

Doulas' Need for Support in Clinical Settings with Ana Rodney, MOMCares Hosted by Dr. Rachel Urrutia, MHLIC

Rachel: So welcome everyone to the Maternal Health Innovation Podcast, Season Two. I'm your host today, Dr. Rachel Urrutia, an OB GYN and assistant professor at UNC Chapel Hill, and I also work at the North Carolina Women's Health Branch at the North Carolina Department of Public Health. This podcast is created by the Maternal Health Learning and Innovation Center at UNC Chapel Hill.

Episodes are released weekly, so be sure you're subscribe to hear future episode. In this podcast, we listen to Maternal Health Innovators about ways we can implement change to improve maternal health in the us. In this episode, we'll be talking to Ana Rodney, the founder of Mom Cares. Mom Cares as a postpartum doula program designed to help support black mothers in the NICU that are under supported in facing financial stress.

To do this, they provide meals, transportation, bedside support, birth planning, education, and self-care opportunities to mothers in need. Ana is also the chair of the Baltimore Maternal Mortality Review Board and a member of the Infant Mortality Review Board. I'm really excited to talk to Anna today. I can't wait to ask her some of these questions and get some more about her experiences and doing this important work.

So first, Ana, let's get to know you a little better. Could you share a little bit about yourself and what has drawn you to this?

Ana: Sure, of course. So first of all, thank you for having me. This is an awesome opportunity and I'm looking forward to a great conversation. So I have been a doula for the last 15 years.

I fell into doula work in college and just decided that it was all that I wanted and more. And so I've stuck with it throughout the years. My own pregnancy and postpartum journey is what drove me to create mom cares. I did have an infant in the NICU and had to navigate that for

six months. And so that gave me plenty of time to figure out where there were gaps and huge gaping holes in areas of need.

Enough to create mom cares. And so, Mom Cares has been around since 2017 and we are very excited to be moving ever forward in our work and support of families here in Baltimore City and beyond. I'm a believer in women in birthing folks and people that give life. All of those folks deserve support, support and love, and as little stress as possible.

And we know that there's studies about how stress can affect the pregnancy and the babies. And so we want to just make sure in our work at Mom care is that we are surrounding our families with as much support and resources and care and compassion as possible. So, we then can see those positive outcomes.

So that is what I'm here. I'm all about birth. I'm also Reiki practitioner, a yoga instructor. All of the hippie things that you can think of. I have either trained to do them or are doing them myself. So that's me.

Rachel: Thanks for that. You spoke about some of the needs that you were seeing when your child was in the NICU or the gaping holes you said.

Can you share a little bit about what some of those gaping holes were?

Ana: Absolutely. So, especially with my work as a doula, my first thought was, Oh, I'm a doula. This is emergency situation. It sucks, but the birth community will surround me. The birth community, that's what they do. They support. They support mothers and birth.

What I didn't realize is because there's such a focus on, rightly so, there's such a focus on natural birth, low intervention, no intervention birth. When there was an emergency, people didn't know how to handle it and weren't equipped To provide support. And so had I been a mother who needed additional support or really deep care and support, but I had a natural childbirth that ended in, um, a healthy baby and we went home, I'm confident that we would've been able to find support in our community because my son came out on morphine and was in an incubator and on life support.

There were a lot of folks that I was looking to for support that didn't know how to support. So that was Jarring and heartbreaking and again, led to us kind of creating what Mom cares is today. Also as far as the medical structures concern. I found myself being black and overweight and single and underemployed and unemployed at one point.

I'm in all of those other identities seem to trump my identity as mom in the NICU, and I found myself having to explain myself, having to take up for myself, advocate for myself in a space where I really should have been focused on the health and wellbeing of myself and my son. Instead of kind of combating.

These biases and these instances of discrimination. And so, my thought was every time I went head-to-head or toe to toe with a medical provider about my background or my education, my thought was always, What about the moms who don't have this to pull back on? What about the moms who don't feel like doing it?

What about the moms who you know are too tired? to. You know, rattle off their resumes to a doctor in order to get them to listen. And so that is really where, what run in my head as we were creating the programming and the structure of Mom cares is, um, how can we stand in the gap for our moms who shouldn't be asked to prove themselves in order to get compassionate care and support for their little ones.

Rachel: So, you actually had experiences where you felt that if you hadn't been able to advocate for yourself and rattle off your cv, that maybe. Baby would've gotten less standard care or less high-quality care.

Ana: Absolutely. I mean, there were, you know, I was pretty- I looked pretty rough back in those days, you know?

Coming out of Emergency surgery, having three morbidities of my myself, I didn't look like I looked today. You know, I looked like someone that might not be as well educated or whatever that's supposed to look like, and especially with doctors knowing that I was single at the time and really just leaning on other biases that we know are present in the medical system.

I'm absolutely sure that. Me having to kind of will myself to stand up straight enough to say no, I'm college educated. I know my rights. I am well versed in medical practices and best practices and birth. Having to push myself into that position enough to get people to listen was a lot of work and where my heart was broken and I was angry and scared and sad and hurt, and I still found myself having to do that to qualify myself enough to get the response that I needed.

About, you know, my son's care, our options, and just responding to, to my concerns.

Rachel: I'm really sorry that we have to hear those stories, but I'm really glad that you're doing work in this space to try to improve the situation for other people who are in your situation. I guess from here, there's a lot of questions I have for you about the work you're doing, but wanted to start by talking to you a little bit about the work that you're doing with the MMRC or the Maternal Mortality Review Committee, in Baltimore City.

So I know that you're aware of this, and I don't know that our audience is, but the Black Mamas Matter Alliance. Recently published along with the CDC, a report for MMRCs called Sharing Power with Communities, and they were outlining for guidance for MMRCs that wanted to work with community members in the process of the MMRC

So maybe so I would love to hear your thoughts about that report, but maybe you could start by, 'cuz I don't know if everybody in our audience knows exactly what. And MMRC does. So maybe you could just start by saying a little bit about what you all do as the chair there, and then how you incorporate that report or what your thoughts are about that report in

Ana: Absolutely. So MMRC is a, we have a monthly meeting in which we gather as Stakeholders and professionals in the world of birth, maternal and child health. We gather together as a team and go over one to two cases in depth. A mom who has passed away and it's been determined that it's either pregnancy related or pregnancy associated.

So, and there's a difference. So pregnancy related means because this woman. Was pregnant and had this baby, she died or in pregnancy associated is this woman was pregnant, had a baby, and she died within

the, within a certain timeframe of having that baby or being pregnant. And so we go through both of those types of deaths and death.

And as a, as a group, we look at how the system failed. Mom, that birthing person. and we basically dissect with all of the information that we have on the birthing person, where the gaps and service are, where the feelings were.

Was there a space or a point in time in which we could have saved this mother? What in her treatment? Could have been improved or could have been changed. And from there we use these instances and cases throughout the year to create suggestions and recommendations for the, the birth community, specifically hospitals, health department, and other larger institutions that impact and support largely birthing folks in our city.

And so that's what we do. It can be very emotionally taxing. It can be triggering, it can be enraging. I usually end up at some point angry about. Happened to the person that we're reviewing. But our intention and our goal is to make sure that this doesn't happen again, to make sure that eventually we don't have any cases to review because we're not losing mothers in the way that we've been losing mothers.

And so at the end of the year, usually the MMRC here in Baltimore, will create. A report and we'll publish it and share it widely with our recommendations around what needs to be improved to make sure that we're not losing folks in birth or in their postpartum period.

Rachel: What are your thoughts about, So I know in the everything you're saying, I'm, I also assist a maternal mortality review committee here in North Carolina, and so I can empathize with, you know, even sleepless nights, thinking about cases and just that experience, like the visceral experience about hearing it and confronting it.

And I can't even imagine for you when you're. Confronting it as someone who's gone through some of the same experiences and like you were talking about different types of discrimination that you experienced. I know the Black Mama's Matter alliance was trying to, the CDC has wanted to have community members and people with lived experience to inform the work that the MMRC does.

And there's definitely, the CDC says that we should do that, and there's lots of places that try to do that, but are we actually really doing it? And are we doing it in a meaningful way? And so I know that was kind of the focus of Black Mamas Matter alliance and they, you know, actually looking at how was this happening in some of the review committees around the country and was it happening in a meaningful way?

And they gave some guidelines. What are your thoughts about those guidelines and how do you, how do you try to adhere to those guidelines or not adhere to them? Or do you agree with them or, you know,

Ana: Well, yeah, so I think that the Black Mamas Matter Alliance is, has, has done a good job at positioning themselves as the, main arm of advocacy that is representing the larger population of black mamas, black birthing folks.

And so you're not gonna' get me to say anything against, what, what they have put forth. I can speak to some of the things. The MMRC here in Baltimore incorporated in searching for members. I believe personally that I kind of cheated. I am, you know, I have the lived experience. I am an active community member and I'm also a birth professional.

But there was a call that came out through the health department looking for participants. There was an application, there was, a third party, was brought in to do the interviews and, and to manage the application. And so the third party came in. We went through the interview process. We, I was able to meet and speak with, you know, the folks at the health department where our MMRC is housed, and then we were selected by that Third party, there's always been a intention to include doulas and other people with lived experiences.

I personally serve on the fetal Infant Mortality Review Board as well, not as the chair, but just as a member. And just seeing the juxtaposition between the two committees. One that is very much almost exclusively professionals, institutions that are being represented, government organizations that are being represented and that, and having.

That be what's guiding the femur as opposed to the MMRC that also has doulas and people with lived experiences and you know, the professionals and we have a doctor, you know, a high-risk doctor on so

conversations can get heated, right? Because everybody is coming to the table with their own experience, their own expectations, their own vested.

Some folks like myself, , don't really, aren't really willing to subscribe to the niceties of that you might see in one of these other meetings. And so when I say I'm angry, I say that to the board, like, we know what's going on. We can look at the, the narrative in these cases and say, this is discrimination.

Okay? We, we've gone over 60, you know, cases. When is there, what are we gonna' do about it? What. Recommendation. We can say how terrible it is and shed a tear even in these meetings. What are we doing past the meeting? And I think that having that mix of folks kind of brings it home to people who don't, aren't living it, and people who aren't living it but are supremely invested.

People who aren't living it and may not be as invested. You know, this work is hard and it is taxing. And so to be able to have such a diverse group of folks, it makes it harder, but it also makes it more fruitful because we aren't, we don't have the usual suspects at the table, and there are people with peer intention who really wanna see a resolve from these meetings and reviewing these cases.

Rachel: Really great. It also, I also hear you saying that, you know, there's this space of we have to be uncomfortable, we have to be angry, we have to do these things that aren't necessarily like the way that the medical community's been doing things for many years. Cuz' we are not fixing the problem. Like we have to do something different.

Ana: Absolutely. There has to be an acknowledgement of the fact that we're here because something is broken. Like we're not here to pat ourselves on the back. We're here because something isn't working and hasn't been working for quite some time, and especially those who are working within the system that hasn't been working, that can be hard and bring up emotions that you, we might not even be aware of until they're there, you know?

Rachel: Mm-hmm... Right? I think it can be really hard for people who feel like they've devoted their whole life to helping people and then to hear and provide. Care. That's a very hard thing to grapple with, and. So can you give us some examples of how you feel that you are being the chair of the committee and also being a doula as opposed to say be, you know, a medical professional being the chair.

Are there like some actionable items that have come or things that have changed directly as a result of that, that you could share with us some examples?

Ana: Absolutely. So may I have a Medicaid at the end of last year decided to reimburse. Doula work. And so to be clear, I am not the only doula that made it onto the MMRC.

There are a number of doulas and on the committee and I as the chair, I try my best to make sure that we're including their voices because again, this is not. A space that all of us as doulas are familiar with or comfortable with. You know, there are a number of different type of review boards within the city, and so a lot of these people kind of have overlap and know what the process is.

And so I work very hard to kind of pull in the doulas and see, you know, that, you know, you have to say, Is there something, some feedback we haven't heard from you. We also, gave an opportunity, at a couple of meetings to have some of the doulas. Present on their work and their area of focus and why their work is important.

And I think that was really important as far as community building to give them a chance to take center stage and explain why their work is important to maternal health outcomes here in Baltimore City. Again, because it's so hard to, you know, doulas seem to be constantly begging to be acknowledged as professionals in the field of birth work.

And so to be, to, for me to be in a position to invite other doulas to the table to be able to present, I am a accomplished professional in this field, and this is the work that I do in front of other medical professionals. I think it's important and it, it's humbling for me to be able to stand in that space and, and be that person to make sure that that is done.

And at this point, we. You know other people on the MMRC who are seeking out the opinion of the doulas. And we have a number of recommendations that speak to the Medicaid reimbursement rate, that speak to the ease or lack thereof to get enrolled in the Medicaid system as a doula. And so we also have some plans to make sure that we're supporting other doulas and smaller doula organizations to be able to do that because we acknowledge that doula.

Is important and compensation for that support is important. And the people that need it the most, at least a portion of that population is going to be dependent on Medicaid to be able to access that, especially because of the thought or the feeling that doula support is something extra or something for elite folks.

And so we really are grateful to be able to make sure. People that feel like they may not have had access to it a couple of years ago or last year now know that they do indeed have access to it and are able to use those services to make sure that their outcomes are better. And so I'm very, very proud that we've been able to do that and highlight that in the work that we're doing at the MMRC.

Rachel: It's really great to hear you did just start to mention how there are some barriers to doulas for working with patients. You talked about the one access for clients who don't maybe have financial resources. What about pushback from medical institutions? Have you experienced that? I understand you've been a doula for 16 years and so that's a lot.

A lot of experience times when nobody even probably knew what a doula was.

Ana: And I didn't know what a deal was. I was just,

Rachel: What, how, what are some of the barriers that, especially from the medical institution that you've experienced in being a doula and being able to serve patients? Right.

Ana: So I, so access of course, but also unfortunately in, depending on the hospital, when you walk in as a doula, There's this adversarial thing that is there between the nurses and the medical staff, and you know,

this person that thinks they know everything that's gonna get our way, that's gonna stop us from doing our job is here.

And so I also train doulas, train and certified doulas. And so what I talk about. To my doulas is the fact that we need to make sure that we are, We stay in the room and acknowledge that we might be paid or compensated. There might be a contract, but ultimately at the end of the day, we're in the room at the grace of the medical professionals who have us in the room.

So we wanna position ourselves as a help and a support and not a adversary, not someone who is pushing or, you know, getting in the way and all of these other things that it's not fair for us to have to navigate cuz we really truly are doing our job. But coming up with ways to make sure that we're disarming folks that have that idea or thought of.

And that can be hard because at the top of the list is making sure that you're advocating and supporting your, but also there's a, a very thin line that you have to kind of toe around being in community and being in concert with the medical professionals. So I, I tell our doulas all the time, that is emotionally taxing because you are not only serving and advocating for mom, but you're serving and advocating for any other family member that's in the room.

You have to manage. And monitor emotions and energy feeling while also making sure that you are doing just enough to stay in the room. So that, because the, the fact of the matter is you can advocate and be, be a ball of fire and then out in the hallway, right? And so then you lose access to your family.

And so we talk very at length about how to manage that identity and that role and all the responsibilities that comes with it. So that's number one is really. Acknowledging that you're not there just for mom. You're there to manage the environment and the energy of that environment. And that means that you're managing a lot of different people.

And then for me also is, you know, I don't want it to sound passe, but the selfcare, you know, everybody's talking about selfcare and selfcare, not in like marshmallows and bubble baths, but selfcare and the fact that you have to exercise a. Inordinate amount of emotional restraint by, but

all at the same time being vulnerable and raw with your client, which is almost impossible.

And so making sure that you have that place to cry and to break down and hit a wall and to, you know, get frustrated, to get happy or get, you know, excited in a space where it's not taking away. Your family's experience because feeling like you are not being heard, feeling like you're not being acknowledged, Not having a place for you to put your emotion can lead to burnout.

And I think that it's important for us, especially us doulas of color, that we maintain ourselves enough because it's clear that we're needed and if we're constantly burning out, our families are going without that support that they can identify.

Rachel: Do you have some tips for birth workers who are also people of color specifically to avoid burnout?

Ana: I think having backup doulas is important, so having someone that can come and relieve you for an hour or two so you can take a shower, you know, go home, take a bath, manage the kids, take 'em from one babysitter to the other babysitter. I think being a part of community as well, having those face those meetups and having, finding those confidence that you can share information with and talk to about your experience.

I am an advocate of mental. Support and therapy. I, I engaged with my therapist three years ago after supporting a mom through a birth where we knew the baby was not gonna make it. And I had the point where I was like, I could make a bad decision to kind of make me feel a little bit better right now, or I can call a therapist tomorrow.

And I decided to call the therapist and I, so I think. Mental health support, whatever that looks like for you is imperative as as doulas of color because we are traumatizing retraumatizing ourselves often, especially knowing that we are in the space of acknowledging, especially acknowledging the maternal health crisis, but also findings.

Lot of joy. Like you don't wanna go into a birth with a black riding hood on, you know, like you don't wanna go on there. Sad. These are, these

are experiences that should be celebrated and embraced and given a shout for. And so I think that monitoring yourself to make sure that you still do enjoy it and you still are engaged in.

In a joyful way is important because that energy can translate into your service as well. And so I think just really like all things of color. I think being engaged with your own community and having support your G to making sure that you have a long career in a space. I'll also say, that you don't have to do everything.

I think there are a lot of, like I, at the beginning, you know, at doula I'm, yoga instructor. I think that the feeling is that we need to have all of these other things to do to validate our work, where that can just. Also burn us out. And so finding a focus and being focused on that, I think is very important and existing, the urge to have to go above and beyond with credentials and, skills and things that, and that again, is where your community is concerned.

You don't have to be certified in 10 or 15 different things to serve your families. You can be certified in five things and have 10 other folks to refer out to resources. And I think that's very, I. What

Rachel: can I as a provider do if I'm having an interaction with a doula that doesn't feel positive for me?

What are some tips that, how can I improve that interaction or that relationship?

Ana: I think resetting the expectation, acknowledging the person in the space for me. On the other end when I have felt like there's been some, some energy between me and a provider, I've literally said, I'm here to be supportive.

Like I'm here to make sure that this birth is successful and what are the things that I can do to make it successful and, and you know, what are the things that you can do to make it successful? I think it's really important to acknowledge a doula in their role and their importance in the room. And then also, everybody be reminded that we're here for this.

event. We're here for this family, we're here for this mama, this birthing person, and just saying, what do we need to do to make sure that we, we are all on the same page so that we're not bringing this to the family? Cause they don't need to manage that. I think that's important. I think when, when I have been in a room as a doula and I have felt like I needed to prove myself or kind of like stand up a little bit bigger or straight, it becomes an ego thing, right?

Because I have to prove myself to the provider so that I can feel comfortable taking care of the family, and that takes my energy away from the work that I'm actually doing. And so I think just giving space and acknowledging I know that you're here for this family. I know that, you know, it's very important that they have your advocacy and your support, and I think it's, I, and it's even more important that we are collaborating.

And so what can we do to make sure that we're collaborating, This is what I'm doing, these are the things that I'm worried about, or I'm responsible for. How can we collaborate to make sure the things that you're responsible for and the things that I'm responsible for aren't conflicting and are actually complimenting each other?

Yeah. I think that's, that's a really beautiful, you know, conversation. Having a convers.

Rachel: Relationship building, community building cross.

Ana: Yeah. Right? Yeah. If you sense anything, everything sitting down and just grounding.

Rachel: Yeah, so I know we're all coming at this work in that in the context in our country of systemic racism, institutional racism, that has basically previously excluded black birth workers from hospitals.

So like with the history of the granny midwives who used to do. You know, many deliveries, especially where I live in the, in the southern part of the us, many of them were enslaved, you know? And even after that, were still really involved in their communities doing births. And because of a number of decisions that were, you know, mostly to benefit white male institutions, that process kind of did not allow that wisdom and that

of black birth workers to continue to be, you know, invested in their communities.

I'm sure you could all say this better than I just did, but what I know, I've heard some people within. The community doula world worry that if there's too much connection between doulas and medical institutions, maybe even insurance reimbursement, maybe credentialing, maybe training, that could also have an end result of pushing some people out of this work and further.

You know, creating disparities. So I was just curious to see what your thoughts were about that and whether and how you think we could prevent that from happening. What has happened historically, but now prevent it from happening for black doulas specifically.

Ana: I think that we're always at risk for repeating the mistakes of the past.

I think it's gonna take a lot more than talking about the work and talking about the need than, it's gonna take more than that. We're, we're gonna actually have to put our money where our mouth is and allow people to lead what this is supposed to look like, I think. And here in Maryland, Medicaid.

Invited a group of folks to come and inform the process of creating this reimbursement. That's not to say that they got it right completely, but inviting people into the conversation is, I think is important. And looking at them as partners, looking at us as partners and not as people that are being serviced or being allowed to do something, but really looking at us and treating us.

As if we are partners in this work, equal partners in this work, I think is important. And then also understanding that not everything can be, dare I say, evidence based in the work, in the hard work of being a doula, that the work of emotional. Support of spiritual support. You, We may not have measurable outcomes and goals, but we know that it works.

We know that I, I might not know, you know, the instance of having, you know, how many times I need to rub someone's back before it actually effects an outcome. But I know that when I'm talking to a mama after

they've given birth, they can remember that I was just focusing on you rubbing my back while I was going through the contraction.

And we know that that, that that's a benefit. And so I think that while I understand and respect evidence based work, we also need to make space for that more. I call it hard work, that more hard work type of support that may not be quantifiable in a scientific.

Rachel: Right. So that, I mean, we might be able to, we might be able to see that outcomes are better.

We have seen that outcomes are better for people who have doulas for their birth. And I think the tendency of doctors and scientists is like to try to figure out why, but why, what's the key ingredient? And it sounds like you're saying we we're not gonna be able to figure that out. Right. It's the whole, the...

Ana: Ethers are not several picture not give us that secret.

The ethers are gonna let us use it, but not give us the secret of, of why or how. Right. I think it's. We need to treat each other like humans. You know, when I'm crying and upset, I want somebody to hold me or hug me. And sometimes when I'm crying or upset, I want somebody not to touch me and then leave me alone and to work through it, right?

There's no, there's not a prescriptive formula for how to hold space for someone. And so I, you know, I can say, Oh, well, Last week it was you know, it worked with my client that I, you know, patted her on her leg when she was feeling bad this week. She might want me to just sit and be quiet and listen to her cry, you know?

And I think that's the difference I think between doulas and other, I don't wanna say non-traditional cuz we are traditional, but nonmedical support. Right. And the more medical institutionalized. There is, how can we do this faster? How can we do this easier? How can we make sure that this is, that we can do this in the most efficient way possible?

And that becomes formulaic. And I understand for different reasons why that would benefit, institution. But we're looking at institutions that are handling and caring for people. And people are not one size fit all.

People do not always. Respond well to formulate equations about what care should look like because we're each different.

And so I, I think that we just need to make space for each other and understand that it can be both and, Right. It doesn't have to be. I think for me, that was the largest lesson for me. You know, with my son, before I gave birth to my son, I was saying, Oh, I'm gonna go to the woods and find a tree and I'm gonna squat down and breathe my baby out.

And that would've been the most, the most beautiful experience possible had it happened. My baby came three months early and had to be in, in an incubator for two more months, and he had to be on morphine when he came out and it sucked and it was horrible. But those things are what saved his. My son was in an incubator, had the artificial humidity going on around him.

He also had crystals on his ISEC, right? Like there it's both. And science saved my baby, but my affirmations. Save my baby as well. My son's the same song that I played every night before I left. We listened to that song seven years later for him to go to sleep. So we know that there's a both and that we really need as practitioners and as colleagues, we need to get on the same pay mails things because it's important.

You know, we're at the place where medical advancements are absolutely saving people's lives. But also we know that touch saves a person's life. We know that presence saves a person's life. When I would walk into the hospital, into the room, my son's isolate was at the very back of the room, and as soon as I walked into the room, my son's stacks would stabilize because he felt the presence of his.

Like, that's not something that I can make. That's something that for the six months that I was walking into those, that room every day, I saw that happen. And so we have to acknowledge that as much as science and medical innovation is saving families, connecting to people and being compassionate and seeing each other as humans is also saving lives as well.

And we need to make space for.

Rachel: Fairly beautiful. And I think as a, as a medical person, I have to grapple with the fact that we aren't, we don't have all the answers. Like clearly, we haven't fixed the problem even though we've known about it for many decades. And so I think the work that you do offers this additional, you know, value and need that, you know, brings these additional resources to our patients that we can't do.

So we do need, we need each other. We need each other exactly. What do you think is next? What do you think, if you could think of the future of maternal health and everything? How you would want it to be. What are your dreams? What does it look like for equitable maternal health in the future?

Ana: So, I always say this as a joke, but I think equitable maternal health means that me and all of my sister doulas are on an island somewhere soaking up sun because there's no need for us.

To do it any work, right? Because we, we don't have to be on the front lines because we figured it out and we know what we're doing as far as keeping our, our families alive and our mama's alive. But I, I think that in all honesty, I think there's more unraveling that needs to be done. There's more mess that needs to be made so that we can put it together.

In the right way. The institutionalized racism and discrimination that is bringing us to the point of needing other people to intervene. The care of our families took centuries to, to implement and to make sure it was in place. And so it's gonna take some more time for us to unravel that. It's gonna take more uncomfortable conversations and more commitment for, from people who say that they are.

It's more than a hashtag more than a, a flag [00:35:00] outside of the hospital, right? There's more work to be done, and it's more than you probably signed up for, and it's more than you probably expected or wanted to do. But in the. The space of committing and acknowledging that there's an issue that needs to be corrected.

We really have to kind of dig in and I think that there's a lot of trust building that needs to happen. There's a lot of power shifting that needs to happen, power sharing that needs to happen, and we are not gonna

get to a space in which our family. Feel 100% supported by their medical staff without doing that work, right?

Without building that trust, without saying, “Hey, we know, you know, we know what we did. We know what your ancestors went through for the innovation of birth work and gynecological work, right? We know that and we're willing to, to work to correct that.” Right. I think there needs to be an acknowledgement and then work, actual work and so not just, you know, a day or like I said, a flag on the side of the hospital or a button that everybody's wearing, but actual tangible work that's being done and collaboration with the communities that are requiring that work to be done.

I think also funding is very important. I will never, ever not say or mention funding. I think funding and supporting organizations. That are grassroots, that are from and of the community to do the work. And that does not mean meeting with the that organization and replicating it internally, but meeting with the organization and finding out how you can contract that organization to come and do the work.

We don't need anybody to replicate our work. We're doing the. We need the funds and the support and the fiduciary support to make sure that we're doing, that. We're able to do the work that we're, everybody's acknowledging needs to be done. And so we don't need to put anything else on a nurse's plate. We don't need to require nurses to now be nurses and doulas.

We don't need to ask student doctors and students, medical students to now become doulas or lactation consultants if that's not what they wanna do. We need to make room for the people that are passionate and want to do it and pay. Equitably to do that work again, at the end of the day, it comes down to joining together to make it happen, and acknowledging that doulas are not multimillion dollar institutions that have multimillion dollar budgets to buy whatever they wanna buy to support their work.

So we are dependent on the organization's, the institutions, the hospitals, to bring us into that fold. Requiring us to change, to assimilate into the social, I'm losing my words, but that just don't want us to assimilate, that don't expect us to assimilate into, the culture of the

hospital setting that understand that we have our own culture and that we can exist together without being disruptive to each.

Yeah.

Rachel: finding a way so that the community organizations can still operate as they always have, but just having partnerships with partner

Ana: institutions, partnerships, paid partner, like I can't, not enough. It is maddening how many meetings I've had with institutions and I, and then six months later, oh, they're piloting a program and it's like, this looks a lot like what we talked about.

Yes. And again, especially coming out of the pandemic, our nurses and medical staff already have enough on their plate. Yeah. They don't need to add something else, especially if there's an entire community of folks who are already doing it and doing it well.

Rachel: And as you said earlier, there's a secret.

Ingredient not a secret. And there is a deeper heart work that you were talking about that can't probably be replicated anyway by an institution. So I mean, you can replicate the nuts and bolts, but you can't replicate the heart work per se. And I think that, you know, even that trust that the community has, because the institutions have done them wrong, but there.

You know, people from their community, there's, there's definitely more of a trust and openness there. And yeah, in my work, I've just even noticed something as simple as I think is not simple, but the fact that institutions, we get paid after we do the work, right? But I still get my salary every month. I don't have to wait until my patients deliver their babies in seven months to get paid.

Like I get my salary. The institution has. You know, financial resources to be able to front the money, right and wait for the payment later. But community-based organizations can't do that. So, you know, when we say you need to put all this work through, but we'll pay you later. Like even that's how a lot of grants work, but community organizations can't do that.

So there's just so many ways that we have asked community organizations to conform to the standards of the industry, and it's just not, it won't work. Well, thank you so much. I don't know if you have any other last minute things that you feel like you really wanna say that we did not get to . I always have more to say, but I will encourage anyone who is listening.

Ana: If you are interested in the work of Mom Cares, please visit us @momcares.org. We are always looking for donations and volunteers and support, and people who are interested in and committed to supporting the work and however that looks. I think that I will just end on the fact that every birthing person is a seed to a larger.

Goal of a healthy, thriving community. And every community is a part of a state, and every state is a part of a country, and every country is a part of the world. So being kind and compassionate to. Someone who is bringing life into the world is literally changing the world, and we need to remember that because I believe it's my belief that a number of the social ills that we find ourselves combating every day would dissipate if we could just be kind and supportive and give our families a soft place to be as they are growing and [00:41:00] bringing life into the.

Rachel: That's really beautiful. Made me teary. Thank you. Thank you everyone for taking the time to join us today to share these experiences. And thank you for listening. For more podcasts, videos, blogs, and maternal health content, you can visit the Maternal Health Learning and Innovation Center maternalhealthlearning.org.

And Ana's, the website that she mentioned will also be linked there. And on this podcast, we want to hear from you. Tell us what you want to hear more of. Review our podcast and share with like-minded innovators. Please be subscribed because we have some great other episodes recording right now. And let's keep talking.

Tag us in your post using the hashtag Maternal Health Innovation. I'm Rachel Urrutia and we'll see you again next week on the Maternal Health Innovation Podcast.