Overview of Connecticut’s Reproductive Justice Alliance

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(She, Her, Hers)
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Connecticut Department of Public Health
Connecticut Birthing Hospitals, Birth Center, and Rate of OB Licenses per 1,000 Live Births

Source: CT DPH Practitioner Licensing and Investigations Section; active licenses as of May 2022.
Maternal Health in Connecticut

Distribution of Births and Proportion of Births on Medicaid at Birth by Race + Ethnicity, 2021

Source: 2021 Birth Provisional Data
There are racial and ethnic disparities in severe maternal morbidity in CT. SMM is more likely to occur among Black non-Hispanic, Asian non-Hispanic, and Hispanic mothers compared to White non-Hispanic mothers.
The Issue

An important contributor is racism and discrimination experienced while accessing maternal health services.

8.9% of CT mothers reported being treated unfairly in getting health-related services during pregnancy based on one or more factor, such as their race, ethnicity, or culture; age; language spoken; citizenship; insurance or Medicaid status; or some other reason.

Source: PRAMS 2018-2020
NYC DOHMH Strategies to Address Inequity in Maternal Outcomes

- Maternal Mortality and Morbidity Review Committee (M3RC)
- The Severe Maternal Morbidity (SMM) Project (Merck for Mothers)
- NYC Standards for Respectful Care at Birth
- Birth Justice Defenders
- Maternity Hospital Quality Improvement Network (MHQIN)
- PRAMS Birth Justice Supplement

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Reproductive Justice Alliance (Alliance)

- Individuals with lived experiences
- Community-based organizations (CBOs)
- CT State Agencies
- CT statewide organizations

The Alliance
Reproductive Justice Alliance (Alliance)

Leadership Team
- Provides leadership and oversight
- Meets Weekly

Core Team
- Provides guidance and expertise
- Meets Quarterly

Workgroups
- Individuals from Core Team
- Provides support
- Meets as Needed
The Approach
Objectives are to increase:

Access to respectful, quality maternity care;

Respectful interactions between patients, providers and staff;

Quality of health care systems, resources, and policies related to maternal health; and

Accountability of health care systems by centering patients’ voices.
The diagram represents a logic model for the Reproductive Justice Alliance. The model outlines inputs, activities, outputs, outcomes, and impact. Key points include:

**Inputs**
- Staffing
- Funding, including community grants
- Reproductive Justice Alliance
- Data and reports to inform work, including:
  - Pregnancy Risk Assessment Monitoring System (PRAMS) Data to Action
  - Results Based Accountability (RBA) to identify priorities
  - CT Maternal Mortality Review Committee Report

**Activities**
- Qualitative Research
  - Focus group discussions
  - In-depth interviews
- Mixed Methods Research
  - Severe maternal morbidity analysis
  - Policy analysis
  - Geographic mapping and analysis of maternity care
  - Resource mapping
- Community Engagement
  - Ensure participation of community-based organizations, pregnant people of color, and tribal nation among others
  - Identify partners at hospital, policy, and legislative levels

**Outputs**
- Data reports on state of maternal health in CT - with a strategic plan
- Infographics
- Presentations
- Know Your Rights Campaign for birthing people
- Assessment of needed structural and policy changes or improvements (e.g., provider trainings)
- Establishment of community sub-committee OR community advisory boards
- List of hospital, legislative and policy partners/champions

**Outcomes**
- Improved data sharing and transparency with communities
- Pregnant and birthing people are informed and empowered on their rights to maternity care
- Programmatic initiatives and next steps are informed by community needs and experiences
- Increased educational opportunities with staff and providers around respectful maternity care
- Increased community engagement and participation
- Hospital, legislative and policy partners are engaged on issues around respectful care

**Impact**
- Pregnant and birthing people of color have improved access to quality maternity care
- Improved structural systems, resources and policies related to maternal health (TBD)
- Increased accountability of health care providers and systems to patients
- Providers are well trained to provide pregnant and birthing people of color with respectful maternity care
- Affected communities have equal power and shared decision making in the research

*Additional activities may be added*  
*Results of qualitative research will help determine next steps and products*
Why Focus Group Discussions (FGDs)?

• To get an understanding of the thoughts and experiences of respectful maternity care in CT and access to care.
• To generate ideas of how to improve respectful care in CT from those who experienced disrespectful care, including racism and discrimination.
• To promote community engagement in strategizing ways to improve respectful care.
FGDs Research Questions

a) How do Black and/or Hispanic or Latina birthing people in CT experience disrespectful maternity care?

b) What are some strategies to improve respectful maternity care in CT, given the shared experiences and recommendations?

c) What are some barriers and facilitators to maternity care services for Black and/or Hispanic or Latina birthing people?
<table>
<thead>
<tr>
<th>Topic</th>
<th>Additional Themes</th>
<th>Logic Model Outcome</th>
<th>Original Question Proposed by RJA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceptions of health facilities and services – General</td>
<td></td>
<td>Pregnant people are informed and empowered on their rights to maternity care</td>
<td>1. What makes you think a health facility (any location where healthcare is provided) has good quality services? What makes you think a health facility has bad quality services? OR 1. What is most important to you when choosing a healthcare facility?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Providers are well trained to provide respectful maternity care</td>
<td>2. Do attitudes and behaviors differ between providers? (If yes, PROBE: Why do you think so?)</td>
</tr>
</tbody>
</table>
Methodology: Discussion Guide Development

**Prenatal Care (20 minutes)**
First, we would like to understand your prenatal care experiences during pregnancy. Thinking back to your most recent pregnancy:

2. How did you choose where to go for prenatal care services?
   ⇒  **NOTE:** This response can be for both clinical or non-clinical prenatal care services.
   
   [**PROBE:** What factors influenced your decision? Whose opinions did you consider?]
   ⇒  Understanding what factors influenced where and how they chose prenatal care

3. What did you like about the prenatal care you received?
   [**PROBE:** Who or what made a difference? What did the facility do well?]
   ⇒  Identifying positive experiences during prenatal care both at provider and facility level
Planned to recruit from 6 (out of 8) counties for a total of 12 FGDs (one for each English and Spanish language)

Changes to number of FGDs:
• Greater Waterbury funding
• Windham & New London were combined due to low recruitment
Process

**IRB Approval**
- DPH Human Investigations Committee
- Multiple protocol submissions across the development process

**Recruitment**
- Eligibility: Identify as Black and/or Hispanic/Latino(a), delivered in CT in past year, 18+ years of age
- Worked with community-based partners in specified counties to advertise/recruit

**Registration**
- DPH staff were points of contact for interested individuals
- Informed Consent
- Brief demographic survey
Number of individuals participating in FGDs, by targeted geographic region of residence and spoken language.

<table>
<thead>
<tr>
<th>Region</th>
<th>English</th>
<th>Spanish</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>30</td>
<td>26</td>
</tr>
<tr>
<td>Waterbury</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>New Haven</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Hartford</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Farfield</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>New London &amp; Windham</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Litchfield</td>
<td>5</td>
<td>4</td>
</tr>
</tbody>
</table>
Tolland and Middlesex were excluded from recruitment.
Majority of participants had a baby that is 7-12 months of age and about 47% preferred Spanish language.
Majority of participants were in their 30s, Hispanic or Latina, and had a high school diploma or GED or completed some college or trade school.
Among the participants, 91.1% had Medicaid for insurance during pregnancy and childbirth, and 74.6% during postpartum. More participants reported no insurance during postpartum.
How will the Alliance use this information?

• Data reports on state of maternal health in CT – with a strategic plan in improving respectful maternity care.
• Infographics
• Presentations
• Know Your Rights Campaign for birthing people
• Assessment of needed structural and policy changes or improvements (e.g., provider trainings)
  • Including developing a method for accountability for when staff is mistreating patients.
• Support community, county and state activities around respectful maternity care.
Successes

• Participants were excited to participate in the FGDs and future follow-up.

• FGDs have provided CT with valuable information on how to improve respectful maternity care.

• Through HRSA Technical Assistance funds, we were able to gain qualitative skills from a subject matter expert in respectful care.

• Brought a focus of racism and discrimination and respectful care in Title V work.

• Had multiple funding sources to support this work—Health Resources and Services Administration (HRSA) Technical Assistance; HRSA State Systems Development Initiative (SSDI); HRSA Title V Maternal and Child Health Services Block Grant; March of Dimes Connecticut Chapter; Connecticut Health Foundation; and Northwest Connecticut Community Foundation.
Challenges

• There have been several time delays due to the contractual process and resubmissions to human investigations committee.

• State level analysis—community organizations are interested in data in their specific area, but this is a state level analysis.

• Recruitment through community-based organizations had challenges.
  • Staff turnover
  • Staff time to recruit
  • Interested clients/patients who did not meet eligibility criteria
What can state health departments do?

• Find a champion at your health department
• Find who is doing this work in your state and create effective partnerships
• Reach out to other states
• Find funding opportunities
• Hire outside consultants who are experts in subject matter
THANK YOU

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The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.