Saving Lives! Transforming Maternal Health Care in America's Materno-Toxic Zones

Jennie Joseph, Executive Director



HRSA's Maternal Mortality, June 19-21, 2018

- HRSA convened the summit to discuss evidence-based approaches and identify innovative solutions to decreasing maternal mortality and severe maternal morbidity rates
- The report summarizes key findings from the 3-day summit

Summit key findings include areas where action could contribute to decreased rates of maternal mortality and severe maternal morbidity, as listed below including:

- Access: Improve access to patient-centered, comprehensive care for women before, during, and after pregnancy, especially in rural and underserved areas;
- Safety: Improve quality of maternity services through efforts such as the utilization of safety protocols in all birthing facilities;
- Workforce: Provide continuity of care before, during, and after pregnancies by increasing the types and distribution of health care providers;
- **Life Course Model**: Provide continuous team-based support and use a life course model of care for women before, during, and after pregnancies;
- Data: Improve the quality and availability of national surveillance and survey data, research, and common terminology and definitions;
- Review Committees: Improve quality and consistency of maternal mortality review committees through collaborations and technical assistance with U.S. states; and
- Partnerships: Engage in opportunities for productive collaborations with multiple summit participants.



London – circa 1981



Orlando, Florida 2019

The New York Times

Making Pregnancy Safer for Women of Color

By Miriam Zoila Pérez



The New York Times 2018. Jennie Joseph with a patient at The Birth Place, Florida birth center.



Our Babies are Dying!

Twice as many African American babies being born:

Too SOON Too SMALL Too SICK

to survive the first year of life



Women are Dying Too!

Two to three women die every day during pregnancy, birth or their postpartum in the USA.

There is an alarming increase in severe pregnancy-related complications that nearly cause death, known as 'near miss' incidents.

50,000+ per year

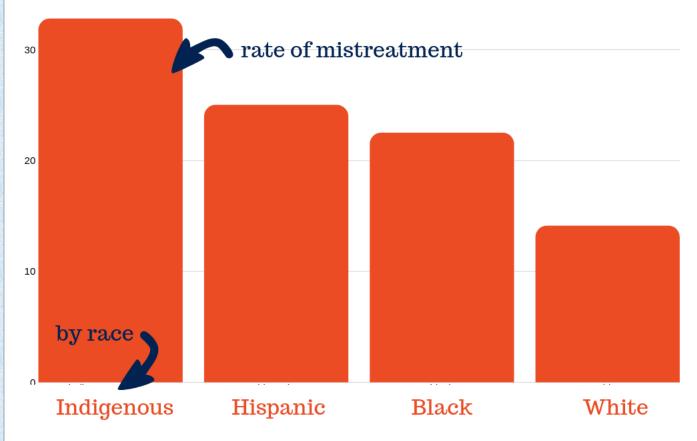


Three to four times as many African American women are dying as White women

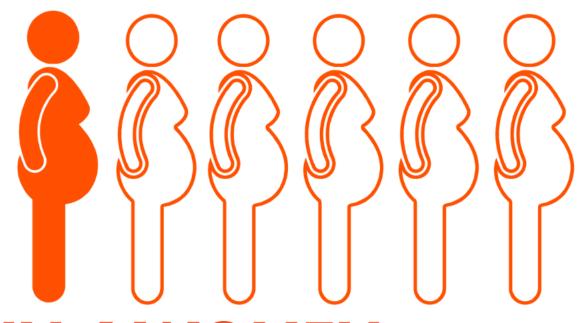
Ah, but it's those social determinants of health.....those Materno-toxic neighborhoods (JJ)



PEOPLE OF COLOR EXPERIENCE MORE MISTREATMENT IN BIRTH







1 IN 6 WOMEN EXPERIENCE MISTREATMENT

DURING CHILDBIRTH MOST COMMON:

- Being shouted at or scolded by a health care provider
- Health care providers ignoring women, refusing their request for help, or failing to respond to requests for help in a reasonable amount of time

Vedam, S., Stoll, K., Taiwo, T. K., Rubashkin, N., Cheyney, M., Strauss, N., . . . & the GVtM-US Steering Council. (2019).

"The Giving Voice to Mothers study: Inequity and mistreatment during pregnancy and childbirth in the United States". *Reproductive Health,* June 11, 1-18. DOI: 10.1186/s12978-019-0729-2



TOP 4 TYPES

OF MISTREATMENT DURING CHILDBIRTH BY HEALTH CARE PROVIDERS

Being shouted at or scolding

Ignoring women, refusing their request for help, or failing to respond to requests for help in a reasonable amount of time

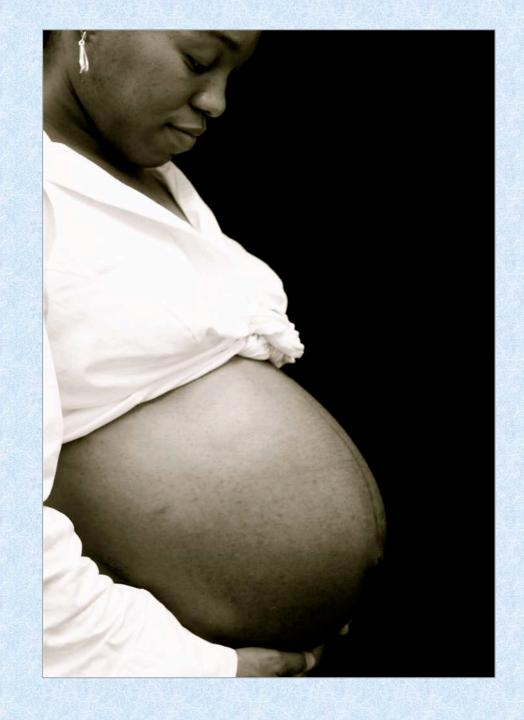
Violation of physical privacy

Threatening to withhold treatment or forcing them to accept treatment they did not want

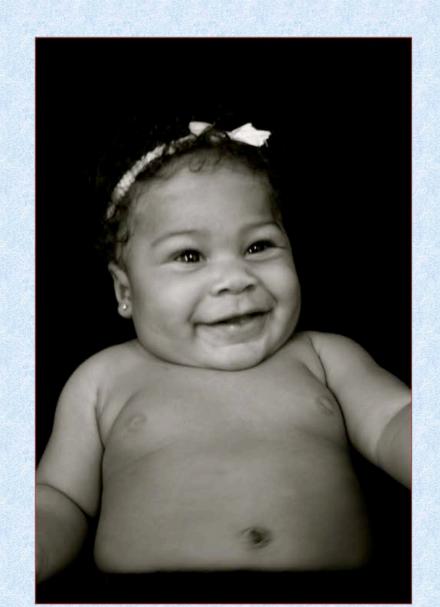


The JJ Way® A Maternal Child Healthcare System

Could it be possible that creating a culture and environment that supports all pregnant people could make the difference between health, gestational age, birth weight and breastfeeding rates in women at risk for poor maternal health outcomes in the USA?



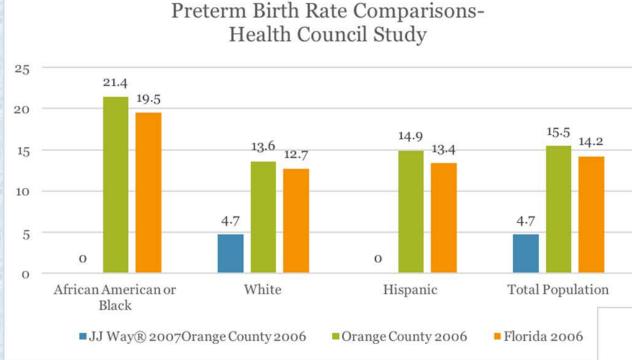
The JJ Way® Fundamental Premise



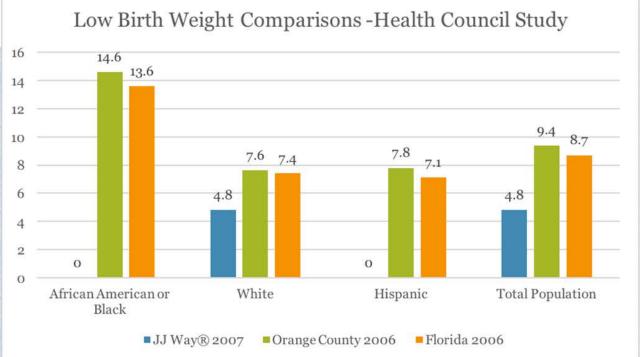
Every woman wants a healthy baby and every woman deserves one







Preterm Birth and Low Birth Weight by Race 2006 - 2007



Elimination of the Racial Disparity

NO low birth weight or premature infants born to African American or Hispanic women in the 2007 Study

- 100 'Easy Access Clinic' women enrolled
- 95% of babies weighed an average 7lbs 7ozs
- 95% of women delivered at 39 weeks

The JJ Way® Works!







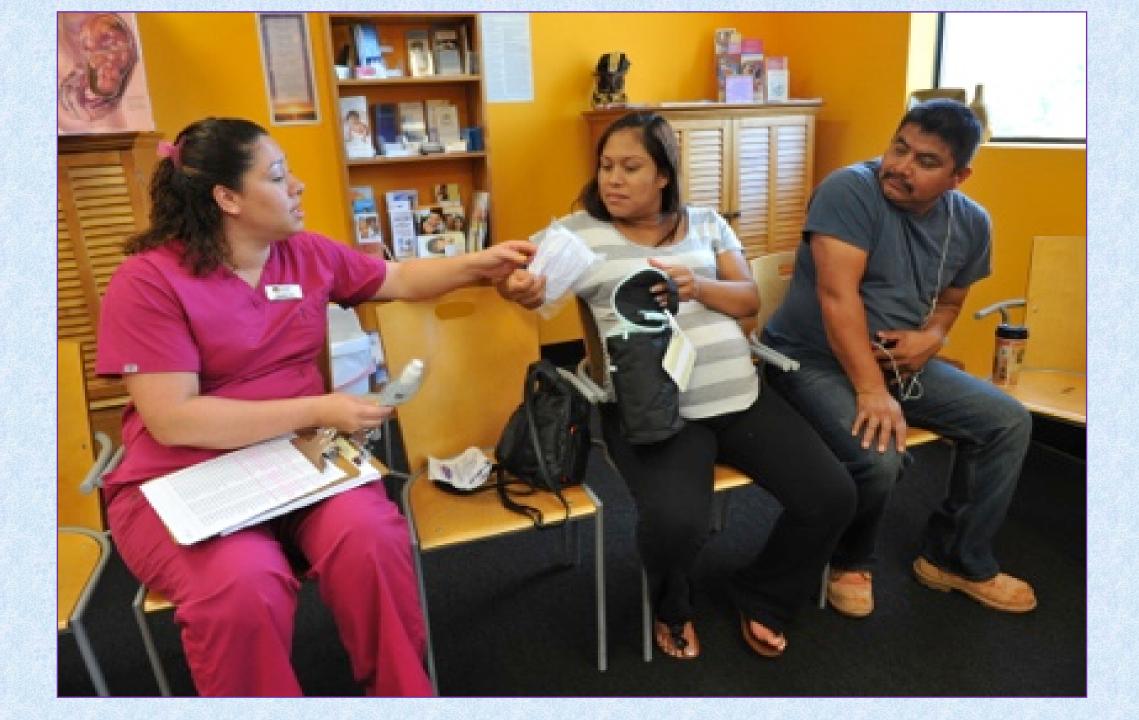












Cornerstones of SAFE Perinatal Care - The JJ Way®

- 1. Access
- 2. Connections
- 3. Knowledge
- 4. Empowerment



The JJ Way®: Reducing Perinatal Outcome Disparities

A Retrospective Matched Comparison Group Study on Birth Outcomes in At-Risk Populations Sarah J. Day, MSM, Wendy Gordon, LM, CPM, MPH, Tyan Parker Dominguez, Ph.D., MPH, MSW

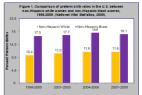
Mark Martzen, Ph.D., CIP, Jennie Joseph, LM, CPM



Introduction

Preterm birth (PTB), defined as birth prior to 37 weeks gestation, is the world's leading cause of infant mortality (\$ owards, 1999).

The United States ranks 13 lstout of 184 countries in preterm birth (March of Dimes, 2011), placing it behind Canada, the UK, and France, as well as Afghanistan, Mali, and the Democratic Republic of the Congo.



Extreme racial disparities exist in birth outcomes in the U African American women have higher rates of PTB and LBW infants than any other racial group in the U.S.

"The JJ Way®" is a model of prenatal care designed by midwife Jennie Joseph to reduce health disparities and advene birth outcomes, such as preterm births and low birth weight infants.

Specific Aims

- To analyze and compare the birth outcomes of patients who participated in The JJ Way® with a matched comparison group of women with the same zip codes, age, and sace, who received standard prenatal care.
- The birth outcomes that were measured were gestational age at birth and birth weight of the infant.
- The researcher hypothesized that The JJ Way® is a more
 effective model of care than traditional prenatal services
 for reducing adverse birth outcomes in at-risk
 populations such as African American women and lowincome women.

Methods

The design was a retrospective matched comparison group study. Institutional Review Board approval at Bastyr University was granted in October of 2012. Data from The JJ Way® initial evaluation was applied for and received.

A historical comparison group was created from the Florita's Vital Statistics live birth records for the same time period (2006-2007). The records with unknown prenatal care status were removed from the analysis in order to attenuate potential bias in comparing some prenatal care with no prenatal care. With the remaining records, a matched comparison group of 67 cases was created by randomly selecting records that matched The JJ Way® subjects on age, race lethicity and zip p code.

A first round analysis was done by coding subjects in each cohort as either "White," which included women who self-identified as White and non-Hispanic, or as "Women of Color," which included women who self-identified as African American, Haitian, and/or Hispanic.

A secondary analysis was performed comparing only the outcomes of non-Hispanic White women with non-Hispanic Affician American women. The sample size for this secondary analysis was small (n=104, 52 matched cases) and did not produce statistically meaningful results, but its discussed in the paper.

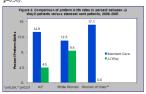
The two primary outcomes examined and compared across the two groups were gestational age at birth and birth weight. Both outcomes were analyzed as continuous variables (in weeks and in grams, respectively) and as categorical variables [pretem gestation (<37 weeks) versus full term; and low birth weight (<2500 grams) versus normal birth weight). Differences in continuously measured gestational age and birth weights were tested for significance with T-tests. Differences in categories of preterm and low birth weight infants were examined using Fisher's exact two-sided tests. All tests of statistical significance were calculated using SPSS.

Outcomes were compared by prenatal care group using the entire sample. Potential racial dispanties in the outcome variables within each group were also examined [non-thispanic White versus Women of Color (in the primary analysis)].

Results



As a whole, The JJ Way® prental care group showed a trend toward higher gestational gas at birth that did not quitereach statistical significance (38) 9 weeks versus 37.9 weeks, pp. 007) and a non-statistically significant higher birth weight (3359-4) gramm versus 326.5 gramm, pr-04.1) than the standard care group. When comparing by race, there were no statistically significant differences between White women in the two groups in gestational gas or birth weight. However, for Women of Codor in the Jow groups there was a statistically significant differences in mean gestational gas 4 as group, Wenner of Codor in The JW Women of Codor and higher average birth weight than the standard care group, but the difference was not statistically significant (334.8 j. grams in The JJ Way® group versus 312.9 grams in the standard care group, po-0.30.



The outcome measures were also analyzed as dichotomous variables instanted of continuous, i.e., preterm (C37 weeks) versus full term, and low birth weight (C300g) versus normal birth weight. The overall preterm birth rates were 4.5% and 14.9% for patients of The JI Way® and the standard care group, respectively (pr. 0.4). The overall rates of the wine with reals were 4.9%. When comparing by race, the difference in peterm birth rates for the Women of Color baven groups van prominent. The JI Way® group had no preterm births (9%) among Women of Color where a tendard care group had a preterm birth are of 17.1% (pr. 0.01). See Figure 3.

Conclusions

The findings of fhis study, which matched women from The JJ Way® with those of the same age, race, and zip code from the Florida Vital Statistics data base, revealed statistically significant longer gestational periods and lower preterm birth rates for Women of Color who were cared for within The JJ Way® model.

Given the decades of unsuccessful progress on reducing rates of preterm birth, low birth weight, and infant mortality in the U.S., The JJ Wayb model's success is noteworthy. It should be supported, funded, and larger studies should be conducted.

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Complete reference list available in thesis pape

JJ Way® Solutions

Community-based, community-owned and community-led perinatal providers and practices using doulas, lactation educators, community health workers, medical assistants, nurses and midwives are:

- •PROTECTIVE in all materno-toxic zones and situations
- Able and willing to create and navigate a 'team' approach to maternity care
- Providing quality, culturally-congruent, perinatal care where women 'are' – physically, mentally, emotionally and even financially
- •Able to train and support other willing providers and agencies in interdisciplinary and collaborative practice

What do we need?

- ACCESS to what? Safe, quality maternity care for ALL women
- ACCESS to who? Appropriate level providers, with cultural humility and willingness to acknowledge the true dangers for women
- ACCESS to where? All sites, all levels of care home birth, clinic, birth center, hospital

Who else has ACCESS issues?

Providers need

- ACCESS to understanding the inbuilt historical and structural harms of disconnected, broken and unwieldly medical systems;
- ACCESS to cultural humility training, and training to reach in, and work collaboratively, with underserved communities and providers

Students need

 ACCESS to scholarships, grants, loans for training, and establishing sustainable community-based perinatal practices

The National Perinatal Task Force

THE NATIONAL PERINATAL TASK FORCE

Building a Movement to Birth a More Just and Loving World



Building a Movement to Birth a More Just and Loving World –

www.perinataltaskforce.com

- Organizing for Maternal Justice
- National network of Perinatal Safe Spots
- Best practice, evidence-based models for reducing disparities
- Council of Midwifery Elders





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