continue to parent through cohabitation and visitation, providing caretaking, financial, and in-kind support.[98]

RESPONSIVE STRATEGIES

Cultural and trauma responsive training for health and social care workforce. A critical step towards advancing birth justice is having a robust, comprehensive system of care that is rooted in anti-racist practices, honors the cultural diversity of its clients, and works with communities to provide quality, culturally and trauma responsive care. [88, 89, 90, 91, 92, 93]

- Adopt shared language and commitment to anti-racism and incorporate a framework of equity in care delivery
- Incorporate the expertise of midwives, doulas, home visitors, lactation consultants, and other birth workers and cultural healers into core care practices, rather than viewing these professions as added-on or alternative services—these professionals have been shown to mitigate gaps in care and improve quality with culturally meaningful services
- Develop more effective ways to report experiences of discrimination while receiving care and implementing systems to address the root cause of reported issues
- Improve health screenings for mental health, substance misuse, domestic violence, and social drivers of health with appropriate referral to culturally meaningful resources

Culturally meaningful family planning, counseling, and conflict management. [96] Support training, access, and reimbursement of culturally meaningful family counseling and family planning services and reimburse community-based programs that support multi-generational family networks and engagement.

Actively support fathers and recognize non-dominant culture family structures. Address cultural approaches to family in provider trainings and invest in community-based organizations that support fathers.

Root Cause Drivers of Disparities

Intergenerational trauma. Scholars and community members alike contend that understanding historical trauma is key to addressing health inequities in descendants of historically oppressed groups. [99] Psychological and physical health problems of Black and American Indian people can be a historical trauma response associated with the intergenerational transmission of trauma experienced by their ancestors. The historical trauma response manifests in feelings of grief, anger, depression, and anxiety when thinking of historical losses and collective trauma experiences. [100]

Responsive Strategies

Culturally meaningful trauma healing. Creating new conditions that foster and advance maternal health and birth justice is necessary but not sufficient in that American Indian and Black people also need to heal from and integrate past and current trauma. Many people find such healing in traditional cultural practices. Unlike Western disease prevention approaches, which focus almost exclusively on individual factors and corresponding behavior change, traditional cultural healing focuses not only on the individual or family, but across entire communities and generations.[101]

> *Experienced women in American Indian and Black communities understand the child in utero is a gift from One greater than themselves. Aunties, Grandmothers and Sisters openly share wisdom to navigate the path of birthing, because they KNOW the force of the other influences on one who is pregnant.*
>
> **Makeda Zulu, Executive Director, UROC**

INDIVIDUAL

ROOT CAUSE DRIVERS OF DISPARITIES

Adverse childhood experiences. Adverse Childhood Experiences (ACEs) are potentially traumatic events that occur in childhood and adolescence. Research affirms that ACEs impact morbidity and mortality throughout life and increase family dysfunction by limiting child and adult capacity for self-regulation and executive function.[102] American Indian and Black people overwhelmingly face increased levels of ACEs and their related negative effects due to childhood traumas as well as likely trans-generational transmission[103] of historical trauma caused by historical and ongoing effects of racism, poverty, living in under-resourced or racially segregated neighborhoods, and experiencing housing or food insecurity.

Toxic stress/high cortisol levels. Community and interpersonal violence, poverty, inadequate housing, food insecurity, workplace discrimination, and structural racism individually and cumulatively lead to toxic stress and higher cortisol levels, which negatively impact maternal health.[104]

Substance use and cultural disconnection: Substance abuse during pregnancy is increasing in Minnesota and has been identified as a cause or contributing factor in 31.3% of the pregnancy-associated deaths.[109] Research draws a strong association between substance use and unresolved historical trauma in that substance use can be a coping mechanism for historical trauma triggering risk factors such as discrimination, traumatic life events, unresolved grief, and mourning. Thus, substance abuse disorder should be viewed and treated in the broader context of historical trauma and colonialism with emphasis on resulting cultural disconnection.[110]

RESPONSIVE STRATEGIES

Access to early childhood protective factors. Supportive and culturally meaningful institutions, families, and relationships can prevent or reduce the impact of ACEs.

- Offer ACEs and related trauma screenings or assessments at health, social service, and community settings and provide referrals to responsive and culturally meaningful resources; ensure that these screenings are being conducted by skilled personnel, and that follow up includes culturally meaningful trauma healing practices are part of the intervention.
- Train and equip healthcare and staff from other systems to support rather than undermine adult/parent capacity and to recognize non-dominant culture family and parenting models.
- Invest in culturally meaningful, trauma-informed, and multi--generation models that support adult/parent/family capacity and align and integrate system goals with individual/family goals.
- Invest in and provide resources that strengthen core life skills that adults need to thrive as parents, workers, and family and community members, including self-regulation skills.
- Listen, acknowledge, and support pregnant people and families (*including fathers*) using a strength-based perspective.
- Address substance use disorder and other co-occurring conditions in the context of healing historical trauma and providing protective factors—Including cultural connectedness, traditional spirituality, family connectedness, and supportive community environment—as these have been associated with improved outcomes for substance abuse disorder.[105, 106,107]
- Conduct population-level surveillance and research around childhood adversity and interventions[108]

Acknowledge and assure access to culturally meaningful and community-oriented trauma healing: Culturally meaningful approaches[111] include among others:

- Processing the grief of past traumas, creating new historical narratives, and connecting people and communities to the strengths of their ancestry, culture, and ceremony.
- Engaging culturally grounded healing strategies and mindfulness[112] to reconnect to self, body, mind, spirit, culture, community, and history.
- Fostering cultural knowledge, language, and identity and understanding and unwinding how historical trauma has impacted culture and survival behaviors.

> *I am both rageful and hopeful. Hopeful that our work matters and enraged that such a commonsense approach to life giving practices has been sidelined and ignored due to supremacist thinking and injustice.*
>
> **REV. DR. ALIKA GALLOWAY, CEO, LIBERTY NORTHSIDE HEALING SPACE**

CONCLUSION: MOVING FORWARD WITH COMMUNITY WISDOM AND LEADERSHIP

This report is only the beginning in that it synthesizes research findings that evidence the history, complexity, depth, and interconnectedness of root cause inequities, traumas, and impacts of colonialism that have harmed, continue to harm, and prevent maternal health and well-being of Black and American Indian people. This foundation surfaces and compels a multi-level set of responsive strategies that will require cross-sector collaboration and commitment within Hennepin County and Minnesota to advance radically better experiences and outcomes in maternal health and birth justice for American Indian and Black people and communities. The Birth Justice Strategy Collaborative will build on this foundation by engaging the leadership, wisdom, expertise, and community networks of Black and American Indian people to identify the strategies, traditional practices, and methods that they value—and have valued for centuries—but that have been repressed and dismissed by structural racism.

APPENDIX 1: CROSS-WALK: COMMUNITY COALITIONS AND RESPONSIVE STRATEGIES:

In addition to peer reviewed literature, the Birth Justice Collaborative drew from and cited recommended strategies from 36 Community Coalitions and Networks across the U.S. (described below) whose work has been evaluated in some manner.

COALITION	COALITION FOCUS	STRATEGIES IN SYNTHESIS	SOURCE DOCUMENT(S)
1. SisterSong	Defined Reproductive Justice in 1994 and is the largest national, multi-ethnic Reproductive Justice collective.	Adopt Reproductive Justice Overarching Framework --the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities	https://www.sistersong.net/reproductive-justice
2. Black Mama's Matter Alliance	A Black women-led cross-sectoral alliance that centers Black birthing people to advocate, drive research, build power, and shift culture for Black maternal health, rights, and justice.	Mandate that birthing rights and care options from pre-conception through post-partum recognize and address the history and life circumstances of oppressed groups	http://blackmamasmatter.org/wp-content/uploads/2018/04/BMMA_BlackPaper_April-2018.pdf
3. The Navajo Nation Breastfeeding Coalition	Supports infants, mothers, and families through their pregnancies, labor, postpartum and breastfeeding journeys via access to midwives/doulas, prenatal/postnatal, and lactation support.	Support Indigenous birth keepers on their midwifery and/or doula journey through childbirth preparation and skills and development workshops, as well as educate health systems and communities about Indigenous-based values and teachings	https://wkkf.issuelab.org/resource/advancing-racial-equity-in-maternal-child-health-and-addressing-disparities-through-a-reproductive-and-birth-justice-lens-full-report.html
4. The Albuquerque Area Southwest Tribal Epidemiology Center (AASTEC) project	Seeks to collect culturally appropriate metrics (data) from American Indian perinatal women and their infants in each of New Mexico's 23 Tribes and use the information to apply data-driven strategies to promote health equity, determine the impacts from the social determinants of health, and implement interventions.	Improve data collection for Black and American Indian communities	https://wkkf.issuelab.org/resource/advancing-racial-equity-in-maternal-child-health-and-addressing-disparities-through-a-reproductive-and-birth-justice-lens-full-report.html
5. The Home Visiting Referral Quality Improvement Initiative (THRIVE) **6. Northwest First Born Program (NWFBP)** **7. The Santa Fe Community College First Born Program (SFCC FBP)**	These three initiatives work to expand home visiting services in cultural communities.	Provider and system training in cultural competency and trauma-responsive care; home based community care; reclaiming traditional practices	https://wkkf.issuelab.org/resource/advancing-racial-equity-in-maternal-child-health-and-addressing-disparities-through-a-reproductive-and-birth-justice-lens-full-report.html

Coalition	Coalition Focus	Strategies in Synthesis	Source Document(s)
8. Bold Futures	Current and former birth justice workers in New Mexico advocating for new models of care.	Place-based birthing model of care and services that strengthen and support families' physical health, social supports, and quality of care	https://wkkf.issuelab.org/resource/advancing-racial-equity-in-maternal-child-health-and-addressing-disparities-through-a-reproductive-and-birth-justice-lens-full-report.html
9. TEWA Women United	An Indigenous woman–founded and led organization located in Northern New Mexico that holds safe spaces for Indigenous women to be positive forces for social change in their families and communities.	Cover doula services in all federal, state, and employer-based insurance programs; educate people and systems about doula care; pay livable wages for doulas; build support for and mentor doulas; support and pay for community-based doulas	https://wkkf.issuelab.org/resource/advancing-racial-equity-in-maternal-child-health-and-addressing-disparities-through-a-reproductive-and-birth-justice-lens-full-report.html AND *Improving Our Maternity Care Now Through Doula Support,* National Partnership for Women & Families, September 29, 2022. Retrieved October 12, 2022.
10. New Mexico Birth Equity Collaborative (NMBEC)	Led by Black women, an inter-ethnic, interdisciplinary coalition of community members, birth advocates, clinical and public health workers.	Develop strategies, policy, and system changes to create equity within health systems and leverage community knowledge, tools, and leadership to advance birth justice	https://wkkf.issuelab.org/resource/advancing-racial-equity-in-maternal-child-health-and-addressing-disparities-through-a-reproductive-and-birth-justice-lens-full-report.html
11. Changing Women Initiative	Indigenous nonprofit with a mission to revive cultural birth knowledge that empowers and reclaims Indigenous sovereignty of women's medicine through holistic approaches.	Advocate for policy change to increase access to birth support, inform and educate Indigenous women, leverage funds, and improve maternal/infant outcomes	https://wkkf.issuelab.org/resource/advancing-racial-equity-in-maternal-child-health-and-addressing-disparities-through-a-reproductive-and-birth-justice-lens-full-report.html
12. – 33. Cash as Care: Healthy Moms. Healthy Families. Healthy Communities	Examines and evaluates the physical, mental, reproductive, economic and other benefits of income supports for women from marginalized communities in **21 Community Initiatives that span the U.S.** including Magnolia Mother's Trust, Abundant Birth Project, and The Bridge Project.	Provide income supports from pre-conception to post-partum for qualifying Black and American Indian birthing people	https://www.economicsecurityproject.org/wp-content/uploads/2022/05/220427-CashAsCare2022.pdf
34. Abundant Birth Project	In a community-academic partnership, Expecting Justice is piloting the first pregnancy income supplement program in the US—the Abundant Birth Project (ABP	Pregnancy income support in a broader context that is also focusing on anti-bias skill building, doula access, and a shared policy agenda to benefit Black and Pacific Islander pregnant people	https://www.expectingjustice.org/ https://abundantbirtheval.ucsf.edu/
35. Community-Based Doula Models as a Standard of Care for Ending Racial Disparities	An analysis by the State of New York of community-based doula programs and the efficacy and potential savings of such programs.	Provide livable Medicaid reimbursement rates for doulas and invest in community-based doula programs	https://everymothercounts.org/wp-content/uploads/2019/03/Advancing-Birth-Justice-CBD-Models-as-Std-of-Care-3-25-19.pdf

COALITION	COALITION FOCUS	STRATEGIES IN SYNTHESIS	SOURCE DOCUMENT(S)
36. Community Informed Model Efficacy Analysis	In contrast to physician centered models, community-informed models, including midwifery-led community-based care, doula-supported care, and home visit nursing programs, aim to achieve collective autonomy and self-determination in care experiences, while simultaneously promoting positive clinical outcomes.	Address structural racism as root cause of inequities; decolonize healthcare systems; adopt community-informed care models; diversify workforce; address racism in medical education; and provide person-centered, culturally meaningful care	Julian, Z., Robles, D., Whetstone, S., Perritt, J., Jackson, A., Hardeman, R. & Scott, K. (2020). Community-informed models of perinatal and reproductive health services provision: A justice-centered paradigm toward equity among Black birthing communities. Seminars in Perinatology, 44(5), pg. 1-8. https://doi.org/10.1016/j.semperi.2020.151267

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