BIPOC Birthing Study:
Centering Lived Experiences and Advancing Maternal Health Equity in Vermont

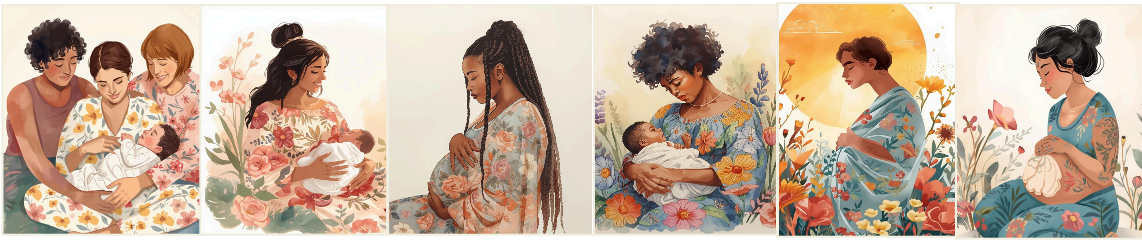

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Table of Contents

Executive Summary

Purpose and Scope of the Study

The BIPOC Birthing Study: Understanding Maternal Health Experiences in Vermont was designed to illuminate how birthing people of color experience maternal healthcare across the state. Conducted by The Creative Discourse Group in partnership with the Vermont Department of Health, this study aimed to capture the lived experiences, challenges, and strengths of BIPOC birthing people and identify systemic factors that contribute to inequitable care and outcomes.

Through a trauma-informed, community-based participatory approach, the study combined qualitative and quantitative methods, including a survey, focus groups, and one-on-one interviews. One hundred and twelve survey respondents, five focus groups, and six in-depth interview participants informed this report, representing the experiences of one hundred and forty birthing people, partners, and supporters. Participants' letters to Vermont leaders captured the spirit of this study: urgent, solution-focused, and grounded in lived experience.

The study's goals were to:

1. Understand how BIPOC birthing people experience Vermont's maternal healthcare system before, during, and after birth.
2. Identify systemic barriers and opportunities for improvement in care, trust, and representation.
3. Center participant voices in defining what safe, dignified, and equitable care looks like.
4. Offer recommendations that guide actionable system change, policy alignment, and accountability within Vermont's maternal health landscape.

Key Findings Overview

The findings reveal that while many participants reported feeling physically safe during their birthing experiences, emotional safety emerged as a far greater concern. Many described experiences of being dismissed, unheard, or minimized – experiences that, though not always clinically harmful, were deeply traumatic and left lasting emotional scars.

> ***"Being medically safe is not the same as feeling supported."***

Thirteen interrelated themes surfaced across data sources:

- **Strengths:** Participants described positive experiences of culturally affirming, relationship-based care and strong community support from family, doulas, and peers that fostered trust, belonging, and emotional safety.
- **Dismissal and Poor Communication:** Participants frequently felt ignored, rushed, or dismissed when expressing pain or concern, eroding trust and emotional safety.

- **Bias, Profiling, and Trust Gaps:** Racial and cultural bias shaped interactions and contributed to ongoing distrust in healthcare settings.
- **Access and Logistics Barriers:** Rural geography, transportation, and resource limitations created significant obstacles to consistent, timely, and equitable care.
- **Cultural Competence and Representation:** A lack of provider diversity and cultural responsiveness left participants feeling unseen and disconnected from their care.
- **Emotional and Psychological Trauma:** More than half described their birth as traumatic, with higher rates among bisexual and Latina/o/x participants, reflecting intersectional inequities.
- **Information and Health Literacy Needs:** Participants wanted clear, early, and culturally relevant information to guide decision-making and reduce anxiety.
- **Autonomy and Decision-Making:** Many felt pressured into medical interventions without full consent or clear explanation, limiting agency during birth.
- **Postpartum Gaps:** Maternal recovery and mental health were often overlooked as care focused primarily on infant health.
- **Policy Rigidity and Systems-First Practices:** Institutional protocols prioritized efficiency and liability over individualized, person-centered care.
- **Coordination and System Navigation:** Poor communication between providers and facilities left participants managing their own referrals and follow-up care.
- **Pain Management Inequities:** Pain was often minimized or undertreated, particularly among Black birthing people.
- **Chronic Condition Management:** Participants with ongoing conditions, such as diabetes, experienced disempowerment and unnecessary complications when their self-knowledge was disregarded.

Implications for Vermont’s Maternal Health System

Vermont’s strong clinical outcomes risk obscuring persistent inequities in the lived experiences of birthing people of color. The data show that “good outcomes” are not synonymous with equitable or humane care. Emotional safety, access to services, and the right to be heard are critical dimensions of health equity — not optional ones.

These findings underscore the need for systemic shifts toward culturally responsive, community-centered care models and greater workforce diversity. They also highlight the importance of data equity: understanding not just what outcomes occur, but how people experience the systems that shape them.

Recommendations Snapshot

This study calls for a maternal health system in Vermont that is trust-centered, trauma-informed, and culturally responsive. Analysis of participant experiences across surveys, interviews, and focus groups revealed seven interconnected priorities for systemic change:

1. **Center Trust, Transparency, and Shared Decision-Making**
   Standardize respectful communication and informed-consent practices; use structured care plans/decision aids; ensure protected time for questions; integrate interpretation and co-designed, plain-language materials.

2. **Name and Address Bias and Racism as Core Barriers**
   Build conscious bias awareness and anti-racism competency; create safe team processes to surface/repair obstetric racism; adopt trauma-informed, bias-interruption routines; publicly track equity outcomes.
3. **Prioritize Emotional Safety and Postpartum Well-Being**
   Make emotional/psychological safety a quality metric; adopt dyad care; ensure postpartum visits address physical, mental, and emotional recovery; offer early home visits; use comprehensive screening (depression, anxiety, substance use, social connection), with targeted supports for BIPOC families experiencing isolation.
4. **Expand Equitable Access, Navigation, and Continuity of Care**
   Screen for and address transportation/childcare barriers; make clinics more child-friendly; expand telehealth; implement **closed-loop** referrals; integrate clinical and community supports; deploy care navigators to build continuity and trust.
5. **Advance Representation and Workforce Equity**
   Recruit, retain, and mentor BIPOC doulas, nurses, midwives, and OB-GYNs; build pipelines and scholarships; surface provider cultural/linguistic competencies; embed ongoing equity, anti-racism, and cultural humility learning.
6. **Build Systems of Accountability and Belonging**
   Establish confidential, accessible reporting with anti-retaliation and visible follow-up; strengthen PQC-VT's Parent and Family Advisory Committee (PFAC) as a trusted patient-voice channel; audit environments for inclusion; publicly report equity metrics.
7. **Develop a Participant-Guided Statewide Implementation Plan**
   Assign clear roles across state, institutional, and community partners; align with existing statewide efforts; set measurable milestones with public reporting; compensate BIPOC participants for governance roles; sustain funding—and adopt national best practices (e.g., AWHONN's *Respectful Maternity Care Framework*) to standardize person-centered, respectful care statewide.

Next Steps

The next phase of this work will focus on collaborative implementation planning that centers the voices of BIPOC birthing people and aligns with existing statewide maternal health initiatives. The Vermont Department of Health and Perinatal Quality Collaborative Vermont have endorsed the *Association of Women's Health, Obstetric and Neonatal Nurses' (AWHONN) Respectful Maternity Care Framework (2022)*, which offers actionable, patient-centered strategies rooted in dignity, autonomy, and respect. Integrating this framework into statewide equity efforts will help translate the findings of this study into lasting systems change.

Introduction

Background and Rationale

Across the United States, Black, Indigenous, and People of Color (BIPOC) continue to face disproportionate risks during pregnancy, birth, and the postpartum period. Although Vermont's aggregate maternal mortality and morbidity indicators appear comparatively strong, the lived experiences of BIPOC birthing people reveal a more urgent and complex reality—one shaped by questions of respect, safety, and whether they are believed throughout their care.

This aligns directly with the vision of Vermont's first Maternal Health Strategic Plan—that all birthing people feel safe, supported, and empowered throughout pregnancy, birth, and postpartum. Yet the findings of this study show that BIPOC birthing people are less likely to experience positive outcomes or respectful, person-centered care. These disparities reflect the cumulative effects of historical trauma, institutional racism, and ongoing bias in medical settings. As Hailu et al. (2022) note, achieving equity requires intentional, sustained efforts to confront bias, transform systems, and ensure culturally responsive care throughout the perinatal period.

Vermont's small, rural, and predominantly white demographics can intensify isolation and invisibility for BIPOC residents. Participants described feeling unseen, stereotyped, or dismissed within healthcare systems that often lack the cultural awareness or relational grounding needed to support them. This invisibility—compounded by geographic, institutional, and interpersonal barriers—creates conditions where bias can persist unchecked.

Vermont Context

Vermont's healthcare landscape is characterized by high-quality clinical infrastructure yet limited racial diversity among providers. Rurality, workforce shortages, and transportation challenges intersect with systemic inequities, producing uneven access to care and varying levels of trust in providers across regions. Despite the state's progressive values, participants repeatedly emphasized the gap between Vermont's self-perception as inclusive and the lived realities of marginalized communities.

As one participant stated: "We ask for them to hear us, but when we do, they don't want to listen. They think, 'That doesn't happen here.' But it does. It happens all the time." This finding aligns with national data showing that perceptions of bias and disrespect often go unacknowledged (Odems et al., 2024; Chin et al., 2021). This pattern is evident across the United States, including in states that pride themselves on fairness and inclusion.

Purpose of the Study

The BIPOC Birthing Study sought to document and understand the maternal health experiences of BIPOC birthing people in Vermont by centering their stories, elevating their insights, and translating their experiences into actionable recommendations. The study was guided by four core commitments:

- **Equity and Justice:** Naming systemic racism and dismantling structural inequities in healthcare.
- **Proximity as Credibility:** Researcher affinity and shared identity enhance understanding and trust.
- **Trauma-Informed Care:** Emotional safety and choice in research and healthcare settings are prioritized.
- **Community Partnership:** Findings inform and are co-owned by the people they represent.

Methodology

Study Design

This study employed a qualitative, participatory, and trauma-informed design rooted in community-based participatory research (CBPR) and transformative research paradigm which provides a framework for engaging researchers in diverse communities where inquiry is explicitly grounded in social justice and the pursuit of equity (Mertens, 2009). The goal was to capture lived experiences, emotional realities, and systemic barriers facing BIPOC birthing people in Vermont through storytelling, dialogue, and mixed-methods inquiry. The research emphasized relationships over extraction, centering participants as experts of their own experiences and honoring the time and energy they put into sharing their accounts.

The study intentionally bridged quantitative and qualitative approaches: a statewide survey captured trends and cross-county patterns, while in-depth interviews and focus groups provided the texture and context needed to interpret those findings. These methods worked in tandem to illuminate both measurable disparities and the emotional and relational dimensions of birthing in Vermont.

Data Collection Methods

Data were collected through three primary methods between August and October 2025.

Survey: A total of 112 respondents across all fourteen Vermont counties completed the statewide survey. Respondents included birthing people, partners, supporters, and healthcare providers. Six counties, Addison, Bennington, Chittenden, Essex, Franklin, and Washington, had sufficient participation to support county-level analysis. While the vast majority of respondents were birthing people, provider and supporter perspectives were also represented through a separate survey track, which provided additional insight into the system-level context in which these experiences occurred.

Focus Groups: Twenty-two birthing people participated across five facilitated focus groups, including birthing people, partners, and community supporters. Each session emphasized collective reflection, shared storytelling, and cultural connection, allowing participants to explore themes of trust, care, and community belonging. As a final reflection activity, participants wrote letters to Vermont's leaders describing, in their own words, what changes would make the greatest difference. The letters provide testimony from those most impacted that can be leveraged to support policy recommendations at the state level. These group dialogues helped surface shared experiences and regional variations that complemented survey findings.

Interviews: Six in-depth, semi-structured interviews were conducted with BIPOC birthing people who shared detailed accounts of their prenatal, birthing, and postpartum experiences. These interviews provided deeper narrative context and individual perspectives that expanded upon themes emerging from the survey and focus groups.

All data collection tools, including surveys and the interview and focus group guides, were co-designed by The Creative Discourse Group team and the Vermont Department of Health Maternal Health Innovation (MHI) team to ensure linguistic clarity, cultural responsiveness, and trauma-informed practice. The interview and focus group protocols were informed by an initial analysis of survey data to allow for a more detailed exploration of the themes most widely captured through the survey.

Participant Recruitment and Demographics

Participants were recruited using a combination of community outreach, snowball sampling, and partnership-based engagement strategies. The Creative Discourse Group and the Vermont Department of Health Maternal Health Innovation (MHI) team worked collaboratively to ensure that recruitment strategies were widespread, culturally responsive, accessible, and trauma-informed.

Recruitment materials were distributed through trusted community channels, including healthcare offices, doulas and midwives, cultural organizations, social media networks, and word of mouth. BIPOC-led community spaces and affinity networks were particularly effective in reaching birthing people who might otherwise be disconnected from traditional research outreach. This relational approach helped build trust and encouraged participation from individuals across both rural and urban settings.

The study successfully engaged participants from all fourteen counties in Vermont, creating a comprehensive statewide snapshot of BIPOC birthing experiences. While overall representation was strong, six counties—Addison, Bennington, Chittenden, Essex, Franklin, and Washington—had sufficient participation to support county-level comparison and analysis.

In total, 112 survey respondents, twenty-two focus group participants, and six interview participants contributed their perspectives and experiences to the study. Participants reflected a broad range of racial, cultural, gender, and linguistic identities, representing Vermont's growing BIPOC and LGBTQ+ communities. They identified as Black, African, African American, Indigenous, Asian, Latina/o/x, multiracial, and included participants who identified as bisexual, queer, and transgender or gender-expansive. Several participants were immigrants or first-generation Americans, bringing essential insight into how culture, language, and migration shape maternal health access and experiences in Vermont.

In addition to birthing people, the study incorporated the perspectives of partners, supporters, and healthcare providers to contextualize system-level factors and relational dynamics within maternal health care. These varied perspectives offered a more holistic picture of the barriers and opportunities for equitable care within Vermont's healthcare landscape.

While recruitment was robust, the research team acknowledges that Vermont's small population of color, rural geography, and limited number of LGBTQ+ birthing people present challenges to representativeness. Rather than seeking statistical generalization, this study was designed to capture depth, nuance, and authenticity in participants' lived experiences. The inclusion of multiple data sources and intersectional identities strengthens the validity of the findings and provides actionable insights for equity-driven policy, practice, and systems transformation.

Facilitation and Researcher Positionality

The depth, authenticity, and integrity of this study were shaped by the proximity and positionality of its researchers. The Creative Discourse Group team approached this project with shared commitments to equity, community partnership, and trauma-informed inquiry, drawing on both professional expertise and lived experience to cultivate trust and openness among participants.

Dr. Nadia DuBose and Hope Elliott served as primary facilitators, while Dr. Reese Kelly led the analytic integration and structural synthesis across data sources. Together, they represented a range of racial, cultural, gender, and lived identities that reflected the populations the study sought to understand. This proximity to community did not compromise objectivity; rather, it created credibility, connection, and relational care that made the study's findings more honest, nuanced, and grounded in lived reality.

Hope Elliott's facilitation was informed both by her professional expertise and by her lived experience as a BIPOC birthing person. Hope wove mindfulness, grounding, and cultural practices throughout the research process. She opened focus groups with stabilizing breathing and meditative anchoring, which participants described as essential to creating emotional safety and presence. Her trauma-informed and culturally grounded approach allowed participants to move beyond guarded responses into reflective and vulnerable storytelling. These methods, rooted in compassion, patience, and community care, helped participants reconnect with their experiences and share them in ways that felt both safe and healing.

Hope's facilitation also drew from her commitment to ancestral healing and mindfulness as pathways to collective well-being. Her integration of self-regulation practices supported participants in maintaining emotional balance and helped create a shared rhythm of reflection that allowed difficult stories to emerge with care. Her work demonstrated how BIPOC birthing experiences can be both studied and honored through culturally relevant, healing-centered practices.

Dr. Nadia DuBose's engagement as a Black birthing person and mother offered a culturally grounded relational framework that encouraged openness, empathy, and reflection. By sharing portions of her own birthing story in interview contexts, Nadia invited participants into a space of shared humanity and mutual respect. Participants often noted that her honesty and vulnerability helped them articulate their own experiences with greater clarity and confidence. Nadia's facilitation also drew upon culturally familiar expressions and affirming communication that built a sense of micro-community within the research setting. Through this work, she modeled what it means to center Black birthing knowledge as both data and truth.

Dr. Reese Kelly provided leadership in research design, data analysis, and thematic synthesis. His personal and professional expertise in gender, sexuality, and systems of inequity provided a critical analytic lens that illuminated LGBTQ+ birthing experiences. Dr. Kelly's analysis revealed that queer and transgender participants often faced disproportionately harmful and traumatic interactions within Vermont's maternal healthcare system, reflecting compounded bias and invisibility. This intersectional approach ensured that these experiences were not erased or generalized but recognized as an important component of the study's findings.

In this study, researcher proximity and shared identity functioned as cultural and relational capital rather than bias. Traditional white-centered research frameworks often treat proximity as a threat to neutrality. However, as Dr. DuBose's and Dr. Kelly's respective scholarship asserts, cultural knowledge and lived experience can serve as vital assets that deepen authenticity and understanding (DuBose Mitchell, 2021; Nordmarken & Kelly, 2014). Drawing from Winkle-Wagner (2010), culture operates as a form of currency in social spaces, where knowledge, norms, and shared references enable access, recognition, and inclusion. Within this framework, the researchers' lived experiences and identities became forms of intellectual and relational capital that strengthened the rigor, trust, and validity of the study.

Through this approach, the research team intentionally disrupted the notion of detached observation, positioning themselves as co-learners alongside participants. Their shared commitment to equity, healing, and accountability allowed the study to move beyond extraction toward transformation. Proximity, in this research, was both method and ethic: a deliberate strategy to ensure that the study honored the complexity, humanity, and resilience of BIPOC birthing people in Vermont.

Data Analysis Approach

The analysis process was guided by the principles of the transformative research paradigm, which positions inquiry as a tool for advancing justice, accountability, and systemic change (Mertens, 2009). The research team approached data analysis as an iterative, relational process grounded in rigor, cultural humility, and deep respect for participant voice. Throughout the analysis, the team engaged in reflexive practice, including ongoing reflection on positionality and potential biases, to support transparency and trustworthiness in interpretation. This approach aligns with established methods for applied thematic analysis in public health (Guest et al., 2012).

All qualitative data, including transcripts from focus groups and interviews, were reviewed in their entirety and coded thematically. Initial themes were generated, compared across researchers, and refined through multiple rounds of review. This process allowed for consistency while preserving the depth and nuance of lived experience.

Quantitative survey data were analyzed first and descriptively to identify patterns across Vermont's fourteen counties, including experiences related to accessibility, emotional and physical safety, and respect in care. These patterns informed the development of focus group and interview protocols, guiding the qualitative inquiry toward areas of greatest significance to participants.

The integration of quantitative and qualitative data produced a comprehensive understanding of birthing experiences among BIPOC participants. The survey illuminated broad trends, while the qualitative data revealed the emotional and relational dimensions underlying those patterns. For example, while many respondents rated their care experiences as positive, narrative accounts revealed a consistent undercurrent of dismissal, bias, and unmet emotional needs. This dual analysis underscored that emotional safety and trust are essential measures of quality care alongside clinical outcomes.

Reflexivity conversations were held among the research team to maintain accountability to the participant community (Guest et al., 2012). These discussions focused on ensuring that stories were represented with accuracy, integrity, and care, and that the analysis contributed to advancing justice rather than simply documenting disparity. The research team used these conversations to remain anchored in the voices and intentions of participants.

Through this combination of descriptive analysis, iterative thematic review, and reflexive dialogue, the findings of this study present a portrait of maternal care that is empirically grounded, emotionally resonant, and rooted in the lived experiences of BIPOC birthing people in Vermont.

Ethical Considerations

Ethical rigor and accountability to participants were central to every stage of this study. The research process was designed not only to protect participants from harm but also to honor their knowledge, agency, and emotional safety. The study was reviewed and approved by the Vermont Department of Health's Institutional Review Board (IRB), ensuring adherence to ethical standards for human subjects research.

The research team grounded all aspects of this study in trauma-informed, equity-based, and community-centered ethics. Participants were provided with clear and accessible information about the study's purpose, use of data, and voluntary participation. Informed consent was obtained prior to participation, and all identifying details were removed from transcripts and analysis to preserve confidentiality.

Emotional safety was prioritized throughout the data collection process. Focus groups and interviews were facilitated using practices that supported grounding, agency, and consent in real time. Participants were encouraged to share only what felt safe and meaningful to them. Facilitators checked in regularly to ensure that participants felt emotionally supported, and mindfulness-based grounding exercises were incorporated at the start and close of each session.

Participants were compensated for their time and expertise as a recognition of the value of their lived experience. This compensation was not transactional but rooted in a restorative framework that affirms participation as an act of community care and systems accountability.

The research team also acknowledged the emotional labor inherent in sharing stories of harm and resilience. Follow-up communication and resource referrals were made available to all participants. The study’s trauma-informed approach extended to the researchers themselves, who engaged in reflective debriefs after data collection to process emotional weight and ensure that the integrity of participants’ narratives was upheld with respect and care.

Throughout the project, equity and justice were not treated as procedural add-ons but as the foundation of ethical practice. The research team approached every decision with attention to power dynamics, cultural responsiveness, and relational accountability. This orientation ensured that the findings presented in this report reflect not only accurate data but also a deep respect for the humanity and dignity of the participants who entrusted their stories to this work.

Findings

Overview of Themes

Participants described a wide range of experiences with maternal health care in Vermont, from compassionate and affirming care to experiences that left them feeling dismissed, disrespected, or unsafe. While many participants expressed gratitude for individual providers who demonstrated care and attentiveness, they also illuminated persistent patterns of inequity and harm.

Some themes that emerged, such as communication challenges, access barriers, and postpartum gaps, are issues that affect the maternal health system more broadly and are not exclusive to BIPOC birthing people. However, for BIPOC participants, these challenges often carried additional emotional and structural weight. Racism, cultural bias, and systemic inequities compounded their experiences, creating greater vulnerability and distress. For many, even routine barriers or misunderstandings felt amplified by an undercurrent of racialized doubt.

Across interviews, focus groups, and surveys, participants described a recurring question that shaped how they interpreted their care: *"Is this happening because I am nonwhite?"* This internal questioning reflected both the cumulative effects of racial trauma and the invisibility many BIPOC birthing people experience within predominantly white healthcare systems. Even in cases where interactions were not overtly discriminatory, the absence of representation, cultural understanding, and explicit acknowledgment of race contributed to mistrust and emotional unease.

These findings reveal that maternal care in Vermont is shaped by two intersecting realities. Some challenges, such as communication, access, and coordination, are system-wide concerns that impact many birthing people across the state. Others, including bias, profiling, and inequitable treatment, are distinct to the experiences of BIPOC birthing people and emerge from deeply rooted systems of racial inequity. Together, they illustrate that while Vermont's maternal health outcomes may appear strong on clinical measures, the lived experiences of BIPOC birthing people reveal enduring gaps in emotional safety, inclusion, and trust.

The following themes present these experiences as described by participants, beginning with the strengths they identified in their care and continuing through the most frequently discussed challenges. Each theme captures participants' voices in their own words, offering an honest portrayal of how care felt, how systems responded, and what participants believe needs to change.

Theme 1: Positive Experiences — Relational Care and Community Support

Many participants described positive experiences that reflected compassion, respect, and connection. They spoke about providers who slowed down, listened, and explained procedures clearly. These moments created a sense of trust and safety that allowed participants to feel seen and valued.

One participant shared, “*When providers truly explained things and answered all my questions, I felt respected and safe.*” Another described how having a provider who shared her background created comfort and trust, stating, *“My OB looked like me, and that made me trust her. I did not have to explain myself.”*

Participants also highlighted the significance of doulas and community-based supports. Several noted that having a doula who understood their culture or language made an important difference in how they experienced care. As one person explained, *“Having a doula who understood my background made all the difference. She spoke my language, literally and culturally.”*

Family and community networks were described as essential sources of strength throughout pregnancy, birth, and recovery. Participants frequently mentioned that these supports provided guidance, reassurance, and emotional stability. One supporter shared, *“Having a support system, like family or community groups, really helps during pregnancy, especially when dealing with stress or feeling alone.”*

Participants also described specific experiences in which clinical environments felt welcoming and culturally attuned. One person recalled, *“The midwife asked about my culture and my past, and I felt seen for the first time.”* Others appreciated when staff used their names, offered clear information, or created an atmosphere that felt calm and inclusive.

These stories show that participants valued relational care and connection as much as clinical outcomes. When care was personalized, culturally responsive, and attentive to emotional safety, participants described feeling respected, supported, and confident in their birthing experience.

Theme 2: Communication Failures and Dismissed Pain

> ***“Nurses delivered a slew of information and left. No one stopped to put it in lay terms.”***

The most common concern across all data sources was being dismissed or unheard by healthcare providers. Participants described feeling rushed, ignored, or minimized when expressing pain or concern. This pattern created lasting mistrust and contributed to feelings of isolation and emotional harm.

One participant shared, *"Pain or concerns were dismissed. Sometimes I stopped sharing because it didn't change anything."* Another recalled, *"They may end up saying, 'It is normal,' which always disturbs me."*

Others described communication that felt one-sided or overwhelming. "*Nurses delivered a slew of information and left. No one stopped to put it in lay terms,"* one participant explained. Another added, *"I felt rushed during appointments or like decisions were being made without really including me in the conversations."*

Across experiences, participants emphasized that poor communication made them feel invisible and powerless at moments when reassurance and guidance were most needed.

Theme 3: Bias, Profiling, and Trust Gaps

Participants described encounters in which racial and cultural bias shaped how they were treated and perceived. Many expressed feeling judged or stereotyped, particularly around pain, finances, and compliance with medical instructions. These experiences eroded trust and reinforced the need for culturally responsive care.

One participant stated, *"I thought, if I was not a person of color, I would have gotten a clearer answer."* Another shared, *"They called my traditional remedy foolish. I am expected to trust the system over what has helped my family for generations."*

Some participants described being questioned or profiled in ways that felt invasive or discriminatory. *"The drug screen at preterm delivery felt weird. Now I wonder if I was profiled,"* one participant said. Another shared, *"A white midwife refused to see me. I felt unwelcome..."*

> **"The drug screen at preterm delivery felt weird. Now I wonder if I was profiled."**

These experiences reflected how bias and cultural misunderstanding can undermine care relationships and limit trust in healthcare systems.

Theme 4: Access Barriers and Navigation Challenges

Access to care was a consistent challenge, especially for participants living in rural areas or managing limited resources. Participants described barriers related to transportation, appointment availability, childcare, and financial strain.

"Transportation is a major barrier. Every appointment becomes a struggle," one participant explained. Another shared, *"Sleep study took approximately 4 weeks because clinics kept saying, 'Call them, not us.'"*

Participants also mentioned the difficulty of navigating multiple systems and facilities that did not communicate with one another. These logistical barriers increased stress and created delays in receiving care.

Theme 5: Cultural Competence and Representation Deficits

Participants repeatedly expressed the importance of receiving care from providers who understood their culture, language, and lived experiences. Many stated that they felt safer and more comfortable when their providers shared aspects of their identity or showed cultural humility.

"I wanted providers from my background so I could trust and open up," one participant explained. Another noted, *"Prenatal classes felt centered on white women. I couldn't see myself."*

Several participants identified the lack of racial and linguistic diversity among providers as a barrier to trust. "There are not enough doctors who look like or understand BIPOC patients," one participant stated.

Theme 6: Emotional Trauma and Psychological Impacts

More than half of all respondents described their birth as traumatic. Participants spoke about grief, fear, and lasting emotional pain, even when births were medically uncomplicated.

"I cried for a day after discharge, grieving another traumatic birth; I'm still in therapy twice a week seven months later. It was that heavy," one participant said.

Participants also connected their emotional trauma to not being heard or supported during critical moments. These experiences reflected the emotional toll of feeling unseen and disempowered during birth.

> ***"I cried for a day after discharge, grieving another traumatic birth."***

Theme 7: Information Deficiencies and Health Literacy Barriers

Participants wanted clearer and more practical information about their care. Many described confusion about medical terminology, uncertainty about when to seek help, and difficulty understanding instructions provided in rushed or technical language.

"I panicked with jaundice. What signs mean urgent care versus watch and wait?" one participant asked. Another explained, *"They did not translate jargon. I needed lay terms, time to absorb, and room for questions."*

Participants emphasized that accessible, plain-language communication is essential to informed decision-making and emotional calm during pregnancy and postpartum recovery.

Theme 8: Reduced Autonomy and Decision-Making

Many participants described feeling pressured into medical procedures or interventions without clear consent or full understanding. Several noted that their preferences were ignored or overridden, particularly around cesarean deliveries and vaginal birth after cesarean (VBAC) options.

"They strapped me up for surgery while I was still deciding," one participant said. Another shared, *"I said I did not want trainees closing my C-section, but they let a resident do it anyway."*

These accounts reveal that participants often felt excluded from decision-making processes that directly affected their bodies and births.

Theme 9: Postpartum Support Gaps and Neglected Maternal Care

Participants described significant gaps in postpartum support. Many felt that once their babies were delivered, their own recovery and emotional needs were overlooked.

"The concentration was more on my baby. There was no time for me," one participant shared. Another reflected, *"At home I had to replicate hospital help because once you discharge, it is gone."*

Participants emphasized the need for continued care focused on maternal recovery, mental health, and practical support during the postpartum period.

Theme 10: Policy Rigidity and Systems-First Practices

Participants described systems and policies that felt inflexible, punitive, or centered on institutional convenience rather than individual well-being. Hospital procedures were often experienced as impersonal or lacking empathy.

One participant recalled, "*We failed the car seat test and were told to find another one. No one offered a solution.*" Another described, *"An algorithm said no VBAC. It felt like a system decision, not mine."*

"We failed the car seat test and were told to find another one. No one offered a solution"

These accounts highlighted frustration with protocols that prioritize rules over relationships and efficiency over dignity.

Theme 11: Coordination Breakdowns and System Navigation Burdens

Many participants reported difficulty coordinating care across different providers and facilities. They described communication breakdowns, delayed referrals, and unclear follow-up instructions that left them responsible for managing complex care systems.

"I had to get a patient advocate because no one was replying. I was bounced between practices," one participant said. Another explained, *"Changes my endocrinologist made did not show up for the unit nurses. I could not eat for hours."*

These experiences underscored how fragmented communication within healthcare systems can create unnecessary stress and risk.

Theme 12: Pain Management Inequities and Unaddressed Suffering

Participants reported unequal treatment in how their pain was assessed and addressed. Several shared experiences of having pain minimized or medication withheld.

"I told them I could feel everything before surgery, they pushed ahead anyway"

Regarding receiving a pain medication dosage as prescribed, one participant recalled that "A young nurse said, 'I will just give you half,' after a C-section." Another shared, *"I told them I could feel everything before surgery. They pushed ahead anyway."*

Participants described these experiences as physically and emotionally distressing, reinforcing feelings of being undervalued or disbelieved.

Theme 13: Chronic Condition Management Failures

Participants managing chronic conditions, such as diabetes, described frustration with hospital protocols that ignored or overrode their established care routines.

"I have managed Type 1 diabetes for twenty-five years. They took control and the system was hit or miss," one participant shared.

These participants often felt that their expertise about their own health was dismissed, leading to stress, confusion, and extended recovery times.

Regional Patterns

The regional findings illuminate both the diversity and the disparity of birthing experiences across Vermont. Counties such as Washington and Addison reflect encouraging trends in respect, communication, and provider cultural humility, suggesting that culturally responsive practices are already taking root in parts of the state. Other regions, however, reveal pronounced inequities that warrant targeted intervention.

Essex County, in particular, demonstrates lower-than-average experiences across most indicators, underscoring the compounded effects of rural isolation, limited provider availability, and potential racial or cultural bias. These disparities show that equitable maternal health outcomes cannot be achieved through uniform statewide strategies alone. Improvement efforts must be locally responsive, grounded in regional data, and co-created with community voice to ensure that strategies reflect the realities of each area.

Integrating these regional patterns into strategic planning and implementation will allow Vermont's maternal health system to identify successful practices worth replicating and regions requiring immediate investment in trust-building, access, and cultural safety. Locally tailored approaches supported by shared accountability at the state level offer the most promising path toward a maternal health system that is both equitable and effective across Vermont's diverse communities.

Conclusion to Findings

Taken together, these findings provide a textured account of both strength and struggle within Vermont's maternal health landscape. Participants' stories reveal systems that can offer moments of care, compassion, and belonging, yet also reproduce patterns of exclusion, bias, and harm. The consistency of these themes across interviews, focus groups, and surveys underscores that the inequities experienced by BIPOC birthing people are not isolated incidents but reflections of broader systemic conditions.

The next section moves beyond description to examine what these findings mean within Vermont's maternal health system. The analysis explores how the interplay of racism, geography, culture, and institutional practice shapes both emotional and physical safety, and how equity and justice can be advanced through intentional policy and practice change.

Analysis and Discussion

Overview

The findings of this study reveal both the persistence of systemic inequities and the extraordinary resilience of BIPOC birthing people in Vermont. While some participants experienced care that was compassionate and culturally attuned, far more described an ongoing struggle to be seen, heard, and respected. Their stories highlight the distance between technical competence and human connection, and they demonstrate that emotional safety is as essential as clinical safety in the birthing experience.

Across interviews, focus groups, and surveys, the data suggest that many of the challenges described by BIPOC birthing people are not isolated to individual encounters but are symptoms of broader structural conditions—policies, norms, and practices that perpetuate inequity even in a state that prides itself on progressivism. Vermont's small and largely rural context adds another layer of complexity. Geographic distance, limited provider options, and the social isolation that comes with being a person of color in predominantly white spaces all magnify the effects of bias and reduce opportunities for trust-building.

At the same time, this study reveals a consistent undercurrent of self-advocacy, community care, and faith in the possibility of change. Participants were not asking for perfection; they were asking to be treated as whole people. Their words point to what makes care work: clear communication, shared decision-making, continuity of relationships, and visible commitment to equity. When these conditions were met, birthing experiences were described as healing, even transformative.

Emotional Safety as a Core Indicator of Quality Care

One of the clearest insights from this study is that emotional safety often matters as much as, or more than, physical safety. Participants repeatedly distinguished between being medically safe and feeling emotionally secure. Many expressed that even when procedures went well, the absence of empathy, transparency, or respect left a lingering sense of harm. This distinction challenges Vermont's prevailing perception that strong clinical outcomes alone indicate equitable care.

Emotional safety is relational. It emerges from communication, respect, and trust. Participants described feeling most secure when providers slowed down, explained procedures in plain language, acknowledged uncertainty, and included them in decisions. Conversely, rushed interactions, dismissive tones, or assumptions about their knowledge or lifestyle produced lasting trauma. This finding aligns with national research showing that perceived disrespect and poor communication are key predictors of negative maternal experiences and that such experiences disproportionately affect Black, Indigenous, and other birthing people of color (Odems et al., 2024; Chin et al., 2021)

Researcher Proximity as Credibility

This study also demonstrates the importance of proximity and representation in both care and research. Within traditional frameworks, researcher distance is seen as a marker of objectivity. Yet in equity-based, community-engaged research, proximity is a source of credibility and connection. The involvement of Hope Elliott and Dr. Nadia DuBose, both Black birthing people whose personal and cultural experiences informed their facilitation, proved foundational to the study's depth and authenticity. Their ability to hold trauma-informed space, share personal narratives when appropriate, and build cultural safety fostered trust that made open storytelling possible.

This approach rejects the notion that empathy and identity compromise rigor. Instead, it affirms that for historically marginalized populations, shared experience enhances rigor by surfacing truths that distance often obscures. In this sense, the positionality of the research team was not a bias to be minimized but a form of relational capital, a strength that advanced understanding, healing, and accountability.

Systemic Bias and Structural Inequities

While individual providers play an important role, participants' experiences point to the deeper systems that shape those encounters. Inconsistent protocols, lack of coordination between clinics, and rigid institutional policies frequently created barriers to equitable care. For example, participants described the "pass-fail" nature of hospital procedures such as car seat checks, discharge timelines, or algorithm-based decision tools that left little room for dialogue or individualized care. These systems often prioritized compliance over compassion and efficiency over empathy.

Additionally, participants' letters revealed how cultural disconnects in Vermont's healthcare environments can exacerbate feelings of alienation. Physical spaces rarely reflected community diversity, and many participants saw little evidence of representation among staff or leadership. When inclusion is invisible, belonging feels structurally unattainable. This invisibility compounds racial stress and undermines trust, even when overt discrimination is absent.

The Weight of Compounded Marginalization

This study underscores that inequities in maternal care do not operate in isolation. For BIPOC birthing people in Vermont, race intersects with gender, geography, income, language, and sexual orientation to create a compounded burden of exclusion. Participants who identified as bisexual or Latina/o/x reported disproportionately higher rates of trauma and emotional distress, suggesting that intersecting marginalizations heighten vulnerability to both bias and neglect.

This compounded nature of inequity reinforces the importance of intersectional frameworks in policy and practice. Efforts to improve maternal health must address not only race but also the overlapping systems of oppression that shape each person's experience. Equity cannot be achieved through single-axis interventions; it requires a holistic reimagining of care that recognizes complexity as the norm rather than the exception.

Trust, Belonging, and the Conditions for Healing

Trust emerged as one of the most consistent and powerful themes throughout this study. Participants described trust not as a static state but as something built through small, cumulative acts—listening without judgment, calling people by name, keeping promises, and acknowledging harm when it occurs. In healthcare environments, these moments carry extraordinary weight, particularly for BIPOC birthing people who often navigate systems that have historically marginalized or dismissed them.

For many, trust was undermined long before entering the delivery room. Past negative encounters with healthcare providers, perceived racial bias, and the broader social experience of isolation as a person of color in Vermont all shaped expectations for care. Participants frequently reported lowering their expectations or emotionally "bracing" themselves for harm. This anticipatory stress adds an invisible burden that not only affects mental well-being but can also influence physiological outcomes, as research on weathering and racialized stress has shown.

Conversely, when participants encountered providers who demonstrated humility, respect, and continuity, trust deepened and outcomes improved. They described feeling calmer, more capable, and more engaged in their care. These findings affirm that equity and trust are not separate domains of quality but mutually reinforcing. The conditions that enable trust, representation, transparency, and respect, are the same ones that produce better health outcomes.

Institutional Accountability and Systemic Change

Participants' experiences also point to a persistent gap between institutional intention and lived reality. Vermont's healthcare institutions often express commitments to diversity, equity, and inclusion, yet these commitments have not been consistently translated into policy, accountability, or measurement. Without mechanisms for transparency and follow-through, equity remains aspirational.

Many participants described experiences of bias or cultural insensitivity that were not only interpersonal but institutional. In some cases, hospitals lacked clear processes for reporting discrimination or consent violations; in others, families who did report harm received no follow-up. This absence of visible accountability undermines trust not only in specific providers but in the healthcare system as a whole.

A key lesson from this study is that accountability must be relational as well as procedural. Policies alone cannot restore trust; institutions must demonstrate responsiveness in real time and ensure that families see evidence of learning and change. Participants repeatedly emphasized that acknowledgment of harm, apology, and clear communication about next steps are as important as the resolution itself. In this sense, accountability is a form of care. It communicates respect, integrity, and shared humanity.

Community, Cultural Knowledge, and Collective Care

The letters and focus groups also revealed a profound longing for community-centered models of care that extend beyond the medical system. Participants expressed a desire to reconnect birthing with collective support, family networks, doulas, cultural traditions, and peer spaces that affirm identity and belonging. Many voiced frustration that Western medical models treat pregnancy and birth as isolated medical events rather than as deeply social and cultural processes.

For BIPOC families, this disconnect can be especially harmful. It not only erases cultural knowledge but reinforces dependence on systems that may not feel safe or affirming. Participants envisioned an alternative in which Vermont invests in community-rooted care, recognizes ancestral and cultural wisdom as legitimate forms of expertise, and redistributes resources toward trusted local networks.

Rebuilding community as part of the birthing ecosystem is also an equity strategy. When care is shared, responsibility and knowledge are shared too. Community-based programs, peer navigators, and culturally specific supports not only reduce isolation but act as protective factors against trauma. They help transform care from a transactional process into a relationship of solidarity and mutual accountability.

A State Context of Contradiction

Vermont occupies a complex position in the national landscape of maternal health. Clinically, outcomes for pregnancy and birth are relatively strong, yet this data often obscures the inequities that BIPOC families experience on emotional and systemic levels. The prevailing narrative that Vermont “does not have these problems” reflects a broader challenge: when inequities are less visible statistically, they are easier to dismiss socially.

This study disrupts that comfort. It shows that inequity is not always reflected in mortality data but in the emotional and psychological costs borne by marginalized communities. In a small and predominantly white state, even subtle forms of bias can have profound effects because systemic isolation and the scarcity of culturally safe spaces compound their impact. These experiences are not the result of individual sensitivity but of structural conditions that limit opportunities to recover, seek support, or find validation. A commitment to equity, therefore, must move beyond avoiding harm toward intentionally creating conditions of belonging.

From Understanding to Action

Taken together, these insights call for a transformation in how Vermont defines, measures, and practices maternal care. They urge a shift from procedural compliance to relational accountability, from isolated encounters to coordinated systems of support, and from performative equity statements to tangible redistribution of power and resources.

The data and analysis reveal systemic patterns of inequity. However, the meaning of those patterns is best understood through the people who live them. The following section shares the words of BIPOC birthing people, partners, and supporters who wrote directly to Vermont's leaders. Their voices transform statistics into stories and evidence into purpose, reminding us that every finding in this report reflects a lived reality.

Voices to Vermont Leaders: Letters from BIPOC Birthing People

As part of this study, participants were invited to write letters directly to Vermont's leaders, describing their experiences with pregnancy, birth, and postpartum care and sharing their visions for a more just and supportive maternal health system. These letters were written in participants' own words and speak to both the challenges and the possibilities within Vermont's healthcare landscape.

They are deeply personal, but they are also civic. Each letter represents a direct appeal to policymakers, healthcare leaders, and community partners to act with urgency, compassion, and accountability. These messages illuminate the everyday realities of birthing in Vermont as a BIPOC person, such as what it feels like to be unseen, unheard, or dismissed, and what families believe must change.

The letters also express profound hope. Participants spoke not only about the harms they experienced, but about what care should look like when it is rooted in dignity, trust, and belonging. Their reflections are the foundation of this report's recommendations and are presented here as a collective voice to guide policy and practice. Full Letters are provided in Appendix F.

What Families Advise, in Their Own Words

Theme	In Their Words
Respect and Autonomy	"Let people make decisions about their own bodies." "Respect consent boundaries." "Explain risks clearly, but also listen and respect their choices."
Communication and Trust	"Keep speaking up." "Bring a support person." "Ask for second opinions when something doesn't feel right." "Being medically safe is not the same as feeling supported."
Cultural Belonging and Representation	"Get the basics right—names, signage, and staff training all communicate who belongs and who doesn't." "We need providers who understand or represent BIPOC birthing parents." "Employing equivalent numbers of both Black and white midwives and OB-GYNs will make families feel seen and cared for."

System Accountability and Empathy	"I wish my fears and insecurities had been recognized as valid." "I needed someone to sit with me, walk me through what was happening in my body, and check on how I was coping mentally." "Our consent should be counted and valued."
Access and Equity	"Long travel distances to birthing centers and limited mental health support have been challenges for many." "We need consistent follow-up, culturally sensitive care, and real education around pregnancy complications." "Affordable care and transportation make all the difference."
Community-Based Support	"Having a professional healthcare provider who can care for you both mentally and physically matters." "Ask the community health workers to help rural people who are pregnant and have little knowledge on what to do." "We need more resources that come from our communities, not just hospitals."

Together, these letters offer more than reflection; they form a community-defined policy agenda grounded in lived experience. Participants called for culturally responsive care, stronger community networks, and systems that honor both the physical and emotional dimensions of birthing. Their voices affirm that the path to equity begins with listening and continues through accountability.

These narratives do not stand apart from the findings—they are the connective tissue that links data to meaning. They should be regarded as more than testimony; they are a roadmap for action. The Vermont Department of Health and its partners can use them to inform equitable policy development, guide statewide maternal health implementation, and shape institutional reforms that advance justice and belonging. They also serve as a powerful resource for provider education, community dialogue, and quality improvement, ensuring that the wisdom of BIPOC birthing people continues to shape decisions about care, policy, and investment.

The next section translates these lessons into a set of actionable, community-informed recommendations. Each recommendation is grounded in participant voice and designed to move Vermont's maternal health system toward a future where every birthing person is safe, seen, and supported in both body and spirit.

Recommendations

Overview: From Voices to Action

The recommendations that follow are grounded in the voices and lived experiences of BIPOC birthing people, partners, and supporters who participated in this study. They represent not only what participants identified as essential for equitable care, but also how Vermont's maternal health system can respond in ways that are just, accountable, and sustainable.

Participants consistently emphasized that the most significant and lasting change will occur when healthcare systems truly listen to communities, act transparently, and share power in decision-making. The recommendations therefore move beyond clinical or procedural adjustments to address the structural, cultural, and relational dimensions of care. They highlight what participants said works—trust, communication, representation, and connection—and identify what must change to ensure that these conditions are not exceptions but the norm.

Central to these recommendations is the call for an implementation plan that delineates specific partnerships across Vermont's maternal health ecosystem. This plan should identify the state agencies, healthcare institutions, community-based organizations, and family-led networks best positioned to take collective responsibility for advancing maternal health equity. Implementation must be guided by participant voice at every stage, ensuring that the same people who informed this study continue to shape the actions and accountability that follow.

The recommendations are organized into seven priority areas that reflect interconnected opportunities for transformation across systems, practice, and community:

1. Center Trust, Transparency, and Shared Decision-Making in Provider-Patient Relationships
2. Name and Address Bias and Racism as Core Barriers to Equitable Care
3. Prioritize Emotional Safety and Postpartum Well-Being
4. Expand Equitable Access, Navigation, and Continuity of Care
5. Advance Representation and Workforce Equity
6. Build Systems of Accountability and Belonging
7. Develop a Participant-Guided Statewide Implementation Plan

1. Center Trust, Transparency, and Shared Decision-Making in Provider–Patient Relationships

Participants identified communication and shared decision-making as the most important indicators of quality care. They described how clear explanations, compassionate listening, and respect for cultural expression built trust and understanding. Conversely, rushed interactions or unclear information left them feeling powerless and unheard.

Recommendations:

- Standardize communication and consent practices across Vermont's birthing facilities to ensure care is transparent, respectful, and culturally responsive.
- Use structured care plans and decision aids to support patients in leading the decision-making process and in understanding all available options, including the option to defer a procedure or intervention.
- Ensure adequate time and space during appointments for patients and their support people to discuss decisions, ask questions, and reflect without pressure.
- Integrate interpretation services and plain-language educational materials across all stages of care to promote equitable understanding and informed consent.
- Co-design patient education materials with BIPOC birthing people so language, imagery, and content reflect cultural, linguistic, and spiritual diversity.

2. Name and Address Bias and Racism as Core Barriers to Equitable Care

Participants described how unexamined bias, microaggressions, and systemic racism undermined trust and safety during pregnancy, birth, and postpartum care. They emphasized that communication and respect are inseparable from equity—when bias goes unacknowledged, it becomes a form of harm. Building an accountable culture requires providers and institutions to recognize, discuss, and actively address racism in obstetric care.

Recommendations:

- Build conscious awareness of bias among all perinatal care providers through ongoing reflection, training, and peer dialogue that center lived experience and accountability.
- Create safe mechanisms for discussing and addressing obstetric racism within healthcare teams, including case reviews, staff debriefs, and restorative learning processes when harm occurs.
- Require equity and anti-racism education as a core competency for licensing, credentialing, and continuing professional development.
- Integrate trauma-informed and bias-interruption practices into daily care routines to reduce harm and promote psychological safety for patients and providers alike.
- Model transparent leadership accountability by requiring institutions to measure and report on equity outcomes, demonstrating that anti-racism is both clinical and organizational responsibility.

3. Prioritize Emotional Safety and Postpartum Well-Being

Across the data, emotional safety emerged as a priority equal to physical safety. Participants described experiences of fear, dismissal, or anxiety that left lasting emotional impacts—often more traumatic than the clinical aspects of birth itself. They also described feeling unseen after delivery, with postpartum care focused almost entirely on the baby rather than the birthing person.

Recommendations:

- Make emotional and psychological safety core indicators of perinatal quality and include them in statewide maternal health standards.
- Integrate trauma-informed and mindfulness-based practices into all stages of care, supporting both patients and providers in managing stress and promoting healing.
- Adopt a dyad-care model that recognizes both the birthing person and the infant as the center of care, promoting coordinated attention to the health and emotional needs of both.
- Ensure postpartum visits address physical recovery as well as mental and emotional well-being, providing time for meaningful dialogue about healing, fatigue, and adjustment.
- Offer early postpartum home visits for families, especially those with limited support, ensuring connection to community-based services and resources.
- Include standardized and comprehensive postpartum screening for depression, anxiety, substance use, and social isolation, in every postpartum encounter with special attention to the compounding impact of isolation among BIPOC birthing people in Vermont.

4. Expand Equitable Access, Navigation, and Continuity of Care

Participants highlighted how rural geography, transportation challenges, and limited provider availability made accessing timely and coordinated care difficult. These structural barriers disproportionately affected BIPOC and low-income families.

Recommendations:

- Provide transportation and childcare support as part of prenatal and postpartum scheduling to ensure equitable access to care.
- Make clinical environments more accessible and child-friendly, recognizing that many families face logistical and caregiving challenges when seeking care.
- Expand telehealth for non-urgent visits, education, and follow-up appointments, particularly in rural areas.
- Develop referral systems with clear guidance on follow-up and a closed-loop process to confirm that patients successfully connect with needed services.

- Integrate clinical and community supports to ensure coordination across hospitals, community clinics, public health programs, and trusted community partners.
- Establish dedicated care navigators for families receiving services across multiple providers to promote continuity, trust, and timely communication.

5. Advance Representation and Workforce Equity

Representation in care delivery was identified as a cornerstone of trust. Participants described how having providers who shared their racial, cultural, or linguistic background created a sense of safety and understanding that improved care outcomes. The lack of diversity in Vermont's healthcare workforce was seen as both a symptom and cause of inequity.

Recommendations:

- Prioritize recruitment and retention of BIPOC healthcare providers, nurses, midwives, and doulas in all Vermont healthcare systems.
- Create educational pipelines and scholarships for aspiring BIPOC birth workers, including doulas, nurses, midwives, and obstetric providers.
- Highlight provider profiles that reflect cultural and linguistic competencies so patients can make informed choices about their care.
- Embed ongoing professional learning in equity, anti-racism, and cultural humility for all perinatal staff.
- Fund mentorship programs to support BIPOC providers and promote leadership within Vermont's maternal health workforce.

6. Build Systems of Accountability and Belonging

Participants expressed the need for systems that recognize and respond to harm when it occurs and create environments that reflect Vermont's racial and cultural diversity. Accountability and belonging are fundamental to trust and are essential for systemic change.

Recommendations:

- Establish confidential, accessible mechanisms for patients and providers to report bias, consent violations, or unsafe experiences, with clear anti-retaliation policies and visible follow-up.
- Expand and strengthen existing structures such as the Parent and Family Advisory Committee (PFAC) of the Prenatal Quality Collaborative (PQC-VT) to serve as a trusted avenue for patient voice, feedback, and systems learning across birthing hospitals.
- Publish de-identified summaries of bias reports and institutional responses to promote transparency and accountability.
- Regularly audit healthcare environments for inclusivity, ensuring signage, imagery, and language reflect the diversity of Vermont families.

- Partner with community-based organizations to design environments and messaging that promote belonging and affirm the dignity of all families.
- Integrate equity metrics into state-level maternal health reporting systems to monitor and publicly track progress over time.

7. Develop a Participant-Guided Statewide Implementation Plan

The findings of this study make clear that change must move beyond recommendations to coordinated and accountable action. Implementation should be intentional, inclusive, and grounded in the ongoing leadership of those most impacted by inequities. Implementation planning should draw from participant letters to legislators, which outline concrete priorities in participants' own words. These letters are a blueprint for community-defined accountability.

Recommendations:

- Develop an implementation plan that assigns roles and responsibilities across Vermont's maternal health network, identifying partners at the state, institutional, and community levels.
- Align the plan with existing statewide efforts, including the Early Childhood Strategic Plan and Maternal Health Innovation initiatives.
- Establish a shared accountability framework with measurable milestones and public progress reporting.
- Create structures for compensated participation of BIPOC birthing people and community representatives in every phase of planning and evaluation.
- Build sustained funding streams to ensure that equity and community engagement are embedded, not add-ons, to maternal health work in Vermont.

Next Steps

Together, these seven areas outline a path toward a maternal health system that is not only effective but equitable, relational, and just. The recommendations are grounded in the lived experiences of those most affected by systemic inequities and are guided by their visions for change. Realizing these recommendations will require courage, collaboration, and shared responsibility among healthcare systems, policymakers, and communities.

The next phase must focus on collaborative implementation planning that centers the voices of those most affected—the BIPOC birthing people who generously shared their stories in this study. Aligning this work with existing statewide strategic efforts will ensure coherence, sustainability, and shared accountability across Vermont's health systems.

The Vermont Department of Health and the Perinatal Quality Collaborative Vermont have endorsed and are supporting the implementation of the *Association of Women's Health, Obstetric and Neonatal Nurses' (AWHONN) Respectful Maternity Care Framework and Practice Guidelines* across all of Vermont's birthing hospitals, home health agencies, and local health offices. This framework and its accompanying toolkit provide actionable, patient-centered strategies rooted in dignity, autonomy, respect, and shared decision-making. These practices directly respond to the findings of this study and offer a clear, evidence-based foundation for statewide implementation of the recommendations within.

Together, these priorities chart a path toward a maternal health system that is equitable, relational, and just—one that honors trust, representation, and belonging as essential to health and healing.

Conclusion

This study offers a detailed and deeply human account of what maternal health care feels like for BIPOC birthing people in Vermont. It demonstrates that while clinical outcomes may appear strong, the emotional, cultural, and relational dimensions of care tell a different story. Participants described both moments of affirmation and connection, as well as experiences that reflected dismissal, bias, and structural inequity. The findings reveal that emotional safety, trust, and representation are not peripheral to healthcare quality; they are its foundation.

Through the voices of more than one hundred birthing people, supporters, and providers, this study illuminates patterns that extend beyond individual encounters. It shows how systemic barriers, cultural invisibility, and policy rigidity intersect to create disproportionate burdens for those already navigating racialized and marginalized identities. Yet, participants also revealed what is possible when care is grounded in compassion, community, and cultural responsiveness. These strengths offer a roadmap for transformation rooted in practices that already exist within Vermont's healthcare landscape.

The collective insights of this study reinforce a clear message: equity and justice in maternal health require more than good intentions. They demand structural change, ongoing accountability, and deep cultural humility. The voices in this report remind us that transformation begins with listening and continues through sustained action. Every provider, policymaker, and institution has a role to play in ensuring that BIPOC birthing people in Vermont experience care that honors their expertise, affirms their identity, and protects their physical and emotional well-being.

The Vermont Department of Health, along with its partners, has the opportunity to lead by example. Implementing the recommendations in this report can establish a model for equitable maternal health that is not only responsive to the realities of BIPOC birthing people but also reflective of Vermont's broader commitment to justice and community well-being.

Ultimately, this report is both documentation and invitation. It captures stories that have too often gone unheard and calls upon Vermont's maternal health system to respond with accountability, empathy, and sustained commitment. The path forward requires courage, collaboration, and the willingness to see equity not as an aspiration but as an obligation. By centering the lived experiences of those most affected, Vermont can move toward a maternal health system where every birthing person is safe, respected, and seen.

Acknowledgements

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We also acknowledge the lands and peoples on which this research took place, recognizing the Indigenous Abenaki communities whose presence and knowledge precede Vermont's colonial history. Their ongoing stewardship and resilience remind us that true justice in healthcare must be rooted in relational accountability to both people and place.

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Appendices

Appendix A: Survey Questions

SECTION 1: Welcome + Identity Screening

- **Are you 18 years of age or older?**
  ☐ Yes
  ☐ No → [End survey: "Thank you for your interest. However, you must be at least 18 years old to participate."]
- **Are you currently pregnant or have you given birth within the last two years?**
  ☐ Yes
  ☐ No → [End survey: "Thank you for your interest. However, this study focuses on BIPOC birthing individuals and providers of BIPOC birthing individuals in Vermont in the last two years."]
- **Do you identify as Black, Indigenous, or a Person of Color (BIPOC)?**
  ☐ Yes → [Go to question 4]
  ☐ No → [Go to question 5]
- **Did you live in Vermont during your pregnancy or postpartum period?**
  ☐ Yes
  ☐ No → [End survey: "Thank you for your interest. However, this study focuses on BIPOC birthing individuals and providers of BIPOC birthing individuals in Vermont in the last two years"]
- **Are you a Provider that offers services to BIPOC birthing people in Vermont?**
  ☐ Yes
  ☐ No → [End survey: "Thank you for your interest. However, this study focuses on BIPOC birthing individuals and providers of BIPOC birthing individuals in Vermont in the last two years"]
- **Are you interested in participating in a short survey about your experiences with pregnancy, birth, or postpartum care in Vermont?**
  ☐ Yes → [Proceed to survey]
  ☐ No → [Thank you and end]

SECTION 2A: BIPOC Birthing People
Perceptions and Experiences

1. Overall, how do you feel about your experience with maternal healthcare in Vermont?
   [Very positive, Mostly positive, Neutral, Negative, Very negative]
2. I felt respected during my interactions with maternal healthcare providers.
   [Strongly agree, Agree, Disagree, Strongly disagree, I don't know]
3. I felt physically safe during my perinatal healthcare experience.
   [Strongly agree, Agree, Disagree, Strongly disagree, I don't know]
4. I felt emotionally safe during my perinatal healthcare experience.
   [Strongly agree, Agree, Disagree, Strongly disagree, I don't know]
5. Would you describe your birthing experience as traumatic?
   [Yes, No, I'm not sure]
6. Based on my experience, my thoughts and concerns were included in decision-making about my care.
   [Strongly agree, Agree, Disagree, Strongly disagree, I don't know]
7. The healthcare providers and systems I engaged with reduced barriers for BIPOC individuals.
   [Strongly agree, Agree, Disagree, Strongly disagree, I don't know]
8. The healthcare providers and systems I engaged with promoted equitable outcomes for BIPOC individuals.
   [Strongly agree, Agree, Disagree, Strongly disagree, I don't know]
9. I believe the healthcare system cares about ensuring everyone receives the support and services they need.
   [Strongly agree, Agree, Disagree, Strongly disagree, I don't know]

Equity and Justice in Care

10. In your opinion, how important is it for Vermont's maternal healthcare system to focus on racial justice?
    [Extremely important, Very important, Moderately important, Slightly important, Not at all important]
11. In your opinion, how important is it for Vermont's maternal healthcare system to focus on social justice?
    [Extremely important, Very important, Moderately important, Slightly important, Not at all important]
12. Most maternal health providers are skilled in talking about race, racism, and how these affect care.
    [Yes, Moving in that direction, Not yet, I'm not sure]
13. Most maternal health providers demonstrate cultural humility and respectfully relate to individuals from diverse racial, ethnic, and cultural backgrounds.
    [Yes, Moving in that direction, Not yet, I'm not sure]

Access and Inclusion

14. The maternal health system is accessible to me (e.g., language services, appointment availability, transportation, physical/mobility).
    [Yes, Moving in that direction, Not yet, I'm not sure]
15. There is a visible effort to ensure the voices of BIPOC birthing people are centered and respected.
    [Yes, Moving in that direction, Not yet, I'm not sure]

Systemic Practices and Accountability

16. How would you describe the healthcare system's willingness to address racism and racial inequities in maternal care?
    [Very willing, Willing, Neutral, Hesitant, Not willing]
17. How would you describe the healthcare system's willingness to address inequities, broadly, in maternal care?
    [Very willing, Willing, Neutral, Hesitant, Not willing]
18. Are the goals of reducing racial disparities and barriers reflected in how maternal health resources are distributed?
    [Yes, Moving in that direction, Not yet, I'm not sure]
19. Do clinics and hospitals have plans to recruit and retain staff that reflect the racial demographics of the communities they serve?
    [Yes, Moving in that direction, Not yet, I'm not sure]
20. Are there regular trainings and discussions for healthcare staff on racial equity and culturally responsive care?
    [Yes, Moving in that direction, Not yet, I'm not sure]
21. Is there a process in place for patients to raise concerns about barriers or inequities in their care?
    [Yes, Moving in that direction, Not yet, I'm not sure]

→ Then go to Focus Group Section

SECTION 2B: Providers

Perceptions and Experiences

1. Overall, how would you describe the care your organization or practice provides to birthing people in Vermont?
   [Very positive, Mostly positive, Neutral, Negative, Very negative]
2. I believe that the birthing people I work with feel respected during their interactions with maternal healthcare providers.
   [Strongly agree, Agree, Disagree, Strongly disagree, I don't know]
3. I believe that birthing people feel physically safe during their perinatal healthcare experience.
   [Strongly agree, Agree, Disagree, Strongly disagree, I don't know]
4. I believe that birthing people feel emotionally safe during their perinatal healthcare experience.
   [Strongly agree, Agree, Disagree, Strongly disagree, I don't know]

5. My patients' thoughts and concerns are included in decision-making about their care.
   [Strongly agree, Agree, Disagree, Strongly disagree, I don't know]
6. The healthcare providers and systems I work within reduce barriers for BIPOC individuals.
   [Strongly agree, Agree, Disagree, Strongly disagree, I don't know]
7. The healthcare providers and systems I work within promote equitable outcomes for BIPOC individuals.
   [Strongly agree, Agree, Disagree, Strongly disagree, I don't know]
8. I believe the maternal healthcare system in Vermont cares about ensuring everyone receives the support and services they need.
   [Strongly agree, Agree, Disagree, Strongly disagree, I don't know]

Equity and Justice in Care

9. In your opinion, how important is it for Vermont's maternal healthcare system to focus on racial justice?
   [Extremely important, Very important, Moderately important, Slightly important, Not at all important]
10. In your opinion, how important is it for Vermont's maternal healthcare system to focus on social justice?
    [Extremely important, Very important, Moderately important, Slightly important, Not at all important]
11. Most maternal health providers in Vermont are skilled in talking about race, racism, and how these affect care.
    [Yes, Moving in that direction, Not yet, I'm not sure]
12. Most maternal health providers in Vermont demonstrate cultural humility and respectfully relate to individuals from diverse racial, ethnic, and cultural backgrounds.
    [Yes, Moving in that direction, Not yet, I'm not sure]

Access and Inclusion

13. The maternal health system in Vermont is accessible to the patients and communities I serve (e.g., language services, appointment availability, transportation, physical/mobility).
    [Yes, Moving in that direction, Not yet, I'm not sure]
14. There is a visible effort in my workplace or healthcare system to ensure the voices of BIPOC birthing people are centered and respected.
    [Yes, Moving in that direction, Not yet, I'm not sure]

Systemic Practices and Accountability

15. How would you describe the healthcare system's willingness to address racism and racial inequities in maternal care?
    [Very willing, Willing, Neutral, Hesitant, Not willing]
16. How would you describe the healthcare system's willingness to address inequities, broadly, in maternal care?
    [Very willing, Willing, Neutral, Hesitant, Not willing]
17. The maternal health programs or institutions I work within analyze data by demographics (e.g., income, language, disability status).
    [Yes, Moving in that direction, Not yet, I'm not sure]
18. The maternal health programs or institutions I work within analyze data by race.
    [Yes, Moving in that direction, Not yet, I'm not sure]
19. The goals of reducing racial disparities and barriers are reflected in how maternal health resources are distributed.
    [Yes, Moving in that direction, Not yet, I'm not sure]
20. The clinics and hospitals I work with have plans to recruit and retain staff that reflect the racial demographics of the communities they serve.
    [Yes, Moving in that direction, Not yet, I'm not sure]
21. There are regular trainings and discussions for staff on racial equity and culturally responsive care.
    [Yes, Moving in that direction, Not yet, I'm not sure]

22. There is a clear and effective process for patients to raise concerns about barriers or inequities in their care.
    [Yes, Moving in that direction, Not yet, I'm not sure]

Open Feedback

23. What are things that go well in your experience supporting birthing people? *(Open-ended)*
24. What challenges do you encounter in providing equitable maternal care? *(Open-ended)*
25. Is there anything we haven't asked that you feel is important for us to know? *(Open-ended)*
26. If you could change one thing to improve maternal health outcomes for BIPOC communities in Vermont, what would it be? *(Open-ended)*

→ Then go to Focus Group Section

SECTION 2C: Partners, Advocates, Others

Perceptions and Experiences

1. Overall, how would you describe the maternal healthcare experience of the person/people you supported in Vermont?
    [Very positive, Mostly positive, Neutral, Negative, Very negative]
2. I felt that the birthing person I supported was treated with respect by maternal healthcare providers.
    [Strongly agree, Agree, Disagree, Strongly disagree, I don't know]
3. I believe the birthing person I supported felt physically safe during their perinatal healthcare experience.
    [Strongly agree, Agree, Disagree, Strongly disagree, I don't know]
4. I believe the birthing person I supported felt emotionally safe during their perinatal healthcare experience.
    [Strongly agree, Agree, Disagree, Strongly disagree, I don't know]
5. The birthing person's thoughts and concerns were included in decision-making about their care.
    [Strongly agree, Agree, Disagree, Strongly disagree, I don't know]
6. The healthcare providers and systems we engaged with reduced barriers for BIPOC individuals.
    [Strongly agree, Agree, Disagree, Strongly disagree, I don't know]
7. The healthcare providers and systems we engaged with promoted equitable outcomes for BIPOC individuals.
    [Strongly agree, Agree, Disagree, Strongly disagree, I don't know]
8. I believe the healthcare system cares about ensuring everyone receives the support and services they need.
    [Strongly agree, Agree, Disagree, Strongly disagree, I don't know]

Equity and Justice in Care

9. In your opinion, how important is it for Vermont's maternal healthcare system to focus on racial justice?
    [Extremely important, Very important, Moderately important, Slightly important, Not at all important]
10. In your opinion, how important is it for Vermont's maternal healthcare system to focus on social justice?
    [Extremely important, Very important, Moderately important, Slightly important, Not at all important]
11. Most maternal health providers are skilled in talking about race, racism, and how these affect care.
    [Yes, Moving in that direction, Not yet, I'm not sure]
12. Most maternal health providers demonstrate cultural humility and respectfully relate to individuals from diverse racial, ethnic, and cultural backgrounds.
    [Yes, Moving in that direction, Not yet, I'm not sure]

Access and Inclusion

13. The maternal health system is accessible to the families I support or am connected with (e.g., language services, appointment availability, transportation, physical/mobility).
    [Yes, Moving in that direction, Not yet, I'm not sure]
14. There is a visible effort to ensure the voices of BIPOC birthing people are centered and respected.
    [Yes, Moving in that direction, Not yet, I'm not sure]

Systemic Practices and Accountability

15. How would you describe the healthcare system's willingness to address racism and racial inequities in maternal care?
    [Very willing, Willing, Neutral, Hesitant, Not willing]
16. How would you describe the healthcare system's willingness to address inequities, broadly, in maternal care?
    [Very willing, Willing, Neutral, Hesitant, Not willing]
17. Do maternal health programs and providers analyze data by demographics?
    [Yes, Moving in that direction, Not yet, I'm not sure]
18. Do maternal health programs and providers analyze data by race?
    [Yes, Moving in that direction, Not yet, I'm not sure]
19. Are the goals of reducing racial disparities and barriers reflected in how maternal health resources are distributed?
    [Yes, Moving in that direction, Not yet, I'm not sure]
20. Do clinics and hospitals have plans to recruit and retain staff that reflect the racial demographics of the communities they serve?
    [Yes, Moving in that direction, Not yet, I'm not sure]
21. Are there regular trainings and discussions for healthcare staff on racial equity and culturally responsive care?
    [Yes, Moving in that direction, Not yet, I'm not sure]
22. Is there a process in place for patients or families to raise concerns about barriers or inequities in care?
    [Yes, Moving in that direction, Not yet, I'm not sure]

Open Feedback

23. What went well in your experience supporting or advocating for a birthing person? *(Open-ended)*
24. What challenges did you observe or experience during their prenatal, birthing, or postpartum journey? *(Open-ended)*
25. Is there anything we haven't asked that you feel is important for us to know? *(Open-ended)*
26. If you could change one thing to improve maternal health outcomes for BIPOC communities in Vermont, what would it be? *(Open-ended)*

→ Then go to Focus Group Section

SECTION 3: Focus Group Participation

Would you like to participate in a 20-min individual or 1-hour group interview?

[Yes – Individual / Yes – Group / Maybe / No]

If yes or maybe, please share your:

- Name
- Phone
- Email

Participants will receive a $50 stipend. All data will remain confidential and coordinated by The Creative Discourse Group.

→ Then go to Demographic Section

SECTION 4: Demographic Information

All multiple choice unless otherwise noted.

1. What racial or ethnic categories best describe you? (Checkboxes – select all that apply)

- *Black or African American*
- *Hispanic or Latino/a/x*

- *American Indian or Alaska Native*
- *Asian*
- *Middle Eastern or North African*
- *Native Hawaiian or Other Pacific Islander*
- *White*
- *Multiracial*
- *Another identity (please specify): _______*
- *Prefer not to answer*

2. Do you identify as Hispanic or Latino/a/x? (Multiple choice)

- *Yes*
- *No*
- *Prefer not to answer*

3. What language(s) do you speak at home? (Checkboxes – select all that apply)

- *English*
- *Spanish*
- *French*
- *Somali*
- *Nepali*
- *Swahili*
- *Vietnamese*
- *Other (please specify): _______*
- *Prefer not to answer*

4. What is your preferred language for communication? (Multiple choice or short answer)

- *English*
- *Spanish*
- *French*
- *Other (please specify): _______*

5. What gender identities best describe you? (Checkboxes – select all that apply)

- *Woman*
- *Man*
- *Nonbinary*
- *Transgender*
- *Genderqueer / Gender non-conforming*
- *Another identity (please specify): _______*
- *Prefer not to answer*

6. How would you describe your sexual orientation? (Short answer OR multiple choice)

- *Straight / Heterosexual*
- *Lesbian*
- *Gay*
- *Bisexual*
- *Pansexual*
- *Queer*
- *Asexual*
- *Another identity (please specify): _______*
- *Prefer not to answer*

7. What is your age? (Multiple choice)

- *18–19*

- *20–24*
- *25–29*
- *30–34*
- *35–39*
- *40–44*
- *45–49*
- *50+*
- *Prefer not to answer*

8. Where do you live in Vermont?

- ***Town** (Short answer)*
- ***County** (Multiple choice)*
    - ○ *Addison*
    - ○ *Bennington*
    - ○ *Caledonia*
    - ○ *Chittenden*
    - ○ *Essex*
    - ○ *Franklin*
    - ○ *Grand Isle*
    - ○ *Lamoille*
    - ○ *Orange*
    - ○ *Orleans*
    - ○ *Rutland*
    - ○ *Washington*
    - ○ *Windham*
    - ○ *Windsor*
    - ○ *Prefer not to answer*

9. What is your current employment status? (Multiple choice)

- *Employed full-time*
- *Employed part-time*
- *Unemployed and looking*
- *Unemployed and not looking*
- *Self-employed*
- *Stay-at-home parent*
- *Student*
- *Other (please specify): _______*
- *Prefer not to answer*

10. What is your current monthly household income? (Multiple choice)

- *$0–499*
- *$500–999*
- *$1,000–1,999*
- *$2,000–2,999*
- *$3,000–3,999*
- *$4,000 or more*
- *Prefer not to answer*

11. What is your highest level of education? (Multiple choice)

- *Some high school*
- *High school diploma / GED*
- *Some college / technical training*
- *Associate's degree*

- *Bachelor's degree*
- *Master's degree or higher*
- *Prefer not to answer*

12. Do you have access to reliable transportation? (Multiple choice)

- *Yes*
- *No*
- *Sometimes*
- *Prefer not to answer*

13. What is your current housing status? (Multiple choice)

- *I own my home*
- *I rent my home*
- *I stay with friends/family*
- *I am unhoused or living outside*
- *I live in a motel*
- *I live in a shelter*
- *I live in a residential treatment home*
- *Other (please describe): _______*
- *Prefer not to answer*

14. Who do you currently live with? (Checkboxes – select all that apply)

- *I live alone*
- *My spouse or partner*
- *Some of my children*
- *All of my children*
- *My stepchild or stepchildren*
- *Other family members (e.g., parents, siblings)*
- *Friends*
- *Other (please describe): _______*
- *Prefer not to answer*

15. What is your marital status? (Multiple choice)

- *Single*
- *Married*
- *In a domestic partnership*
- *Divorced*
- *Widowed*
- *Prefer not to answer*

16. Is there anything else you'd like us to know about your identity, background, or experience?

-

SECTION 5: Pregnancy Screening (Only for Birthing People)

- Are you currently pregnant?
  [Yes / No / Prefer not to answer]
- If yes, how many weeks pregnant are you?
  [1–13, 14–27, 28–40+, Prefer not to answer]
- Is this your first pregnancy?
  [Yes, No, Prefer not to answer]
- When did you last give birth? *(Date or month/year)*
- How many children have you had?

Appendix B: Focus Group and Interview Guides

1. **Overview + Informed Consent [10 min]**
    - *Share and review the **INFORMED CONSENT** doc.*
    - *Obtain a verbal YES from all participants.*
    - Express appreciation for participant presence and participation.
    - *Invite to be mindful to take space and make space.*
    - *Explain electronic $50 Visa Gift Cards - to be distributed early next week.*

2. **Introductions [10 min]**

    Introduce yourself and invite participants to introduce themselves
    - *Name, how you'd like to be addressed (e.g. pronouns, nickname, first name only)*
    - *Where you live in VT.*
    - *And if you would like, feel free to share something about your family so we can start to get to know each other.*

3. **Discussion [40 min]**

    Begin the discussion (15 min)
    - *BIPOC birthing parents were recently surveyed to identify what went well with their prenatal, birthing, and perinatal experiences and what difficulties they experienced. As I read through some of the main ideas we heard, note the phrases that ring true for you. If none of them fit, think of a different phrase that describes something that went well or a difficulty you faced.*
    - *Let's go around and hear from each person one or two words or phrases that stood out to you.*
    - Invite a few people to share their stories with the full group.

    Deepen the discussion (25 min)

    Invite several participants to share their experiences
    - *We've heard from some people ways in which birthing parents felt supported and treated with dignity and respect by their providers, hospitals, and staff.*
        - *What are some of the experiences you have had where you may have felt supported or treated with dignity and respect by your provider, hospital, or staff?*
    - *We've also heard from BIPOC birthing parents ways in which providers, hospitals, and/or staff were dismissive of their needs or concerns.*
        - *What are some of the experiences you have had where you have felt like your needs or concerns were dismissed or unmet by providers, hospitals, or staff?*
    - Optional question: *What's one piece of advice you'd give to others who are dealing with a similar situation?*

4. **Gathering Feedback - Letter Writing Activity [20 min]**

    Introduction (2 min)

    Now we're going to spend some time writing letters. This is your chance to communicate directly with decision-makers — legislators, community leaders, and partners who are working to make birthing experiences better for BIPOC Vermonters.

    You can write as much or as little as you'd like. The prompts are just a guide, not a requirement. And there are a few different ways you can create your letter:
    - *You can handwrite it and later send us a photo.*
    - *You can type it directly into the Google Form or Doc I'll share.*
    - *Or you can record yourself reading your letter out loud and send us the audio or video file afterward.*

    Share in Chat (1 min)

    Post the prompts in the chat along with the link to the google form.

- *Please use whichever works best for you. Remember, if you handwrite your letter or record yourself, send your file to* ***nadia@thecreativediscoursegroup.com*** *after this session.*

Writing Time (10–12 min)

- Let's take about 10 minutes to work quietly. Feel free to turn your camera off if that helps you focus. I'll give you a halfway reminder.
- [At 5–6 min in] — You have about 5 minutes left. Wrap up your thoughts or add anything else you'd like to include.

Optional Sharing (3–4 min)

- If anyone would like to share part of their letter, you're welcome to unmute and read it now. This is completely optional.
- [After 2–3 shares, or if no one volunteers] — "Thank you to those who shared, and thank you all for the work you've just put into this. Your voices matter.

Closing and Collection (2–3 min)

Before we close, here's what happens next:

- If you typed in the form, we already have your letter.
- If you wrote it by hand, please take a photo and email it to **nadia@thecreativediscoursegroup.com**.
- If you recorded audio or video, please send that file to the same email.

Your words *may* be shared with legislators, read aloud in meetings, or included in reports — always in line with the consent options you choose. You'll see those options in the form, or you can include your preference in your email.

Thank you so much for your powerful contributions.

5. Wrap Up [10 min]

- Thank people for being part of the conversation and let them know that *Nadia will disseminate Gift Cards next week. Reach out to her if you have questions.*
- Provide a group closing of the facilitators choosing.

Appendix C: Participant Demographics Summary

Total Participants = 140

- Survey = 112
- Focus Groups = 22 (5 total groups)
- Interviews = 6

Survey Demographics

Data Notes:
1. Due to low numbers of providers and supporters, their demographic data is not included. For the same reason, this section does not provide a town-level breakdown of respondents.
2. To not overweight percentages - all percentage totals = 99%; All percentages are rounded down.
3. Participants were screened into different survey tracks including "pregnant/recently pregnant," "partner, advocate, community member," and "healthcare provider" and received only questions relevant to their group.

Relationship to maternal healthcare

- Pregnant/Recently pregnant n=99 (88%)
- Healthcare provider: n=2 (2%)
- Partner, advocate, or community member: n=9 (8%)
- Other: n=2 (2%)

Demographics of Pregnant/Recently Pregnant Survey Respondents (n=99)

What racial or ethnic categories best describe you?

American Indian or Alaska Native	4%
Asian, Native Hawaiian or Other Pacific Islander	3%
Asian, Native Hawaiian or Other Pacific Islander & White	1%
Black or African American	77%
Black or African American & Hispanic or Latino/a/x	4%
Black or African American, Hispanic or Latino/a/x & Multiracial	2%
Hispanic or Latino/a/x	4%

Are you currently pregnant? If yes, how many weeks are you?

Yes	55%
○ 1-14	18%
○ 14-27	34%
○ 28-40+	2%
○ No Answer	1%
No	39%
No Answer	5%

Is this your first pregnancy?

Yes	27%
No	42%
No Answer	30%

How many children have you had?

0	9%
1	35%
2	31%
3	4%
4	3%
5	2%
No Answer	15%

Do you identify as Hispanic or Latino/a/x?

Yes	30%
No	68%
Prefer not to answer	1%

What language(s) do you speak at home?

English	90%
English, Maay Maay	1%
English, Spanish	6%
English, Swahili	1%
Spanish	1%

What is your preferred language for communication?

English	79%
Spanish	1%
No Answer	19%

What gender identities best describe you?

Woman	97%
Woman, Prefer not to Answer	1%
Man	1%

How would you describe your sexual orientation?

Bisexual	11%
Heterosexual/Straight	87%
No Answer	1%

What is your age?

20-24	13%
25-29	47%
30-34	30%
35-39	8%
40-44	1%

What county do you live in?

Addison	10%
Bennington	15%
Caledonia	3%
Chittenden	19%
Essex	7%
Franklin	9%
Grand Isle	1%
Lamoille	5%
Orange	4%
Orleans	5%
Rutland	6%
Washington	10%
Windham	1%
Windsor	3%
No Answer	1%

What is your current employment status?

Employed Full-Time	45%
Employed Part-Time	32%
Found a job haven't started	1%
Self-Employed	8%
Stay at Home Parent	7%
Student	2%
Unemployed and Looking	3%
No Answer	1%

What is your current monthly household income?

$0-$499	10%
$500-$999	16%
$1000-$1,999	20%
$2,000-$2,999	22%
$3,000-$3,999	11%
$4,000 or more	16%
No Answer	4%

What is your highest level of education?

Some High School	2%
High School Diploma/GED	5%
Some College/Tech Training	12%
Associates Degree	20%
Bachelors Degree	50%
Master's Degree or Higher	10%

Do you have access to reliable transportation?

Yes	69%
Sometimes	18%
No	9%
No Answer	3%

What is your current housing status?

I rent my home	61%
Stay with Friends/Family	9%
Own my home	29%

Who do you currently live with?

All of my children	12%
Some of my children	4%
Friends	1%
Live Alone	2%
Spouse/Partner & Children	4%
Spouse/Partner	69%
Other Family Members	3%
No Answer	4%

What is your marital status?

Divorced	4%
Domestic Partnership	10%
Married	74%
Single	10%
Widowed	1%

Appendix D: Comprehensive Thematic Analysis – Coding, Quotes, and Counts

1) Positive Experiences - Relational Care and Community Support

What we heard: When care was culturally responsive, providers listened, slowed down, explained clearly, and representation mattered. Community supports (family, doulas, peers) fostered trust, belonging, and emotional safety.
Mentions: Interviews 5/6; Focus-group excerpts 6; Supporter Survey 1; **Total ≥ 12**

- “When providers truly explain things and answer all questions, I feel respected and safe.”
- “Supportive providers, doulas, and advocates make a huge difference.”
- “Nurses called me by my name and checked in often.”
- “The emergency preterm team was ready; everything was set up and on top of things.” (Interview—G)
- “A pediatrician and an OB advocated to keep me or to discharge me when it actually helped.” (Interviews—S, A)
- “A Black OB made me feel I could trust my care.” (Interview—M)
- “Porter midwives felt inclusive and asked meaningful questions.” (Interview—B)

What the survey shows: 69% rated overall experience very/mostly positive; 74–90% felt respected, safe, included in decisions, and supported by accessible systems.
Regional note: Washington & Addison were consistently above average for respect, humility, and equitable systems.

2) Communication Failures and Dismissed Pain

What we heard: Many felt ignored, rushed, or dismissed when expressing pain or concern; poor explanations and lack of follow-up eroded trust and emotional safety.
Mentions: Interviews 5/6; Focus-group excerpts 10; **Total ≥ 15**

- “Pain or concerns were dismissed. Sometimes I stopped sharing things because it didn’t change anything.”
- “Dismissals included poor communication, not being involved in decisions.”
- “Nurses delivered a slew of information and left; no one stopped to put it in lay terms.” (Interview—A)
- “I felt rushed during appointments or like decisions were being made without really including me in the conversations.”
- “Ultrasound tech was rude and dismissive.” (Interview—G)
- “After everything, no real postpartum debrief.” (Interview—T)

What the survey shows: 74–90% reported respect/safety/inclusion; 11–16% said “not yet” on centering BIPOC voices/cultural humility. Among the 6% negative overall, most did not feel respected/safe or included in decisions.
Regional note: Chittenden County rated inclusion in decision-making below average.

3) Bias, Profiling, and Trust Gaps

What we heard: Racial/cultural bias shaped interactions—stereotyping about finances, pain tolerance, or belonging; trust eroded through repeated micro- and macro-aggressions.
Mentions: Interviews 5/6; Focus-group excerpts 9; Provider Survey 1; **Total ≥ 15**

- “Distrust grows from small frictions; if trust isn’t 100%, there is no trust.”
- “They called my traditional remedy ‘foolish.’”
- “The drug screen at preterm delivery felt weird. Now I wonder if I was profiled.” (Interview—G)

- “A white midwife refused to see me; I felt unwelcome until I found a Black OB.” (Interview—M)

What the survey shows: Most rated providers “somewhat skilled” at discussing race, yet 11–16% ‘not yet’. Negative experiences clustered with low respect, safety, inclusion. Supporters: not enough providers who look like or understand BIPOC patients.
Regional note: Bennington slightly above average on provider skill discussing race/racism; Chittenden below.

4) Access Barriers and Navigation Challenges

What we heard: Transportation, distance, childcare, and cost impeded timely, consistent care—especially in rural areas.
Mentions: Interviews 2/6; Focus-group excerpts 7; Partners/Supporter Survey 4; Provider Survey 2; **Total ≥ 15**

- “Transportation is a major barrier. Every appointment becomes a struggle.”
- “Sleep study took ~4 weeks because clinics kept saying, ‘call them, not us’” (Interview—T)
- “Where do you expect me to get another $350 for a car seat + stroller?” (Interview—A)

What the survey shows: Top challenges included transportation barriers, appointment delays, limited affordable care, lack of housing resources.
Regional note: Essex County (most rural) showed lower access and slower follow-up and scored below average on multiple measures.

5) Cultural Competence and Representation Deficits

What we heard: Lack of provider diversity and limited cultural responsiveness left people feeling unseen and disconnected.
Mentions: Interviews 4/6; Focus-group excerpts 6; Supporter Survey 1; Provider Survey 2; **Total ≥ 13**

- “I wanted providers from my background so I could trust and open up.”
- “Prenatal classes felt centered on white women. I couldn’t see myself.”
- “Porter felt warm and inclusive… I felt seen.” (Interview—B)
- “There aren’t enough doctors who look like or understand BIPOC patients.” (Provider Survey)

What the survey shows: Most perceived some cultural humility, yet 11–16% ‘not yet’.
Regional note: Washington & Addison rated higher on cultural humility; Franklin rated lower for visibly centering BIPOC voices.

6) Emotional Trauma and Psychological Impacts

What we heard: Many described birth as traumatic; lingering fear, grief, and emotional exhaustion; ongoing therapy was common.
Mentions: Interviews 2/6; Focus-group excerpts 6; Supporter Survey 5; **Total ≥ 13**

- “I cried for a day after discharge—grieving another traumatic birth.” (Interview—T)
- “I’m still in therapy twice a week seven months later.” (Interview—T)

What the survey shows: 58% reported birth as traumatic; trauma was higher among bisexual and Latina/o/x respondents.

7) Information Deficiencies and Health Literacy Barriers

What we heard: Participants wanted clear, early, culturally relevant information and jargon-free explanations to guide decisions and reduce anxiety.
Mentions: Interviews 4/6; Focus-group excerpts 8; **Total ≥ 12**

- "I panicked with jaundice. What signs mean urgent versus watch-and-wait?"
- "Give car seat expectations earlier; don't set people up to 'fail'." (Interview—A)
- "They didn't translate jargon; I needed lay terms and time." (Interview—A)

What the survey shows: The high 74–90% reporting respect/safety/inclusion suggests that when communication worked, understanding and trust followed.

8) Reduced Autonomy and Decision-Making

What we heard: People felt pressured into interventions (e.g., C-sections), VBAC preferences were sometimes dismissed, and some reported trainees were involved despite refusals.
Mentions: Interviews 4/6; Focus-group excerpts 6; Supporter Survey 1; **Total ≥ 11**

- "Decisions were imposed; no one was listening."
- "They strapped me up for theatre; when they left, my baby came naturally." (Interview—S)
- "They let a resident close my incision after I said no learners." (Interview—T)

What the survey shows: Most felt included in decisions; among the 6% negative overall, autonomy/consent were much lower.
Regional note: Chittenden below average for inclusion in decision-making.

9) Postpartum Support Gaps and Neglected Maternal Care

What we heard: Postpartum, attention shifted to the baby; maternal recovery and mental health were often overlooked.
Mentions: Interviews 3/6; Focus-group excerpts 7; **Total ≥ 10**

- "The concentration was more on my baby. There was no time for me."
- "At home I had to replicate hospital help—once discharged, support was gone." (Interview—A)

What the survey shows: Supporters cited insufficient home support, work/school stress, and medication incompatibilities with breastfeeding.

10) Policy Rigidity and Systems-First Practices

What we heard: Institutional protocols prioritized efficiency/liability over individualized, person-centered care (e.g., strict discharge clocks, car seat 'fail' without solutions, algorithmic VBAC denial).
Mentions: Interviews 4/6; Focus-group excerpts 4; **Total ≥ 8**

- "We failed the car seat test and were told to find another one. No one offered a solution" (Interview—A)
- "An algorithm said 'no VBAC'. It felt like a system decision, not mine." (Interview—T)
- "It felt like McDonald's: read the chart, do the thing, not see the person."

What the survey shows: Those with negative experiences scored lowest on respect, safety, inclusion—illustrating how rigidity undermines trust.
Regional note: Essex County's below-average pattern mirrors rigidity/under-resourcing impacts.

11) Coordination Breakdowns and System Navigation Burdens

What we heard: Poor cross-provider communication left participants managing their own referrals and follow-up—"bounced around" between clinics.
Mentions: Interviews 3/6; Focus-group excerpts 4; **Total ≥ 7**

- "I had to get a patient advocate because no one was replying; I was bounced between practices." (Interview—T)
- "Changes my endocrinologist made did not show up for unit nurses. I could not eat for hours." (Interview—A)

What the survey shows: Widespread reports of delays, transportation barriers, limited affordable care, and lack of coordination—consistent with the narratives.
Regional note: Essex County reported slower follow-up and lower access.

12) Pain Management Inequities and Unaddresses Suffering

What we heard: Pain was minimized or undertreated; some suspected racial bias in anesthesia/analgesia decisions.
Mentions: Interviews 2/6; Focus-group excerpts 4; **Total ≥ 6**

- "A young nurse said 'I will just give you half' after a C-section" (Interview—T)
- "They took the epidural off the table mid-crisis." (Interview—G)
- "People police Black women's pain."

What the survey shows: The >50% trauma rate aligns with reports of inadequate pain control and emotional/physical unsafety among those with negative experiences.

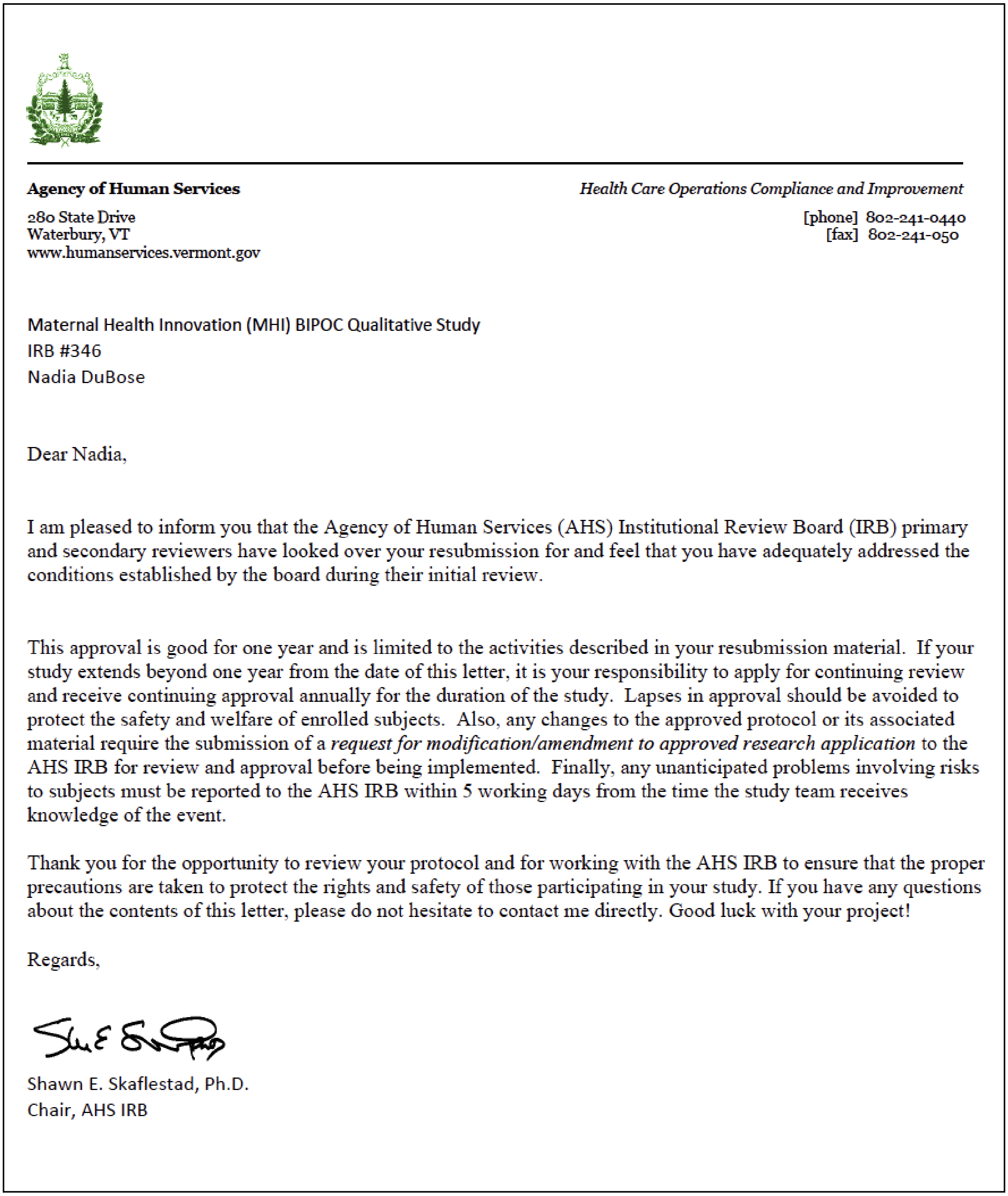
13) Chronic Condition Management Failures

What we heard: For ongoing conditions (e.g., Type 1 diabetes), patients' self-knowledge was sidelined, causing stress and complications.
Mentions: Interviews 1/6; Focus-group excerpts 1; **Total ≥ 2**

- "I've managed Type 1 diabetes for 25 years. They took control and the system was 'hit or miss." (Interview—A)

What the survey shows: Supporters noted medication conflicts and coordination gaps—mirroring disempowerment and protocol inflexibility.

Appendix D: VT Agency of Human Services IRB Study Approval Letter



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Maternal Health Innovation (MHI) BIPOC Qualitative Study
IRB #346
Nadia DuBose

Dear Nadia,

I am pleased to inform you that the Agency of Human Services (AHS) Institutional Review Board (IRB) primary and secondary reviewers have looked over your resubmission for and feel that you have adequately addressed the conditions established by the board during their initial review.

This approval is good for one year and is limited to the activities described in your resubmission material. If your study extends beyond one year from the date of this letter, it is your responsibility to apply for continuing review and receive continuing approval annually for the duration of the study. Lapses in approval should be avoided to protect the safety and welfare of enrolled subjects. Also, any changes to the approved protocol or its associated material require the submission of a *request for modification/amendment to approved research application* to the AHS IRB for review and approval before being implemented. Finally, any unanticipated problems involving risks to subjects must be reported to the AHS IRB within 5 working days from the time the study team receives knowledge of the event.

Thank you for the opportunity to review your protocol and for working with the AHS IRB to ensure that the proper precautions are taken to protect the rights and safety of those participating in your study. If you have any questions about the contents of this letter, please do not hesitate to contact me directly. Good luck with your project!

Regards,

Shawn E. Skaflestad, Ph.D.
Chair, AHS IRB

Appendix F. Participant Letters to Vermont Leaders

Optional Prompt:

Dear Vermont leaders,
I want you to know that________________.
My experiences with pregnancy, birth, or postpartum care have shown me________________.
What would make the biggest difference for me, my family, or my community is________________.
I hope you will________________.
It's important for you to understand that________________.
Thank you.

LETTER 1

Dear Vermont leaders,
I want you to know that I am safe and in good shape
My experience with pregnancy, birth,or postpartum care have shown me to have a good partner by your side. What would make the biggest difference for me and my family, community is having a professional healthcare doctor that can take care of you both mentally and physically. I hope you will consider my thoughts. It's important for you to understand that child birth is not easy for every woman

LETTER 2

Dear Vermont Leaders,
I want you to know that the health and well-being of families during pregnancy, birth, and postpartum periods are critical to building strong communities. As a woman I've seen how access to quality care can shape these experiences for better or worse.
My experiences with pregnancy, birth, or postpartum care have shown me that while there are dedicated healthcare providers in our state, gaps in access to resources, especially in rural areas, can leave families feeling unsupported. Long travel distances to birthing centers, limited mental health support, and inconsistent postpartum follow-up care have been challenges for many.
What would make the biggest difference for me, my family, or my community is increased investment in local maternal health services. This includes more accessible prenatal education, affordable doula and midwifery options, and comprehensive postpartum support programs that address both physical and mental health needs.
I hope you will prioritize policies that expand access to maternal healthcare, particularly in underserved areas. Funding for community-based programs, telehealth options, and training for healthcare providers on culturally sensitive care would be transformative.

It’s important for you to understand that these issues affect not just individuals but entire communities. When parents and babies thrive, our state grows stronger. Supporting families during these critical times is an investment in Vermont’s future.

Thank you for listening to my voice.

Sincerely,
Anonymous

LETTER 3

Dear Vermont Leaders,

I want you to know that my experiences with pregnancy, birth, and postpartum care have shown me how important it is for BIPOC birthing parents to feel seen, heard, and supported. I am a 27-year-old parent with one 3 year old child, and my journey highlighted both the strengths and gaps in our maternal health system.

What would make the biggest difference for me, my family, and my community is:

- More providers and staff who understand or represent BIPOC birthing parents.
- Care that truly listens to our concerns and includes us in decision-making.
- Better access to support systems like doulas, culturally competent care, and mental health resources.
- Solutions for practical barriers such as transportation, language, and affordable care, especially in rural areas.

I hope you will continue to invest in policies and programs that make maternal care equitable, respectful, and accessible for all families. It is important for you to understand that even small changes in provider communication, support services, and representation can make a huge difference in birthing experiences and outcomes.

Thank you for listening to my voice and for your commitment to improving maternal care for BIPOC parents in Vermont.

Sincerely,
Anonymous

LETTER 4

Dear Vermont leaders

I want you to know that some BIPOC birthing women in Vermont are underrepresented

I actually had a mixed experiences with the care i received during pregnancy, Delivery and post delivery

I hope to see some positive changes especially among the healthcare providers since they are the most needed people in the hospital during pregnancy, Delivery and post delivery

Thank you for the consideration

LETTER 5

My experiences with pregnancy, birth, or postpartum care have shown me that while some providers offer compassionate and respectful care, many women still feel unheard, rushed, or dismissed and it impacts our trust in the system.What would make the biggest difference for me is ensuring that every pregnant person has access to care that is respectful and culturally sensitive and sometimes we wish there are some other birthing options to like housewives and others.
Investing in maternal health is great and also patient voices being heard and acted upon is a big flex for us because everyone deserves to feel safe during this critical experience.
Thank you for listening to my voice.
Sincerely
Anonymous

LETTER 6

To the Leaders Supporting BIPOC Birthing Parents in Vermont,
As a BIPOC parent, I want to share my perspective. Too often, BIPOC birthing parents face barriers to care whether it’s feeling unheard, not seeing providers who understand our culture, or lacking access to trusted support during pregnancy and postpartum.
What makes the biggest difference is care that is respectful, culturally responsive, and community-driven. We need providers who listen, resources that reflect our realities, and systems that honor our traditions and experiences.
I urge you to center BIPOC voices in your planning so that every parent feels safe, respected, and supported through their birthing journey.
Your's Sincerely,
Anonymous

LETTER 7

Dear Vermont Leaders,
While my own experience with pregnancy, birth, and postpartum care in Vermont was largely positive, I am deeply aware that this is not the reality for many others—especially within the BIPOC community. The persistent disparities in maternal healthcare are undeniable, and they disproportionately affect Black, Indigenous, and other people of color.
I urge you to listen to our voices and take meaningful action to ensure that prenatal, birth, and postpartum care are equitable, safe, and respectful for all. Every parent deserves to bring life into this world without fear—supported, heard, and protected throughout the journey.
Thank you for your time, and for your commitment to a more just and compassionate Vermont.

LETTER 8

Dear Vermont leaders,

I want you to know that my experience with my birthing was really good.i had some negative and positive response with my black OBGYN. I first met a midwife who was a white lady who totally gave me a different view about my journey. I first met her and told her about my baby and I was feeling pains and having early morning sickness and anxiety but I was turned down by her.She told me that I should go meet another midwife who can take care of me because she was busy and wouldn't attend to me. I felt bad and devastated and I had to call my husband who introduced me to a OBGYN that I could trust and rely on. I felt safe,secure and listened to whenever I was with my OBGYN.

What would make the biggest difference for me,my family and my community is the support from people,the doctors who can always attend to us to solve our problems when needed. Employing equivalent number of both black and white midwife and OBGYN so we don't have to wait up in lines and feel turned down when the necessary action could have been taken.

I hope you will find time and ask also the Community Health Workers to help the rural people who are pregnant and have little knowledge on what to do during pregnancy and postpartum period,how to overcome anxiety, depression.

LETTER 9

As a mother of two, my first experience was difficult and I felt that certain things were not handled well. During my second pregnancy, it was different—I had prior experience, I had more contact with the service, and I was able to navigate things more easily. Still, I believe there are areas where the system could improve.

I wish that pain had not been dismissed and that my spiritual concerns and beliefs had been acknowledged instead of overlooked. It would have helped if my questions were taken seriously and if I had been fully informed about all of the choices available to me. That kind of support would have made it easier for me to make confident, informed decisions.

I also wanted my fears and insecurities to be recognized as valid, rather than something I needed to hide. As a person, my beliefs are important to me, and even when they are difficult to reconcile, I still need them to be respected.

For me, what is missing in the healthcare system is exactly that: the understanding that these needs—respect, validation, and clear information—are very normal and should be part of every woman’s care.

LETTER 10

I want you to know that the voices of BIPOC birthing people are often overlooked, even though our experiences reveal important truths about how the healthcare system is working and not working. My story is just one among many, but it reflects larger patterns that deserve attention.

My experiences with pregnancy, birth, and postpartum care have shown me that while there are providers who genuinely care and do their best, there are also deep gaps in equity, respect, and access. At times, I felt my concerns were dismissed or minimized, and I had to advocate harder than others to be taken seriously. This left me feeling stressed and unsafe at moments when I should have been supported. I have also seen how transportation challenges, financial barriers, and cultural misunderstandings add extra layers of difficulty for families like mine.

What would make the biggest difference for me, my family, and my community is having providers who reflect our diversity and are trained in cultural humility and anti-racism. It would also help to expand access to doulas, interpreters, mental health supports, and community-based care models that center BIPOC voices. Having more BIPOC professionals in the system — from doctors and nurses to social workers — would go a long way toward building trust and improving outcomes.

I hope you will commit to listening to BIPOC families and providers, not just during this study but in an ongoing way. Our voices should help shape policies, programs, and funding decisions that affect maternal and child health in Vermont.

It’s important for you to understand that our health outcomes are not just about individual choices —l they are shaped by systems, policies, and histories of inequity. Change is possible, but it requires intentional action, investment, and accountability.

Thank you for listening to my voice

LETTER 11

Dear Vermont Leaders,

I would like to briefly talk about my experience birthing my two kids in Rutland, Vermont. I have had both good and bad experiences and my most difficult ones were that my needs were ignored, my pains and symptoms dismissed because of my cultural background, especially during my first pregnancy. I would love a system where health care professionals are assigned to me with my choice and consent being considered, someone that is empathic towards me and would respect my cultural beliefs and practices.

Thank you for giving me this platform.

LETTER 12

Dear Vermont leaders,

I want you to know that my journey through pregnancy and postpartum has been both beautiful and challenging, and it has taught me how deeply important it is to have care and support during this time.

My experiences with pregnancy, birth, and postpartum care have shown me that while medical attention is critical, emotional and mental health support is just as vital. There were moments I felt uncertain, exhausted, and even alone—times when a listening ear, timely advice, or access to services would have made all the difference.

What would make the biggest difference for me, my family, and my community is having a system that ensures every parent can access affordable and reliable care before, during, and after childbirth. This means better access to midwives, mental health providers, lactation consultants, and safe spaces where families feel supported rather than overwhelmed.

I hope you will continue to prioritize maternal and child health by expanding resources, especially for rural and underserved families, and by creating policies that give new parents the confidence and reassurance they need.

It’s important for you to understand that investing in pregnancy and postpartum care is not just about mothers-it’s about raising healthy children, nurturing strong families, and building resilient communities across Vermont.

Thank you for listening to my voice and for considering the real experiences of families like mine.

LETTER 13

Dear Vermont leaders,

I want you to know that it is my pleasure to write this letter.

My experiences with pregnancy, birth, or postpartum care have shown me that we birthing mothers need special care,we need a listening ear and a person to forward all our questions, concerns, thoughts, complaints to without being shut out, without being treated differently.

What would make the biggest difference for me, my family, or my community is if our health care provider can do all this for us and we also do know and acknowledge their efforts but a little more support will count,our consent should also be counted and valued

I hope you will give us all necessary support,

It’s important for you to understand that we need these and we do understand our care providers are heroes

Thank you for listening to my voice.

LETTER 14

leaders,

I want you to know that being a mother in Vermont especially as a Black woman facing complications during pregnancy can feel incredibly isolating and confusing, even when you're doing everything you're told to do.

During my pregnancy, I was diagnosed with incompetent cervix, something I had never heard of before. I was told to go on bed rest, which I followed carefully, but I was given very little guidance beyond that. What did "bed rest" really mean? How was I supposed to care for myself emotionally, stay physically well, or prepare for my baby in that state? No one helped me figure that out I had to rely on Google and support groups, not my care team.

What made a positive difference was that I submitted a birth plan, and my provider actually implemented it. For that, I'm truly grateful. It made me feel respected and like my voice mattered especially during labor, which can be overwhelming. That moment of being heard stayed with me.

But what would make the biggest difference for me, my family, and others like us is having more empathetic, proactive guidance especially when complications arise. Being told to rest isn't enough. I needed someone to sit with me, walk me through what was happening in my body, and check on how I was coping mentally.

After the birth, all the focus shifted to my baby but I was still recovering too, emotionally and physically. I felt dismissed when I expressed how exhausted and anxious I was. Postpartum care should not just be a one-time check-in. Mothers need real, ongoing care — not just medically, but emotionally, spiritually, and socially.

I hope you will look at the full journey of birthing people, not just the delivery. We need consistent follow-up, culturally sensitive care, and real education around pregnancy complications like incompetent cervix. We shouldn't have to research our conditions on our own or feel afraid to ask too many questions.

It's important for you to understand that being medically safe is not the same as feeling supported. I needed more than checklists and quick appointments. I needed to be seen as a whole person navigating a complicated and emotional journey.

Thank you for listening to my voice. I hope my experience helps move the system toward one where Black mothers in Vermont don't just survive pregnancy we feel cared for, heard, and held.

Sincerely,
Anonymous