An Exploration of the Potential for Culturally Specific Maternity Homes in Minnesota

African American Infant Mortality Project
Community Co-Learning Cohort IV Final Project Report[1]

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Background: Mini Project Selection

Throughout our time participating in the cohort, we listened to a variety of speakers and watched presentations by service providers throughout the state of Minnesota in the non-profit and government sectors. They spoke about their agency's role in maternal and child health and wellness, including best practices, gaps in services, and solutions. We also learned from the lifework of members of the project's community leadership team (Community Voices and Solutions) such as Beverly Propes and Hazel Tanner, retired public health nurses who played prominent roles in community-based initiatives around maternal and child health in Minneapolis. Their work affirmed our belief in the value of prevention, and helped us understand what has and has not worked in the African American community.[2]

As we began to learn more about the scope of maternal and child health programming in Minnesota, we saw a clear connection between housing stability and healthy pregnancy. We felt that housing was at the core of stability and was the biggest crisis that pregnant mothers face.

We decided to create the mini project focused on opening a culturally specific maternity home. This non-profit maternity home would serve as a resource and service space with doulas, midwives, CHWs, doctors, nurses, and advocates in a holistic setting for African American mothers. Clients would be eligible for admission at any stage of pregnancy and could stay at least until 6-8 weeks postpartum. This home would be a shelter and resource center for expecting mothers and fathers who would receive infant and life skills education in group settings.

Mini Project Activities

Taking all the information that we gained from our cohort presenters, we began our research on maternity homes in the state of Minnesota. Additionally, we hosted a community listening

[1] Cohort IV members are Kalice Allen, Jacqueline Coleman, Jessica Coleman, Shantinee Dillard, Chandra L. Jones, Rebecca Nathan, Sophia Thompson, and Rochelle Vincent.

[2] The work of Ms. Tanner and Ms. Propes laid the foundation for much of the infant mortality prevention efforts in Minneapolis. We cite a few examples here. Ms. Tanner coordinated MinCHIP (community-based program that provided home support services and peer parenting/support groups to minority teens who are pregnant or are already parents), Neighborhood Health Professionals group (minority women trained as paraprofessionals who provided home support services), and Parent Group Facilitators (minority mothers who provided group services). She was also involved in the Way to Grow home visitor program. Ms. Propes served on the Minnesota Department of Health's Maternal and Child Health Advisory Task Force and worked at the Children's Defense Fund. She also designed a Sick Child care program for Minneapolis Children's Hospital and an Infant Toddler Care Center for Nursing Staff, helped develop the nationally recognized Success by Six Initiative at United Way Minneapolis, and served as Executive Director of Community University Education Services at the University of Minnesota.

session to learn about the specific needs of the community in order to address maternal and child health disparities.

Through our research, we found out there were five maternity homes in the state of Minnesota. We reached out to three and toured two of them, Amazing Grace in Crystal, and Esther Homes in Saint Paul. None of them are culturally specific, although most are faith-based.

- Amazing Grace Maternity Homes - Crystal, MN
- Esther Homes - Saint Paul, MN
- Start of the North - Duluth, MN
- The Nest - Buffalo, MN
- The Philomena House - Saint Paul, MN

Both maternity homes that we visited were supported 100% by private funding. As such, their administration and programming are not subject to government regulations like other residential homes; however, they still have to meet the state's health and safety standards. The maternity homes are members of the National Maternity Housing Coalition (NMHC), "a group of life-affirming housing efforts throughout the United States committed to promoting positive housing practices and transformational ministry." NMHC provides training, education, and networking for housing providers that focus on providing services to pregnant women in need. This national organization is faith-based and provides models for maternity home care for maternity homes across the country.

We held the community listening session on September 7, 2019 from 10:00 am to12:00 pm at the Webber Library in Minneapolis. The cohort developed the goals and questions for the discussion. The goals were:

1. To gain a better understanding of barriers and challenges that African American women experience in childbirth
2. To build awareness of community needs and assets impacting the health of women and infants
3. To identify what systems changes are needed to create equitable birth outcomes

Cohort members passed out flyers in the community to recruit participants (Attachment 1). There were six women, each of whom received a gift card in appreciation for their participation. Light refreshments were provided. Kalice Allen facilitated the listening session.

The participants had a very rich discussion. The themes that stood out strongly support the building of more maternity homes in Minnesota, and especially in Hennepin County where African American families are three times more likely to lose an infant compared to white families. We heard from participants that:

- Nutrition education is critical in pregnancy. However, providers in regular hospitals and clinics do not have a lot of time to provide nutrition education to their patients.
- Women need more social support during pregnancy in order to cope with stress and difficult life circumstances. They need health care providers who will listen to them and understand them because black women do not always feel heard.

- Men are often left out, but they are also invested in the childbirth process and deserve more credit. They show up to classes, takes notes, and are active participants. We should make them more visible and help them figure out how they can be helpful. There should be peer mentoring groups specifically for men.
- Women need to be creators of their own birth plan, and they need to review it with their provider prior to delivery. In some hospitals, the midwife reviews the birth plan, but it does not always happen in regular health care settings.
- Black doulas and midwives can play an important role during and after pregnancy. Almost no infant deaths occur when mothers are in the care of doulas. However, there is still stigma around black individuals asking for providers who look like them.
- Private and government insurance must cover doula services. The pay structure must reflect a livable wage with all doulas receiving equal pay regardless of insurance type.
- More resources should go to creating physical spaces where education, programming and training are centralized. These supports must be provided before and after pregnancy. More attention should be paid to the "fourth trimester," the 12-week period immediately after delivery. This is a time when the baby adjusts to being outside the womb and the woman adjusts to being a new mom, and the family will need a lot of support.

Conclusions and Recommendations

Based on our research and conversations with services providers, community members, and maternity home operators, we still feel that a culturally specific maternity home here in the state of Minnesota would be a great step towards reducing African American infant and maternal mortality. While the National Maternity Housing Coalitions models and similar faith-based models can have stringent requirements, and the differing belief systems and practices limit general applicability, they could still serve as a resource for overall maternity home general operating support. There is no directed or regulated way to open a maternity home as there is for a group home or shelter. This allows for a wide range of possibilities to explore the opening of a culturally specific maternity home. Moving forward, the cohort would recommend the continuation of the process to open a culturally specific maternity home, and elevating the role of black doulas and midwives during and after pregnancy. Culturally congruent care leads to better health outcomes because there is agreement in the values, beliefs, and worldview of both provider and patient. Additionally, there should be more support, including financial support, given to community members who have already begun the planning process of opening a black maternity home. Muna Abdirahman's Uzima Maternity Center is one example.[3]

[3] Muna Abdirahman RN, BSN is the founder of Uzima Maternity Center (UMC). UMC will be the first culturally specific maternal home in Minnesota to offer racially responsive holistic services. Targeting women from Black communities experiencing homelessness with prenatal and post-partum needs, its services will include nutrition and lifestyle counseling, home visiting, birthing and parenting education, mental health services, and transitional support. It is currently fundraising to purchase a property in south Minneapolis that will house UMC.

References

1. Star of the North Maternity Home (https://togetherforlifenorthland.org)
2. National Maternity Housing Coalition (https://natlhousingcoalition.org/about-us)
3. The Philomena House (https://www.philomenahouse.org)
4. The Nest Maternity Home (https://www.thenestmn.org)
5. Amazing Grace Maternity Home (https://metrowomenscenter.org/amazing-grace-maternity-home.html)
6. ESTHER Homes (https://www.estherhome.org/programs-impact)

Attachment 1: Community Listening Session Recruitment Flyer

Attachment 2: Community Listening Session Notes

9/7/19

African American Community Conversation on Infant Mortality

What is needed for healthy babies?

- Nutritional education for pregnancy. Helps to combat "hereditary" diseases.
- Support- social support to help cope with stress and difficult life circumstances. Help folks overcome adversary.
- Better access to health care- having providers who actually listen to patients and understand patients.
- Young women/women who advocate for themselves don't always feel heard.

What assessment is done when a pregnancy woman goes into the hospital, to help you understand what nutrition health a woman is in?

- There are none. It really is about prevention and education on diet. Providers don't have a lot of time to give proper education.
- We need more community clinics.
- Nutrition education for infants. Linked to infant mortality in Minneapolis/Minnesota.
- Development of intake forms to access nutrition health, and if needed they are referred to a dietitian or nutritionist. Finds that mothers cannot afford nutrition.

What are some challenging and positive experiences you or your family experienced during pregnancy?

- Emotional support- when you feel good you are able to make better choices.
- Women are invested in their pregnancy and their babies even when they don't have a lot of support.
- Men are also invested in the childbirth process. Show up to classes, takes notes and are active. Giving more credit to dads who are supportive in this process, making them more visible and helping them figure out how they can be helpful.
- Policies are harmful- For mothers to receive MFIP if the father is in the home, mothers receive a lower assistance level or none at all. Systems are not designed to really help uplift families. It punishes mothers who and fathers who need help.
- These systems that kids have to go through impact children neurologically.
- Who is advocating for mothers? Doctor did not ask mother whom she wanted to deliver her baby.
- People need to know what their rights are. They have a right to their own body. Give education around how to advocate for themselves. How do we teach mothers to advocate for themselves?

What can we do as a community?

- Mentoring group/peer group, specifically for men. They are often left out of the programs or services for mothers.
- Having someone in clinics and hospitals to explain patient rights.
- Creating a birth plan.
- Within hospitals, midwives do review birth plans prior to delivery.
- Train folks in the community to help mothers navigate systems/ medical system. Medical terminology language translator. Culturally specific community advocates who spend more time with mothers to help them understand what this medical information is and why it is important. Providers don't have enough time to provide education in a short visit.
- There is still stigma around black individuals asking for people who look like them.
- Everyday Miracles give mothers free doula if they have state health insurance- the state pays $411.00
- Insurance- needs to pay doulas. They don't see doulas as a necessary medical expense, there is no code that says doula. They tell clients to continue to submit claims in the hopes that it will spark a flame for the insurance company to realize that it's a need.
- Because doulas are not provided a livable wage, they only have so many hours in a day. Doulas of color are expected to take on all the clients who can't pay. Hospitals need to learn the role of Doulas, they don't speak for clients, they help the client learn to advocate for themselves. Doulas need to be able stay in the hospitals.
- The "4th trimester" – after childbirth when no one is around.
- Can we use grassroots/politically power to create programs?
- How many infant deaths have occurred with mothers who have doulas? None. How much money we have saved? How can we use financial incentives to help get support?
- How do we create incentives for hospital or clinics to have healthy babies?
- We have to change the language that we use when talking around these issues. Creating solutions that are asset based and non-manipulated.
- We need a physical place where education, programming and training are centralized. More resources are directed at these issues.
- An idea: a child life coach- comes in to help the child understand the procedure and to help them feel comfortable. Pregnancy life coach.
- There is still a pushback when African American specific programming is pushed.
- We collect data and research to help us get resources. Like the heritage act.
- It starts before pregnancy. We have to look at other health disparities throughout a woman's life.
- If we want more providers, we have to inspire children to go into the medical field.