A ‘village of support’:
Changing the game for Black expectant parents

“And I was also crashing and in fact, I remember saying, I feel like I'm going to die. I feel like I'm going to die, and I wasn't immediately attended to.” - *Dr. Melissa Franklin*

911. What's your emergency?

America's healthcare system is broken and people are dying.

Welcome to **Code WACK!,** where we shine a light on America's callous healthcare system, how it hurts us and what we can do about it. I'm your host **Brenda Gazzar**.

(music)

This time on **Code WACK!** How can we as a society better support Black expectant parents and their babies in light of how vulnerable they are to dying in America? And what root causes must be addressed to do this most effectively? To find out, we spoke to **Melissa Franklin**, the first Black director of Maternal Child and Adolescent Health for **L.A. County’s Department of Public Health**. Dr. Franklin is a systems transformation leader with over 25 years of experience in organizational development, community engagement and communications strategy. This is the second in a two-part series.

Welcome back to Code WACK! Dr. Franklin.

Franklin: Thank you. Happy to be here.

Q: What are the major trends regarding Black infant maternal mortality today in L.A. County and what are the main drivers of these trends?

Franklin: In terms of our disparity data the rates remain at around a little over two times in terms of infant mortality than any other race, and four times than any other race for maternal mortality. I don't know if you're aware of the CDC report that came out that indicated that infant mortality has increased across the US for the first time in quite some time. That is concerning. In L.A. County, our rates have been pretty stable, but the disparity remains, and that's why we focus on the difference. Root causes of it? We're just starting to look at the data since the beginning of this movement, and I can provide you a data deck with all of our latest numbers. It breaks it down by service planning area. We look at smoking versus non-smoking, education(al) attainment because those are proxies for things we typically think are impacting, and it still demonstrates that it's the uniquely harmed experience of black folks in our country that's a root cause and we endeavor to address it from racism as a root cause.

In terms of other trends, I would have to say the response itself. So doulas being really core to our response. Midwives being really core to our response. Engagement of fathers from a lens of supporting dads and partners in their support of their pregnant partner with the lens of preventing infant maternal mortality and being advocates. So really it is about igniting and activating the village of support around a Black person in terms of addressing the disparity, and I would have to add budding is the various guaranteed income pilots in our county. We will be launching a guaranteed income pilot that's focused on pregnant individuals. You know, there is quite a bit of research that suggests that the reduction in stress, that access to no strings attached income supplement has a positive impact on birth outcomes and so that'll be launching hopefully in 2024.

Is it one intervention? Oh, no, ain't no way one intervention's going to resolve something that has been so persistent and that is truly system wide, but a host of interventions or responses can, and I would add advocacy. Activation of the people in communities has been huge to this work. We have four community action teams covering five service planning areas, and there are folks that are looking at on the ground, community specific responses, but also keeping the momentum around this work upfront. And I would have to say there were key during the closures due to the (COVID-19) pandemic of keeping an eye on Black birth outcomes and not losing sight of that, or not kind of pulling back because we had this really other very important pressing issue. Actually, we saw it as intersecting, right? And so that was just so, so much a testimony of the work of our communities on the ground.

Q: That's great. So the pilot program for guaranteed income, is that for Black people who are expecting or what populations?

Franklin: For multiple groups that are at risk of adverse birth outcomes, prior preterm birth, heart conditions, history of preeclampsia with a prior birth or high blood pressure.... So it's multiple at-risk and our intents are to look at 'does it have a positive impact on birth outcomes overall?'

Q: You've mentioned some things L.A. County's doing to help prevent deaths of black people who are expecting or delivering babies. What else can be done to prevent these deaths from a systems perspective?

Franklin: From a systems perspective, there are a couple things that I believe that we can do. One that we've begun working on is our Chair's Futures Hospital Engagement Initiative matched hospital leaders with community leaders around just getting to know the disparity as an issue of concern, as getting to know our communities from a perspective of a Black birthing person, and then take on certain efforts together to increase either their understanding or their learning or steps to improve care within their health centers.

Implicit bias training is really like a first step, I would say for many hospitals and hospital systems. You know, SB 464 really has put that forward as an imperative and really taking that first step is tremendously valuable, right? To help folks shift how they approach care for Black individuals and other individuals from a frame of what's possible from them and setting aside any held notions or stereotypes and providing culturally affirming care, I believe is absolutely vital.

Fostering a welcomingness of birth support in particular doulas, right? The doulas do not replace an OB, do not replace a midwife but they do focus on the birthing person, the pregnant person, and ensuring that they have an advocate and someone that centers them in their birth experience. You know, today, hospitals can continue to foster policies that are welcoming of doulas and of community midwives. That's definitely an actionable step and then locking arms, I'll say it with our community action teams. You know, if you're a hospital in a service planning area where there are folks coming together for joyous and healthy births, you know, I offer that you collaborate with them – who best to identify how best to move forward together and address birth inequity than those most impacted by it and who are activated to see a change.

Q: What can Black expectant people do personally since they're so vulnerable to dying while giving birth?

Franklin: Whenever I get that question, I think about what I wish I would've known as a Black pregnant woman and really it is activating your village, of getting your village on deck. So often we're fed this story that, oh, we decided to get pregnant, and it's on us, like for us to make it happen and carry the load and be strong and don't cry. You can do it. You know, that sort of thing. And that is such a fallacy, you know, this can be so stressful and you know having a village of support is such a game changer for having access to the birth that you desire, starting with a birth plan, which really is all about what are your hopes and dreams for your birth experience, that's so key.

And then moving into activating your village of getting folks around you in your space who are going to be advocates, who are going to show up for you when you need it, who are going to encourage you, who are going to bring you meals, be a source of respite or go to your appointments with you. Whenever I come across a Black pregnant person, I ask them a question, do you have a doula? So starting there is so foundational. I know somebody who had a doula, a midwife, a lactation coach, a black OB, a home water birth, and it was beautiful, right? ... All the supports that MCH provides, Black infant health or doulas and other programs like home visitation, they're all free. They're at no cost. And they're delivered in a culturally affirmative manner with joy and wellbeing at the heart of it.

Q: Beautiful. Can you remind us of the difference between a doula and a midwife?

Franklin: I have a great colleague here on our team Ashley Skiffer-Thompson, who says it perfectly. You know, midwives are for the waist down, doulas are for the waist up. You know, doulas do not deliver babies. Like I said, they do not replace an OB or midwife. They really are about the mental health and wellbeing and the experience of the person of the pregnant person. They can be an advocate, they can be a translator, meaning translating doctor speak to a pregnant person. They also support families through their birth day journey, whether it's a home birth or a hospital birth, or a birth center birth. And so that's the primary difference. All great supports. Like, like I said, if it was me, it would be, I'd have all the things, any support that we could have, I would've had it. And then I would've added ongoing mental health support as well, even though these are sources of that. You know, any ways to mitigate stress and to support my family and supporting me in that regard and support my job and supporting me in that regard are all game changers in terms of having the birth that we dream of.

Q: So you're a Black woman who nearly died while delivering your second child. Do you think having a doula for example or having the opportunity to have a doula and a midwife could have altered that experience for you?

Franklin: I think what would have changed is my being heard that I was crashing, that I felt like I was going to die. That would've been attended to a little faster than it was. You know, when you know have a baby, a lot of focus is on the baby, which is good, and, you know, as it should be. And then when you have a baby who is in peril when they're born, a lot of focus is on the baby and saving their life, which it was for me, right? I heard a faint cry, and then I heard all the work to save her life, right? That's what I could hear. And I was also crashing <laugh> and I remember saying, I feel like I'm going to die. I feel like I'm going to die. And I wasn't immediately attended to so I think that part would've changed. Would it have changed whether or not my babies came early or whether I would've experienced something that was life threatening? I'm not sure. I really do believe that my lifetime of experiences is what contributed to that.

I'm so glad you asked that question because that is often lost on this conversation, is that it's not just the interaction in the healthcare setting or just the not being heard by a provider, right? And that we don't want to place the entire burden of positive birth outcomes on the shoulders of the wonderful midwives and doulas that are doing this work, this heart-centered work, because that's not exactly what the root cause is. You know, our Black folks' history of trauma through slavery and generational oppression and also structural racism in our society today and our interactions in society, how we're treated – often in other settings – is a huge factor.

You know, it's that one thing that comes up when we look at, okay, she has an MBA, all right? She has a job, okay. Did the prenatal care, okay, have a great OB, all right? Still a challenging birth outcome, and that that still, that thing that's left is the weathering effect of chronic exposure to the trauma and the harm of racism and systemic oppression. So I could show up in an ER and myself and my colleague who's not black, could have the flu. It's like we're both showing up with the flu, but I have a knife in my back and you only treat us for the flu. I'm showing up with a greater vulnerability that is causing me to be at risk of losing my life or losing my baby, or having a birth outcome that I did not want. Right? And that's, we have to look at it from the whole approach, right?

And I acknowledge that that also means that there's work that's outside of (L.A. County's Maternal Child and Adolescent Health department) too that needs to be done of creating a better community context, of addressing economic oppression and of creating more fair policies and a more fair and just society. I know it sounds like really aspirational, but it really is what we have to do if we want to see L.A. County become a place where we're known for beautiful births and abundance

and health and joy and wellbeing. We'll need to address the context too, in addition to our interventions or our supports.

Q: Okay. So what are your thoughts on a major health policy change to universal health care? Something like Medicare, but for everybody? Could it help Black people and their babies have a better survival rate?

Franklin: Well, I'm not able to respond to Medicare policy or Medi-Cal policy as we talk about it in L.A. County. But what I can share is having access to culturally affirming high quality care is a game changer and that means addressing all the things that serve as barriers to that care, that's our economic realities, the affordability of that care, where that care is located geographically in a county, so huge as L.A. And then other things that are considered to be baseline quality and those things that are emergent or that we're now becoming to know or understand should be a part of quality, culturally affirming diverse staff. Operating cultural humility, human dignity at the center, and I have to say it, joy and abundance being the outcome. And not merely birth <laugh>, right? And not really birth being the outcome, right? Birth and survival being the outcome, ensuring that those things are in place. And then finally, you know, respecting the voice of the people, you know, what the people are identifying as important to them, to us needs to be at the center of how we approach accessibility to high quality maternal and infant care.

Thank you, Melissa Franklin.

Do you have a personal story you'd like to share about our 'wack' healthcare system? Contact us through our website at heal-ca.org.

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