Safer Childbirth Cities

Supporting Communities, Transforming Maternal Health:

A Spotlight on the Safer Childbirth Cities Initiative

EVALUATION REPORT

BMMA
BLACK MAMAS MATTER ALLIANCE

MAY 2024

Acknowledgements

We would like to thank the Safer Childbirth Cities Initiative grantees for their time and for sharing their experiences for the purposes of this evaluation report

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Executive Summary

The United States stands out as the sole high-income country experiencing an escalation in maternal deaths. This alarming trend is compounded by stark and enduring racial and ethnic inequities.

According to the Centers for Disease Control and Prevention (CDC), Native Hawaiian or Other Pacific Islander, Black, and American Indian or Alaska Native people face higher pregnancy-related mortality than their White counterparts (CDC, 2023). Delving deeper into the root causes of these untimely deaths, it becomes evident that they extend beyond mere medical complications. Rather, they are intricately intertwined with community factors and the broader social and structural determinants of health significantly shaping maternal health outcomes.

This evaluation spotlights achievements from SCC grantees and illuminates effective community-led solutions, a crucial yet often overlooked aspect of maternal health innovation while catalyzing increased programmatic and financial investments in this vital arena.

The Safer Childbirth Cities (SCC) Initiative supported community-based organizations in U.S. cities with a high burden of maternal mortality and morbidity to implement evidence-based interventions and innovative approaches to reverse the country's maternal health trends and directly tackle racial inequities in maternal health outcomes. Merck for Mothers serves as the Founder and Secretariat for the initiative, which is co-funded by The Burke Foundation, The Community Health Acceleration Partnership, Fondation CHANEL, George Kaiser Family Foundation, Rhia Ventures, The W.K. Kellogg Foundation, Skyline Foundation, and The Nicholson Foundation (currently closed). The SCC Initiative supported community-based organizations in 20 U.S. cities to help improve the maternal health outcomes that matter most in their cities.

This evaluation spotlights achievements from SCC grantees and illuminates effective community-led solutions, a crucial yet often overlooked aspect of maternal health innovation while catalyzing increased programmatic and financial investments in this vital arena. There is a growing recognition of the importance of uplifting community-led solutions in addressing maternal health inequities. An evaluation

team from Black Mamas Matter Alliance, Inc. (BMMA) implemented a mixed methods evaluation design to answer the following questions for each SCC grantee and across SCC grantees:

- → **What activities were implemented and what communities/groups were served?**
- → **What were the challenges and lessons learned? and**
- → **What was the impact on patients, communities, and hospitals/ health systems?**

Evaluation findings can inform future community-rooted maternal health efforts and provide a tangible tool for donors and organizations interested in community-based approaches to improve maternal health.

SCC grantees provided services and programming to people in need, including pregnant and birthing individuals, health care providers, doulas, community health workers, and parents in their respective and neighboring cities. Moreover, SCC grantees implemented an array of activities - programs, and interventions, service delivery, tool and resource development, and research, evaluation, quality improvement, and policy and advocacy - at the local, state, and regional levels to address maternal mortality and morbidity. Overall, SCC grantees provided care and services to thousands of people, trained hundreds of doulas and community health workers, and trained thousands of health care providers. Furthermore, with SCC funding, grantees have worked toward major policy and sustainability wins. SCC grantees were instrumental in efforts that ultimately helped to pass legislation that extended postpartum Medicaid coverage from 3 to 12 months, expanded Medicaid coverage to include doula and home visiting services, required health care systems to provide information and support about postpartum depression, and standardized licensure for birthing centers.

Introduction

The United States stands out as the sole high-income country experiencing an escalation in maternal deaths. This alarming trend is compounded by stark racial and ethnic inequities. According to the Centers for Disease Control and Prevention (CDC), Native Hawaiian or Other Pacific Islander, Black, and American Indian or Alaska Native people face higher pregnancy-related mortality than their White counterparts (CDC, 2023). Shockingly, it is estimated that up to 80% of all maternal deaths in the U.S. are preventable (CDC, 2023). Delving deeper into the root causes of these untimely deaths, it becomes evident that they extend beyond medical complications. Rather, they are intricately intertwined with community factors and the broader social and structural determinants of health—factors such as access to care, socioeconomic status, and environmental conditions—significantly shaping maternal health outcomes.

This confluence of challenges underscores the imperative for comprehensive action to address the multifaceted dimensions of maternal health inequities in the U.S. Acknowledging the preventability of maternal mortality and recognizing the interplay between health outcomes and social and structural determinants allows for targeted interventions with tangible and sustainable improvements in maternal health outcomes nationwide. As a result, innovative initiatives like the Safer Childbirth Cities (SCC) Initiative are emerging to center community-led solutions in addressing this maternal health crisis.

This confluence of challenges underscores the imperative for comprehensive action to address the multifaceted dimensions of maternal health inequities in the U.S.

This impact evaluation shares achievements from the SCC Initiative grantees and highlights effective community-led solutions, a crucial yet often overlooked aspect of maternal health advancement. Community-led solutions approach recognizes that communities are not just passive recipients of interventions but are active participants and agents of change in shaping their health outcomes. Furthermore, this report offers solutions for stakeholders within the field of maternal health and a roadmap for those implementing community-led solutions.

Safer Childbirth Cities Initiative

The Safer Childbirth Cities (SCC) Initiative supports community-based organizations in U.S. cities with a high burden of maternal mortality and morbidity to implement evidence-based interventions and innovative approaches to reverse the country's maternal health trends and directly tackle racial inequities in maternal health outcomes (MfM, 2024).

The SCC Initiative currently funds community-based organizations in 20 U.S. cities to help improve the maternal health outcomes that matter most in their cities.

Merck for Mothers (MfM) serves as the Founder and Secretariat for the initiative, which is co-funded by The Burke Foundation, The Community Health Acceleration Partnership, Fondation CHANEL, George Kaiser Family Foundation, Rhia Ventures, The W.K. Kellogg Foundation, Skyline Foundation, and The Nicholson Foundation (currently closed). The SCC Initiative currently funds community-based organizations in 20 U.S. cities to help improve the maternal health outcomes that matter most in their cities (see Table 1). SCC grantees work to engage communities in maternal health improvements and address the social determinants of health and work with doulas and perinatal support workers to bolster the care support system around women and families during pregnancy, childbirth, and the months after.

TABLE 1

SCCI Grantees — Cohorts 1 and 2

CITY	ORGANIZATION NAME
ATLANTA, GA	Black Mamas Matter Alliance, Inc. (BMMA)
AUSTIN, TX	Maternal Health Equity Collaborative
BALTIMORE, MD	Baltimore Healthy Start
BROOKLYN, NY	Black Women's Blueprint
CAMDEN, NJ	Camden Coalition of Healthcare Providers
CHICAGO, IL	AllianceChicago & EverThrive Illinois
COLUMBUS, OH	Restoring Our Own Through Transformation (ROOTT)
DETROIT, MI	Project Detroit: Voices for Life
JACKSON, MS	Mississippi Public Health Institute
NEW ORLEANS, LA	Institute of Women and Ethnic Studies
NEWARK, NJ	Greater Newark Health Care Coalition
NORFOLK, VA	Urban Baby Beginnings
PHILADELPHIA, PA	Health Federation of Philadelphia
PITTSBURGH, PA	Jewish Healthcare Foundation
SAN FRANCISCO, CA	SisterWeb
ST. LOUIS, MO	Jamaa Birth Village
TAMPA, FL	REACHUP, Inc.
TULSA, OK	Tulsa Birth Equity Initiative
TRENTON, NJ	Trenton Health Team
WASHINGTON, DC	Mamatoto Village

Evaluation Design

The purpose of the evaluation was to showcase the work and impact of SCC grantees as well as delve into challenges and highlight lessons learned to contribute to the maternal health dialogue across the country. The evaluation was conducted by an evaluation team at Black Mamas Matter Alliance (BMMA), an SCC grantee from the first cohort. The team employed a mixed methods design to answer the evaluation questions in Figure 1.

FIGURE 1
Evaluation Questions

ACROSS CITIES

1. What activities were implemented and what communities / groups were served?
2. What were the challenges and lessons learned?
3. What was the impact?

IN EACH CITY

4. What activities were implemented?
5. What were the challenges and lessons learned?
6. What was the impact?

Evaluation findings can inform future community-rooted maternal health efforts and provide a tangible tool for donors and organizations interested in community-based approaches to improve maternal health.

Data Collection and Analysis

The evaluation team collected and analyzed quantitative and qualitative data from SCC grantee quarterly reports to answer the evaluation questions. Data collection and analysis activities were conducted between October 2023 through January 2024 and are described below.

DOCUMENT REVIEW

A document review of Quarterly Progress Reports was conducted by the evaluation team to determine what activities were implemented, challenges and lessons learned, and the achievement of intended outcomes/impact for each SCC grantee (Evaluation Questions #1-3). This information was pulled from the Dashboard, Milestones, and Results Commentary sections of the reports and collected in a *Site Summaries Data Collection Form*. The evaluation team used this information to develop 1-2 page *Site Profile Narratives* for each SCC grantee. The narratives are included in this report and located in the Evaluation Findings section.

CONTENT ANALYSIS

A content analysis of the *Site Profile Narratives* was conducted to systematically identify commonalities in implemented activities, communities/groups served, and challenges and lessons learned across states

(Evaluation Questions #1–3). The evaluation team identified categories for each section and placed this information into a Microsoft Excel spreadsheet. The team used this information to sort through the *Site Profile Narratives* and identify the presence of these categories.

SECONDARY DATA ANALYSIS

A secondary data analysis of quantitative data from the Data Monitoring section of the Quarterly Progress Reports was also conducted (Evaluation Questions #3 and #6). SCC grantees were required to report on the following MfM Core Indicators: number of districts/regions covered, women with improved quality care, women with access to contraception, women empowered to demand quality care, providers equipped to offer quality care, facilities strengthened, and people with access to quality facilities. The evaluation team collected this information in a Microsoft Excel spreadsheet and conducted descriptive statistics to determine grantees' progress towards and achievement of intended outcomes/impact within their respective cities as well as across cities (Evaluation Questions #2 and 4).

SELECTION OF QUANTITATIVE INDICATORS ACROSS SITES

To determine the top three indicators across each site and the top indicators at the aggregate level, the evaluation team reviewed the data across each site and selected the three indicators that were consistently reported and accurately/clearly defined (Question #3). Indicators were eliminated from inclusion, for example, if sites combined multiple indicators within one indicator or if indicators were unclearly defined. The evaluation team then compared the top three indicators across each site to determine three indicators to report at the aggregate level. To accomplish this, the evaluation team grouped similar indicators across each site and created category titles. The three most consistently reported indicators across all sites were selected.

Evaluation Findings

This section provides a summary of the evaluation findings. Findings emerging from across SCC grantees are presented first (Evaluation Questions #1-3). Then, findings for each SCC grantee are presented in 1-2 page *SCC Initiative Grantee Profiles* (Evaluation Questions #4-6).

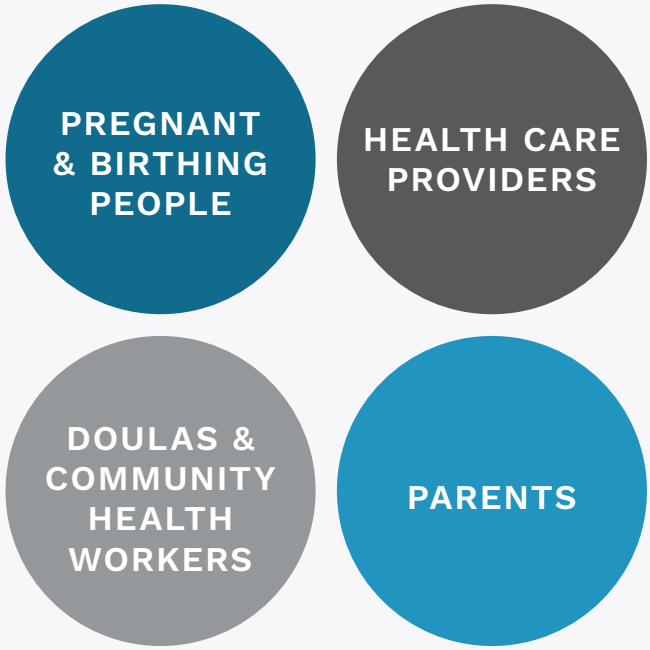
1. Across cities, what activities were implemented, and what communities/ groups were served?

Across SCC grantees in both cohorts, similarities emerged around their activities and the communities and groups they served.

Communities and Groups Served by SCC Grantees

SCC grantees provided services and programming to people in need of care and support as well as those providing care and support to communities in their respective and neighboring cities (Figure 2). This included pregnant and birthing people, health care providers, doulas, community health workers, and parents. Pregnant and birthing people, specifically those from Black, Indigenous, and people of color communities, were the primary beneficiaries of services and programming provided by SCC grantees. The next largest group of beneficiaries were health care providers such as physicians, nurses, midwives, and ambulatory care partners. In addition to those providing clinical support, SCC grantees also engaged those providing non-clinical support, specifically doulas and community health workers (CHWs). While doulas and CHWs differ, they both provide clients, families, and communities with the information, programming, and advocacy needed to be healthy and safe. Lastly, parents were also served by SCC grantees providing childcare support and parenting classes.

FIGURE 2
Primary Communities and Groups Served by SCC Grantees Across Cities



SCC Grantee Activities

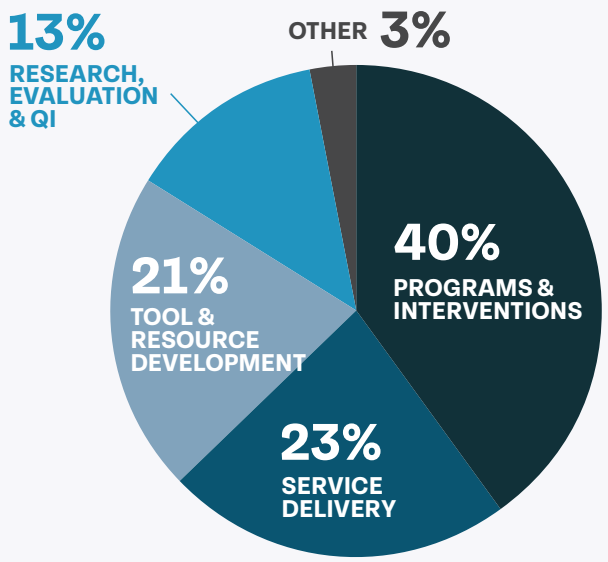
SCC grantees implemented an array of activities. The most prevalent activities were programs and interventions, service delivery, tool and resource development, and research, evaluation, and quality improvement (see Figure 3). Although there is some overlap between programs and service delivery, they were treated as separate categories. Programs and interventions promote community health and well-being to increase healthy life expectancy, improve quality of life, and reduce health care costs. Service delivery describes the delivery of primary and even specialist care to individuals. The evaluation team also included the provision of non-clinical services such as doula care in this category. Tool and resource development describes the development of materials or products (e.g., reports, toolkits, policy briefs, curriculum) that can be distributed to communities, health care providers, and/or policymakers. Research, evaluation, and quality improvement describe the collection, analysis, and reporting of qualitative and/or quantitative data. This diversity in activities across SCC grantees underscores the multifaceted approach taken by each in contributing to maternal health.

PROGRAMS AND INTERVENTIONS

32 out of the 79 reported activities by SCC grantees (approximately 40%) consisted of the development and implementation of programs and interventions promoting the health and well-being of communities as well as addressing the maternal health inequities they experience. Programs and interventions included childcare, home visiting programs, Lamaze classes, support groups, training programs, yoga, and the distribution of diapers, mom and perinatal kits, glucose monitoring kits, and food to families and communities. Other activities included the facilitation of partnerships between doulas/community health workers and health care providers.

Training programs were widespread, focusing on community-based doulas, community health workers, community health advocates, lactation specialists, and implicit/unconscious bias training. One SCC grantee conducted a train-the-trainer doula program. Other trainings focused on quality improvement and how to work with maternal mortality review committees. These programs and interventions were conducted virtually and in-person.

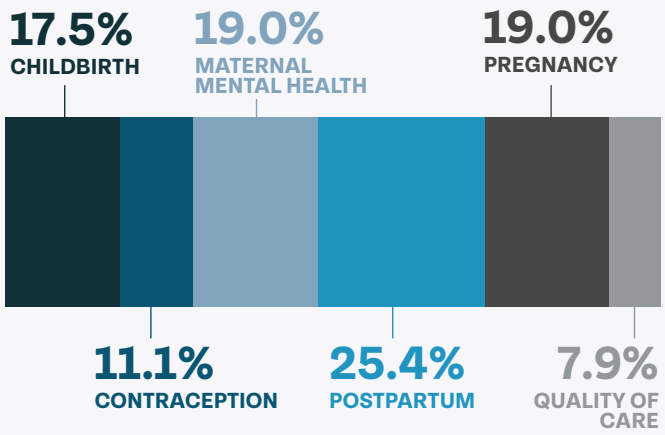
FIGURE 3
Key Activities by SCC Grantees (n=79)



Training programs were widespread, focusing on community-based doulas, community health workers, community health advocates, lactation specialists, and implicit/unconscious bias training.

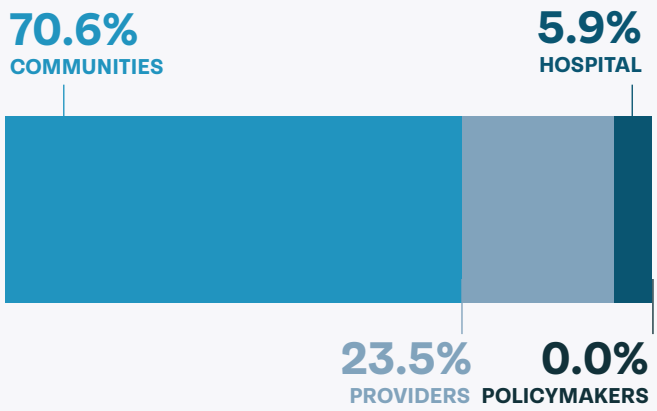
Over 25% of programs and interventions focused on the postpartum period while 19% focused on pregnancy and 19% on maternal mental health.

FIGURE 4
Programs and Interventions by Maternal Health Area



Over 70% of programs and interventions targeted communities while over 23% targeted health care providers.

FIGURE 5
Programs and Interventions by Maternal Health Level



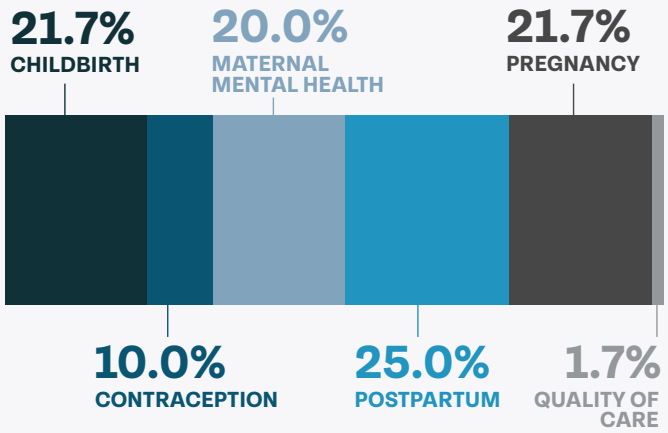
STRENGTHEN SERVICE DELIVERY

18 out of the 79 reported activities by SCC grantees (approximately 23%) consisted of activities to strengthen service delivery. Service delivery describes the delivery of primary and specialist care to individuals and SCC funds could be used to improve quality care and test new, stronger delivery models. In addition to primary and specialist care, the evaluation team also included preventative care and non-clinical services such as doula care. 6 out of 20 SCC grantees provided community-based doula care during the pregnancy, childbirth, and postpartum periods for people in their communities.

SCC grantees reported that health care professionals provided a range of care, case management, counseling, and services on the following health topics across the full range of maternity care, contraception, pregnancy, postpartum, sexually transmitted infections (STI) and Human Immunodeficiency Virus (HIV) testing and prevention, and sexual violence inside and outside clinical settings. Furthermore, SCC grantees created referral networks in partnership with health systems and health care providers.

Approximately 25% of service delivery activities focused on the postpartum period while over 21% focused on the pregnancy period, 21% focused on childbirth, and 20% focused on maternal mental health.

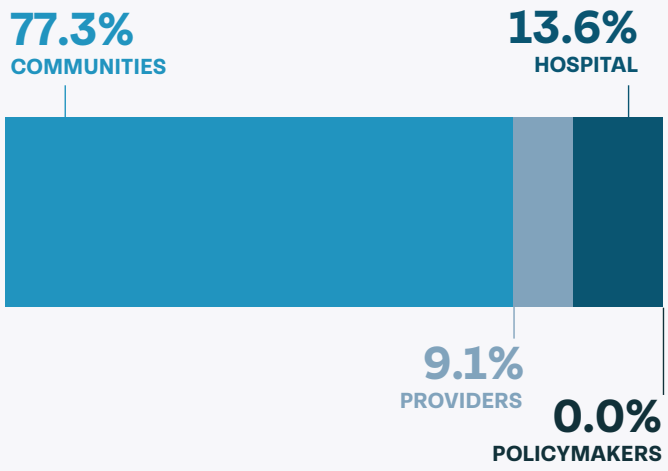
FIGURE 6
Service Delivery by Maternal Health Area



Over 77.3% of service activities were conducted with

communities and 13% were conducted with hospitals/ health systems.

FIGURE 7
Service Delivery by Maternal Health level

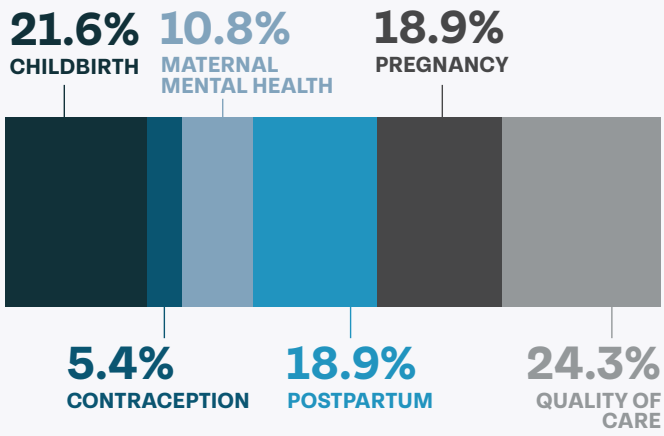


TOOL AND RESOURCE DEVELOPMENT

17 out of the 79 reported activities by SCC grantees (approximately 21%) consisted of the development and distribution of a tool and/or resource for stakeholders. Tool and resource development describes the development of materials or products (e.g., reports, toolkits, policy briefs, curriculum) that can be distributed to communities, health care providers, and/ or policymakers. SCC grantees developed reports on maternal care within Medicaid and recommendations based on maternal mortality cases, assessment tools on housing policies and programs and holistic maternity care, a doula directory, and a toolkit for ambulatory care partners participating in quality improvement efforts to better link high-risk patients to primary care and/or medical home. Other activities included online training tools, curriculum, and webinars for health care professionals to address Black maternal health, and the expansion of a health information exchange to identify thousands of patients eligible for outreach.

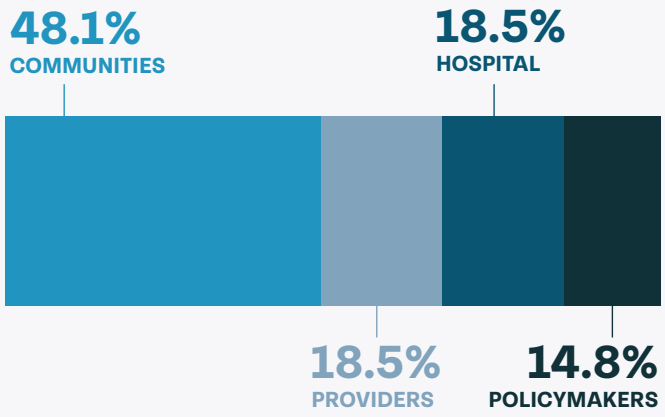
Approximately 24% of these activities focused on the quality of care for pregnant, birthing, and postpartum people while over 59% of these activities focused on pregnancy, childbirth, and postpartum periods.

FIGURE 8
Tool & Resource Development by Maternal Health Area



Over 66% of tool and resource development activities targeted communities while over 18% targeted health care providers and over 18% targeted hospitals/health systems.

FIGURE 9
Tool & Resource Development by Maternal Health Level

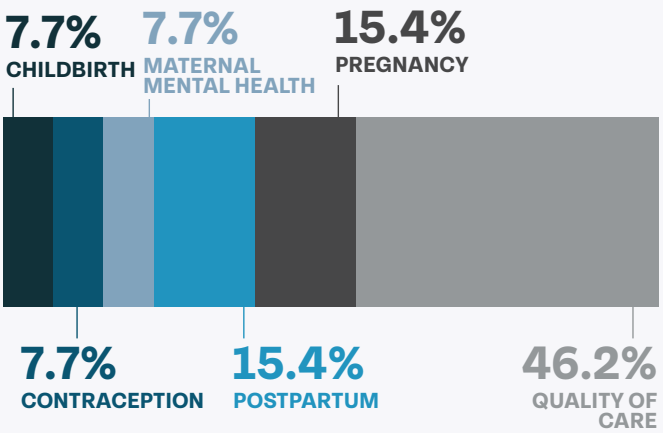


RESEARCH, EVALUATION, AND QUALITY IMPROVEMENT

10 out of the 79 reported activities by SCC grantees (approximately 13%) were related to research, evaluation, and quality improvement (QI). This describes the collection, analysis, and reporting of qualitative and/or quantitative data. SCC grantees conducted individual and group interviews to 1) better understand facilitators and barriers to maternal health, 2) collect the lived experiences of pregnant and birthing people and health care providers and 3) better understand the needs and wants of communities (e.g., wraparound services). Other activities included the development of a self-reporting doula data collection system, conducting an evaluation assessing the efficacy and reach of an early warning signs initiative, and working in partnership with hospitals to gather data to improve transparency and quality.

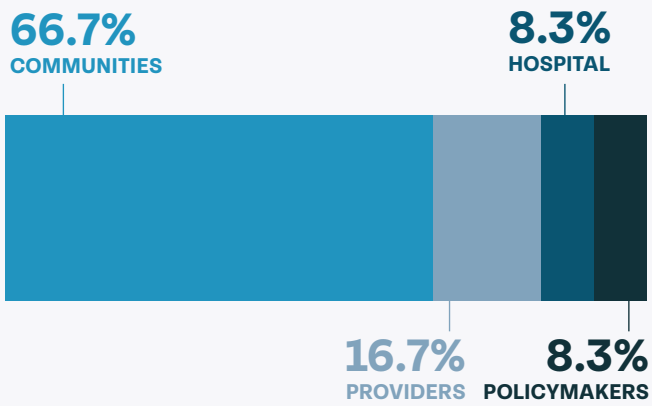
Approximately 46% of these activities focused on the quality of care for pregnant, birthing, and postpartum people while over 30% of these activities focused on the pregnancy and postpartum periods.

FIGURE 10
Research, Evaluation, and QI by Maternal Health Area



Over 66% of research, evaluation, and QI activities were conducted with communities while over 16% were conducted with health care providers.

FIGURE 11
Research, Evaluation, and QI by Maternal Health Level



SPOTLIGHT

Policy Wins

With SCC funding, grantees were able to work towards major policy wins. These wins have an impact that is sustained far beyond the grant period through policy changes. SCC grantees were instrumental in efforts that ultimately helped to pass legislation that extended postpartum Medicaid coverage from 3 to 12 months, expanded Medicaid coverage to include doula and home visiting services, required health care systems to provide information and support about postpartum depression, and standardized licensure for birthing centers.

CHICAGO, ILLINOIS

PROJECT NAME

Chicago Collaborative for Maternal Health

ORGANIZATION NAME

Alliance Chicago

Successfully advocated and assisted in the passing of new policy such as postpartum expansion of Medicaid up to 12 months after delivery, Medicaid coverage of doula and home visiting services, Maternal mortality omnibus bill, and enacted standards in licensing for all birth centers in Illinois.

JACKSON, MISSISSIPPI

PROJECT NAME

Jackson Safer Childbirth Experience

ORGANIZATION NAME

Mississippi Public Health Institute

Through the advocacy efforts of the Mississippi Public Health Institute, a Safer Childbirth Cities grantee, and other local stakeholders, Mississippi extended postpartum Medicaid coverage from 2 to 12 months in March 2023. More than two-thirds of babies in Mississippi are born to people on Medicaid. The change will affect thousands of people in the state.

NEW ORLEANS, LOUISIANA

PROJECT NAME

New Orleans Respectful Motherhood Initiative

ORGANIZATION NAME

Institute of Women and Ethnic Studies

The Institute of Women and Ethnic Studies (IWES) led the Louisiana Perinatal Mental Health Taskforce that created and advocated for The Perinatal Mood and Anxiety Disorders bill. This bill successfully passed the 2022 legislative session. The bill requires all hospitals and birthing centers to provide women with information about postpartum depression, its symptoms and treatment, and other resources before discharge.

2. Across cities, what were the challenges and lessons learned?

SCC grantees faced a plethora of challenges during the grant period. These challenges included the COVID-19 pandemic, stakeholder buy-in, and engaging a diversity of communities and groups. (see Figure 4).

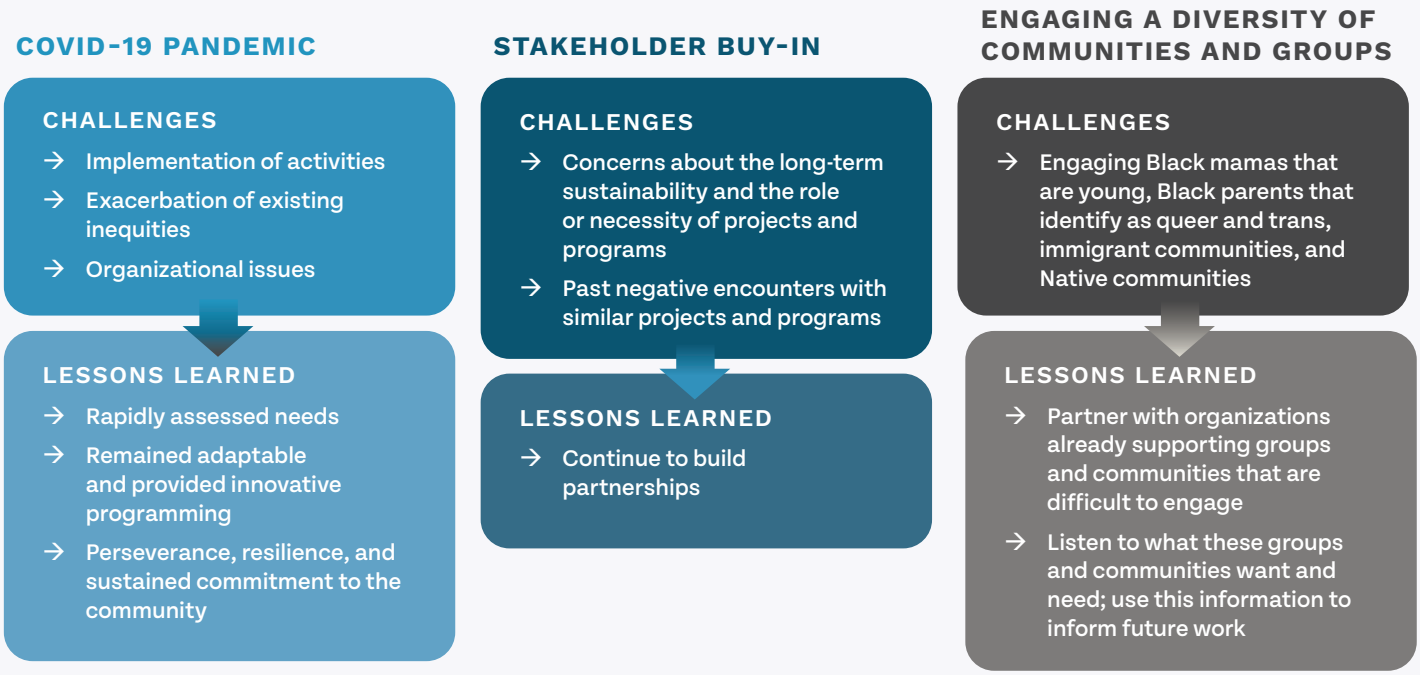
Almost all SCC grantees faced significant challenges arising from the COVID-19 pandemic. The pandemic not only exacerbated and exposed existing inequities in communities (e.g., economic, employment, housing), but grantees shared that it impacted their operations, programming, and staff. Organizations experienced challenges with staff turnover, financial barriers, and team building and interactions without physical in-person meetings. Before 2020, many of these grantees had planned in-person training, community outreach events, and service delivery initiatives. However, the onset of the pandemic required them to adapt, shifting a considerable portion of these activities to virtual platforms or, in some instances, canceling aspects of the program altogether. The unprecedented nature of the pandemic raised questions about program timelines, resulting in substantial delays in their implementation.

Additionally, obtaining buy-in from some stakeholders proved challenging. Stakeholders shared their concerns around long-term sustainability (i.e., funding, infrastructure), the role or necessity of programs, especially those providing perinatal support, and past negative encounters with similar programs. Despite these challenges, SCC grantees shared their continued efforts to build partnerships and offer programs and services.

Lastly, some grantees encountered difficulties in engaging a diversity of communities and groups. These communities and groups included Black mamas that are young, Black parents that identify as queer and trans, immigrant communities, and Native communities. SCC grantees shared their challenges with outreach and

FIGURE 12

Challenges and Lessons Learned Experienced by SCC Grantees Across Cities



engagement in activities and the lack of accessibility of educational materials. As a result, grantees partnered with organizations already serving these communities and groups, conducted focus groups to better understand what they want and need, and updated educational materials to ensure health literacy and cultural competence (e.g., translation of materials into several languages).

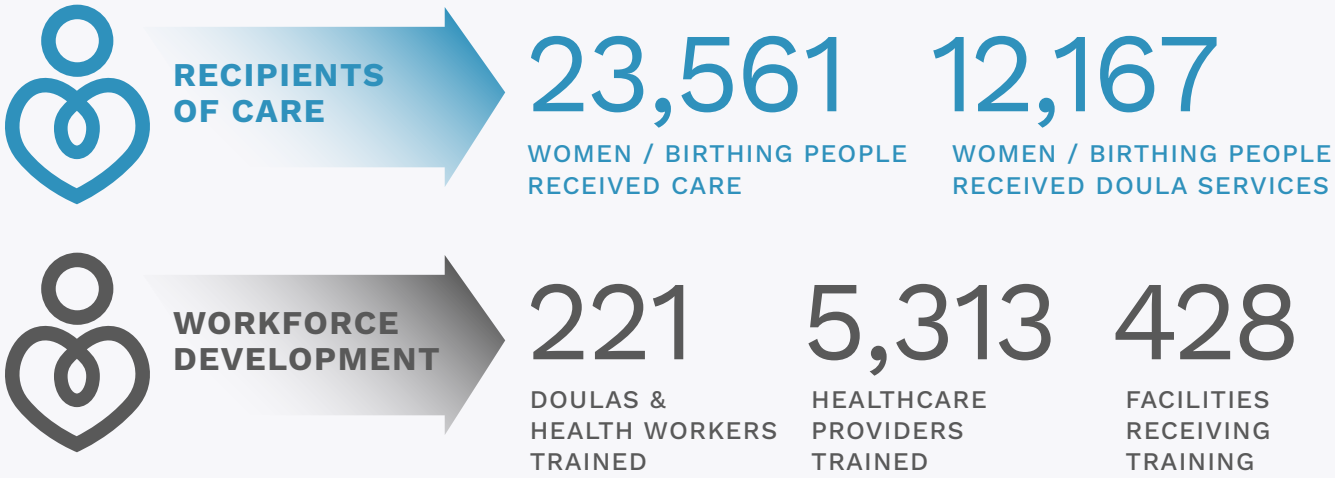
3. Across cities, what was the impact?

SCC grantees across both cohorts worked to implement interventions, programs, and innovative approaches at the local, state, and national levels to address maternal mortality and morbidity. Although the SCC initiative supported grantees in 20 states across the U.S., grantees reported working in 28 states.

All sites reported quarterly on core indicators defined by Merck for Mothers. Core indicators included the number of districts/regions covered, women with improved quality care, women with access to contraception, women empowered to demand quality care, providers equipped to offer quality care, facilities strengthened, and people with access to quality facilities (see Figure below). However, each site developed a definition for core indicators specific to their project to capture their unique work.

FIGURE 13
Core Indicators for SCC Grantees

DISTRICTS & REGIONS COVERED	# of districts/regions with MfM-supported programs
WOMEN WITH IMPROVED QUALITY CARE	# of women receiving services (ANC, delivery, and/or PNC) from MfM-supported maternal health projects and beneficiaries of maternity waiting home users
WOMEN WITH ACCESS TO CONTRACEPTION	# of women receiving modern contraceptive products and services
WOMEN EMPOWERED TO DEMAND QUALITY CARE	# of patient-oriented digital innovation users, beneficiaries of community health worker programs
PROVIDERS EQUIPPED TO OFFER QUALITY CARE	# of health workers (facility and community-based) trained by MfM-supported programs
FACILITIES STRENGTHENED	# of health facilities strengthened to provide quality care and/or modern
PEOPLE WITH ACCESS TO QUALITY FACILITIES	# of people in MfM program affiliated health facilities' or pharmacies' catchment area



Because of the diversity of programming implemented by SCC grantees and the challenges with the data, it was difficult to describe the impact of the work that was done across SCC grantees (see Limitations section). Nevertheless, information for the following core indicators is presented below:

- **Care to Women/People during Pregnancy, Childbirth, and the Postpartum Period**
  - Number of women and birthing people that received care
  - Number of doulas and health workers that were trained
- **Maternal Health Workforce Development**
  - Number of health care providers that were trained
  - Number of health care facilities that received training

Additionally, a logic model for the SCC initiative was created by the evaluation team to capture the intended short-term, intermediate and long-term impact of SCC grantees.

Care to Women/People during Pregnancy, Childbirth, and the Postpartum Period

SCC grantees provided reproductive and maternity care to thousands of people. 23,561 women and birthing people received care from SCC grantees. Out of this number, 12,167 women and birthing people received doula care. 6 out of 20 SCC grantees provided doula care to communities. Doula care is associated with improved satisfaction with care and birthing experience, an increase in the likelihood of spontaneous vaginal delivery, reduced cesarean section rates, lower rates of preterm birth and low birth weight babies, and improved patient-provider communications (Sobczak et al., 2023).

Maternal Health Workforce Development

SCC grantees offered a range of training programs to health care providers and community members. These programs were community-based doula training, community health workers training, lactation specialist training, and implicit/unconscious bias training. 8 SCC grantees provided community-based doula training and 2 SCC grantees provided community health worker training. A total of 221 doulas and community health workers were trained by SCC grantees.

2 SCC grantees provided training to health care providers. Training primarily focused on reducing implicit/unconscious bias during service provision to pregnant, birthing, and postpartum people and quality improvement efforts. A total of 5,313 health care providers were trained by SCC grantees. Furthermore, 428 health care facilities received training by SCC grantees.

SPOTLIGHT

Sustainability Wins

With SCCI funding, grantees were able to work towards major sustainability wins. SCC grantees have worked towards having an impact that is sustained far beyond the grant period through sustainable funding opportunities. SCC grantees were able to secure additional funding from other foundations as well as funding from the local, state, and/or federal government. Over $2.6 million in additional funds were secured so far by 6 of 20 SCC grantees.

BALTIMORE, MD

PROJECT NAME
Baltimore Safer Childbirth Cities Initiative

ORGANIZATION NAME
Baltimore Healthy Start

NORFOLK, VA

PROJECT NAME
Project ReByrth

ORGANIZATION NAME
Urban Baby Beginnings

BROOKLYN, NY

PROJECT NAME
Designing for Equity: Community-led Blueprints for Reimagining Primary Maternity Care

ORGANIZATION NAME
Black Women's Blueprint

SAN FRANCISCO, CA

PROJECT NAME
SisterWeb: San Francisco Community Doula Network

ORGANIZATION NAME
SisterWeb

DETROIT, MI

PROJECT NAME
Project Detroit: Voices for Life

ORGANIZATION NAME
Southeast Michigan Perinatal Quality Improvement Coalition

ST. LOUIS, MO

PROJECT NAME
St. Louis 360 Doulas Initiative

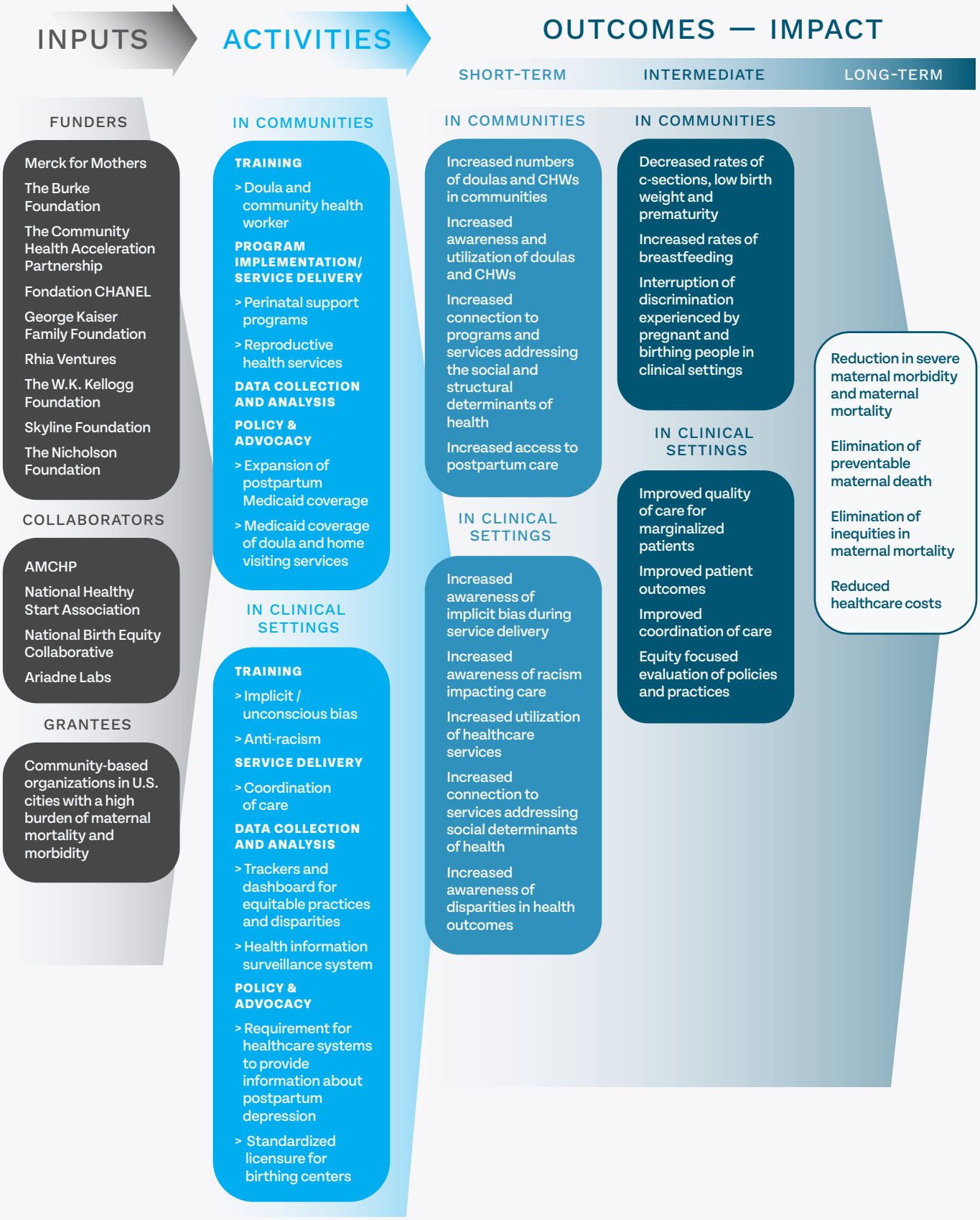
ORGANIZATION NAME
Jamaa Birth Village

$2,688,068

SECURED IN ADDITIONAL FUNDS

FIGURE 14

Safer Childbirth Cities Initiative Logic Model



SCC Initiative Grantee Profiles

COHORTS 1 AND 2

Atlanta, Georgia

PROJECT NAME
Black Mamas Matter Alliance Safer Childbirth Cities ATLANTA Project

ORGANIZATION NAME
Black Mamas Matter Alliance

PROJECT OVERVIEW

Black Mamas Matter Alliance (BMMA) is a national network of Black women-led organizations and multidisciplinary professionals who work to ensure that all Black Mamas have the rights, respect, and resources to thrive before, during, and after pregnancy. BMMA and its Atlanta-based partners and experts in maternal mental health, legal advocacy, lactation, and reproductive and sexual health created a social safety-net model to link women, particularly Black women, to care and critical services that could be scaled to other communities where access to health care is limited. Atlanta-based partners included Center for Black Women's Wellness, SisterSong's Birth Justice Fund, SisterLove, Inc., Feminist Women's Health Center, Kuluntu Reproductive Justice Center, Black Girls' Breastfeeding Club, Emory-Decatur Hospital's Women's & Infant Health Department, Morehouse School of Medicine's Center for Maternal Health Equity, Atlanta Doula Collective, and Flora & Fauna Reproductive Wellness.

KEY ACCOMPLISHMENTS

BMMA and its Atlanta-based partners were able to lay the foundation for a social safety-net model to support Black Mamas outside the hospital setting. **They accomplished the following during the grant period:**

1. **Established a network of community-based, Holistic maternity and reproductive health care providers in Atlanta** committed to meet the health and social support needs of Black Mamas;
2. **Developed a holistic maternity care quality improvement framework for assessing organizational alignment with Holistic Maternity Care.** This framework was used to develop a corresponding assessment tool conducted with organizations. Assessment findings were used for organizational awareness and the identification of potential training areas for the learning community;
3. **Conducted and analyzed focus group and listening session data** to continue refining potential training curricula themes to support holistic model of maternity care informed by BMMA's Holistic Maternity Care standards;
4. **Identified facilitators and barriers as well as necessary resources and tools** to support the implementation of a referral network; and
5. **Engaged in preliminary mapping activities** to support a trauma-informed, full-spectrum referral network of care for Black mamas in the Atlanta area, informed by holistic maternity care principles.

CHALLENGES AND LESSONS LEARNED

The COVID-19 pandemic significantly challenged BMMA's organizational operations, programming, and staffing. BMMA and its Atlanta-based partner organizations also reported ongoing COVID-19 challenges including staff turnover, financial barriers, and provision of services affecting client relationship and care. As a result, all Merck for Mothers Safer Childbirth Cities Initiatives and learning community meetings shifted to virtual meetings, BMMA conducted a COVID-19 Rapid Update Survey, and BMMA direct service partners found innovative ways to pivot services and programs beyond telehealth services to meet client needs during the pandemic. BMMA also became more inclusive of all Black Mamas and their needs by partnering with organizations that support young mothers (i.e, Black Girls Breastfeeding Club) and queer and trans individuals (i.e., Kuluntu Reproductive Justice Center). These are two often overlooked parenting groups.

IMPACT

BMMA and its Atlanta-based partners supported and provided services to thousands of people inside and outside Georgia.

CORE INDICATORS FOR BMMA AND ATLANTA-BASED PARTNERS

180
Districts/regions in Atlanta with MFM supported programs

2,049
Clients receiving maternal health services from MFM-supported projects

14,333
Clients receiving modern contraceptive products and services

5
Health facilities strengthened to provide improved care

656
Children ages 0-3 benefit from Merck for Mothers supported programs

493
Client referrals for reproductive services

358
Client referrals for postpartum care

**The data presented in the "Core Indicators" graphics is Inclusive of all counties (n=159) in the state of Georgia and AL, AR, CA, CO, FL, KY, LA, MA, MD, MI, MS, NC, NM, NV, NY, OK, PA, SC, TN, TX, WA*

Austin, Texas

PROJECT NAME

Closing the Gaps for Black Mamas: Childcare for Health Equity

ORGANIZATION NAME

Maternal Health Equity Collaborative

PROJECT OVERVIEW

The Maternal Health Equity Collaborative (MHEC) aims to make birth safer for Black and Brown families in Texas by building community and using collective power to create lasting change rooted in birth justice and equity. The collaborative comprises the following birth support and parental support organizations: Black Mamas ATX, Giving Austin Labor Support, Healing Hands Community Doula Project, Mama Sana Vibrant Woman, Hand to Hold, and Partners in Parenting. MHEC offered culturally sensitive and comprehensive perinatal childcare services to complement the wraparound community doula support of the collaborative and ensure that Black mothers and their families are able to access the holistic, whole person care needed to alleviate maternal health complications and reduce inequities.

KEY ACCOMPLISHMENTS

MHEC accomplished the following during the grant period:

1. **Expanded services to clients of aligned community doula or midwife organizations outside of MHEC;**
2. **Provided anti-racist training to health care providers and childcare specialists and "on call" trainings for child care specialists;**
3. **Launched *Coworking at the Carver*,** an on-call/ emergency childcare program and appointment based childcare program; and
4. **Incorporated qualitative questions in the childcare program intake process** to assess wraparound needs of clients outside of childcare.

CHALLENGES AND LESSONS LEARNED

MHEC experienced challenges trying to build a large, reliable pool of childcare specialists and accommodating the increased demand for childcare. Although the collaborative best handles prescheduled care that is regular in interval and duration, it has gotten better at meeting emergent needs due to the incorporation of on-call childcare specialists.

IMPACT

Maternal Health Equity Collaborative supported and provided services to hundreds of people in Texas.

CORE INDICATORS FOR MHEC

67
Locations of service delivery

516
Childcare clients served and number of doula clients

62
Women who have had a consultation with a doula about contraception

865
Doula care clients served

117
Birthworkers trained/ childcare specialists trained

54
Hospital/birth centers worked at

701
Doula care clients served

Baltimore, Maryland

PROJECT NAME
Baltimore Safer Childbirth Cities Initiative

ORGANIZATION NAME
Baltimore Healthy Start

PROJECT OVERVIEW

Baltimore Healthy Start (BHS) is one of 105 federally funded Healthy Start programs nationally offering programs and services geared to help support mothers, fathers, and their families living in their targeted communities, through all stages of parenting – from preconception to pregnancy to postpartum and between pregnancies, and during a child's first few years of life – and beyond. BHS garnered support from the community, in addition to partnerships and working relationships with a number of organizations, agencies, health systems, and institutions, in order to achieve the milestones of the Baltimore Safer Childbirth Cities Project. Partners included the Association of Maternal & Child Health Programs, Baltimore City Health Department, Baltimore Healthy Start Community Action Network, Johns Hopkins University, Maryland Hospital Association, MedChi-The Maryland State Medical Society, The Preeclampsia Foundation and Total Health Care. They worked collaboratively to enhance Maryland's Maternal Mortality Review process with Severe Maternal Morbidity reviews, elevated patient experiences to improve quality care, and encouraged postpartum care services to be provided alongside pediatric visits.

KEY ACCOMPLISHMENTS

BHS and its partners accomplished the following during the grant period:

1. **Augmented the state of Maryland's maternal mortality review process** with a Baltimore-focused severe maternal morbidity review process;
2. **Established "Patients as Partners"** to bring knowledge and experience of maternity patients to bear on hospital and health system quality improvement processes;
3. **Implemented maternal health monitoring intervention (MHMI) of prenatal and postpartum home-based assessments for BHS clients,** with immediate medical referral if indicated; and
4. **Provided postpartum care services delivered by certified nurse practitioners** co-located and co-scheduled in federally qualified health center pediatric clinics at the first 6 infant well-child visits.

CHALLENGES AND LESSONS LEARNED

The COVID-19 pandemic required Baltimore Healthy Start to transition to a remote service delivery model and initially delay implementation. Although staff eventually returned, many services and programs remain virtual.

IMPACT

BHS and partners provided services and trained thousands of people in Maryland.

CORE INDICATORS FOR BALTIMORE HEALTHY START AND PARTNERS

2,519
Women with improved outcomes, as a result of Maternal Health Monitoring Interventions

2,519
Women served by Baltimore Safer ChildBirth Cities Initiative

22
BHS facility and community-based health providers/workers trained in MHMI checklist/tool use

Brooklyn, New York

PROJECT NAME

Designing for Equity: Community-Led Blueprints for Reimagining Primary Maternity Care

ORGANIZATION NAME

Black Women's Blueprint

PROJECT OVERVIEW

Black Women's Blueprint empowers Black women, girls, and gender-fluid people to advocate for human rights and to secure gender and racial justice through the eradication of sexual violence, and through access to full-spectrum reproductive health services. Black Women's Blueprint used a community-driven approach to 1) define, design and test an ongoing process for strengthening primary maternity care by integrating community-generated learning, co-design, and evidence-based care models, and 2) integrate and disseminate lessons learned and advocate for structural changes to expand access to primary maternity care services, providers, and facilities through regulatory and payment reform.

KEY ACCOMPLISHMENTS

Black Women's Blueprint accomplished the following during the grant period:

1. **Conducted listening sessions** to welcome over 100 people impacted by birthing experiences in Brooklyn;
2. **Trained over 200 doulas in supporting mothers impacted by trauma;**
3. **Launched Sistas Van,** which includes a wheelchair accessible mobile healing unit designed to serve survivors of sexual violence, reproductive violence, and physical abuse;
4. **Disseminated over 50 perinatal kits** (e.g., blood pressure monitors, compression socks, breast pumps,nipple cream, etc.) for Black, Indigenous and other people of color in Brooklyn; and
5. **Hosted a Birthing Justice Cypher Series using a "Designing for Equity" process".**

CHALLENGES AND LESSONS LEARNED

Black Women's Blueprint faced several external and internal challenges impacting their work. External challenges included the COVID-19 pandemic, Monkeypox, economic and political crises while internal challenges included the Medicaid and midwifery licensure landscape as well as broader issues of medical and racial equity. Nevertheless, the organization stated that their commitment to community kept them grounded throughout these challenges.

IMPACT

Black Women's Blueprint provided services to thousands of people in New York.

CORE INDICATORS FOR BLACK WOMEN'S BLUEPRINT

4
Community districts

1,446
Women served by Sistas Van and all partner organization direct services

1,740
Medical professionals AND number of prevention advocates AND number of midwives AND number of Birthworkers/doulas

22
Hospitals, birthing centers, urgent care facilities, and sexual assault prevention/ rape crisis centers

1,446
People with access to quality facilities as a result of having touch point with Black Women's Blueprint and partner organizations

Camden, New Jersey

PROJECT NAME

Strengthening Citywide Data Infrastructures to Improve Connection to Services and Care Coordination for Pregnant and Postpartum Women

ORGANIZATION NAME

Camden Coalition of Healthcare Providers

PROJECT OVERVIEW

The Camden Coalition of Healthcare Providers is a multidisciplinary, community-based nonprofit working to improve care for people with complex health and social needs in the city of Camden, across New Jersey, and around the country. Camden Coalition of Healthcare Providers and its partners strengthened citywide data infrastructures to improve connection to services and care coordination for pregnant and postpartum women. Partners included Cooper University Health Care, Virtua Health, Inspira Health, Osborn Family Health Center, CAMcare Health Corporation, and Southern New Jersey Perinatal Cooperative. Using the Camden Health Information Exchange, patients presenting to the emergency room (ER) with evidence of pregnancy and no connection to pregnancy care were identified and assigned for outreach across 13 ERs and 6 sites. The Coalition provided sites with support and training through monthly coaching calls. Data was also collected from patients and compiled in monthly site reports.

KEY ACCOMPLISHMENTS

Camden Coalition of Healthcare Providers and its partners accomplished the following during the grant period:

1. **Integrated more partners and training into the Camden Health Information Exchange** as well as updated data sets (e.g., perinatal risk assessments);
2. **Launched outreach workflow pilots at six sites** to connect pregnant women to prenatal and other pregnancy related care and additional support;
3. **Notable Accomplishments include using the Health Information Exchange to identify over 4000 patients eligible for outreach.** More than 650 patients accepted some type of support with 1/3 accepting more than one type of support.
4. **Built the capacity of partner sites t**o talk to people in early pregnancy including those who may be experiencing a miscarriage or considering terminating the pregnancy.
5. **Duplicated the workflow with a health system** that did not participate in the HIE using their existing EMR, indicating possibility for scaling.

CHALLENGES AND LESSONS LEARNED

We learned that people were receptive to the outreach calls. Most people who accepted support accepted more than one type of support.

A challenge was that staff were uncomfortable talking about miscarriage and abortion. The Coalition provided additional training to increase sites capacity to have these conversations. Another common challenge was insurance, especially for those that were presumptively eligible.

One of the sites, Inspira Health, was not a part of the HIE at the time that they launched outreach, so we had to duplicate the HIE report in their own EMR. This report was not as accurate as the HIE report but still allowed us to replicate the workflow for their patients.

IMPACT

Camden Coalition of Healthcare Providers provided training to 5 of the major prenatal care providers in South Jersey and a maternal health focused community-based organization. The Camden Coalition and partner sites conducted outreach to thousands of pregnant or recently pregnant people and provided support to hundreds of people in our community.

CORE INDICATORS FOR CAMDEN COALITION OF HEALTHCARE PROVIDERS & PARTNERS

6
Camden City and Woodlynne zip codes participating in the project

3,000
Women who received any maternal healthcare services from partners

367
Providers who received Health Information Exchange training or workflow coaching

56
Practices who received Health Information Exchange training or workflow coaching

ADDITIONAL INDICATORS

3,619
Patients presenting to the Emergency Room in early pregnancy with no evidence of prenatal care assigned for outreach

2,670
Assigned patients who were attempted to be reached

1,409
Assigned patients successfully contacted

669
Successfully contacted patients that accepted at least one type of support

Chicago, Illinois

PROJECT NAME
Chicago Collaborative for Maternal Health

ORGANIZATION NAME
Alliance Chicago

PROJECT OVERVIEW

AllianceChicago is a dynamic, innovation-driven non-profit dedicated to achieving health equity for vulnerable populations through collaboration, technology and research. AllianceChicago and its partners developed the Chicago Collaborative for Maternal Health (CCMH) to improve the quality and coordination of care to women at highest risk and empower families and social service providers through community outreach. They implemented the following aims: 1) led a quality improvement collaborative to improve health care quality for pregnant and postpartum people receiving care in outpatient clinics, 2) implemented a community engagement effort to build awareness about maternal mortality and morbidity and prevention and empower individuals and families, and 3) advocated for policy and systems change to sustain improvements in health and health care. An Expert Advisory Committee of people with lived experience who reside in the priority communities served as advisors and partners for all activities.

KEY ACCOMPLISHMENTS

AllianceChicago and its partners accomplished the following during the grant period:

1. **Ambulatory care partners participated in quality improvement efforts that contributed to the development of a Quality Improvement toolkit** and the successful linkage of high-risk pregnant patients to a primary care and/or medical home;
2. **AllianceChicago and its partners conducted a community feedback assessment a**nd collected perceived facilitators and barriers to maternal health, hosted community engagement events, and conducted "Shop Talk" focus groups with social service providers and community-based organizations;

3. **AllianceChicago's partner EverThrive Illinois launched "The Gathering",** a digital educational campaign prioritizing Black maternal mortality (https://thegathering.everthriveil.org/), engaging former and current participants of the Healthy Start program as community outreach and engagement coordinators; and

4. **Assisted in the passage of the following bills:** SB0967: Improving Health Care for Pregnant and Postpartum Individuals Act, HB3995: Birthing Center Birth Licensing Act, and HB0068: Hospital Report Card Act.

CHALLENGES AND LESSONS LEARNED

AllianceChicago and its partners experienced limited funding to support ambulatory care partners participating in the Quality Improvement Subcommittee and experienced delays due to the COVID-19 pandemic.

IMPACT

AllianceChicago and its partners connected people to care, trained providers and engaged thousands in its community engagement work.

CORE INDICATORS FOR ALLIANCECHICAGO AND PARTNERS

6
Chicago Community Areas and zip codes impacted by the Quality Improvement and Community Engagement work

97
High-risk pregnant patients successfully linked to primary care and/or medical home (numerator of QI data collection)

37,669
People reached by Community Engagement Work

65
Providers/staff from participating ambulatory care partners trained and carrying out Quality Improvement initiatives

13
Participating ambulatory care partners

134
Patients receiving care at participating ambulatory care partners --> # of high-risk pregnant patients (denominator of QI data collection) 2021 Q2

Columbus, Ohio

PROJECT NAME

WE ARE ENOUGH! Addressing & Impacting Maternal Health through a Community-Based Perinatal (Doula) Support

ORGANIZATION NAME

Restoring Our Own Through Transformation (ROOTT)

PROJECT OVERVIEW

Restoring Our Own Through Transformation (ROOTT) is a Black Public Health Equity, Community Based Organization dedicated to addressing Black Family Health and Stabilization, with a primary focus on Black Maternal and Infant health. These needs are addressed through ROOTT's full spectrum, Perinatal Support Doula services, training, and certification, public policy, advocacy, research, education, and consultation. ROOTT's model focus on Black Women and Families who have limited or no access to insurance. Partners included Lower Lights Health System (FQHC), OhioHealth System, The Ohio State University Wexner Medical Center, Franklin County Public Health, and the Director of Ohio Better Birthing Outcomes. The purpose of the model is to ensure that Black Women and Families in Ohio receive accurate medical information, as well as relevant, consistent, safe, and equitable care through a focus of re-empowerment of the Black Family.

KEY ACCOMPLISHMENTS

ROOTT was able to accomplish the following during the grant period:

1. **Developed online training tools, curriculum, and webinars** for health care professionals to address Black maternal health;
2. **Onboarded, trained, and certified culturally concordant Perinatal Support Doulas;**
3. **Expanded telehealth childbirth education capacity and curriculum;**
4. **Established a direct referral process with several health systems and providers;**
5. **Successfully enrolled clients into the Perinatal Support Program; and**
6. **Expanded the "Safety, Not Just Safe Sleep" marketing campaign.**

CHALLENGES AND LESSONS LEARNED

ROOTT navigated service provision in this project during the COVID pandemic. Advocacy for support during this period, including addressing and negated medically unnecessary inductions, surgical births, and other medical interventions became a primary focus. ROOTT received mixed feedback from stakeholders. Progressive institutions are welcoming of the integration of the Perinatal Support Program care while others have voiced concerns regarding the "role" or "necessity" of Perinatal Support Program care in their population. Feedback from Black Families served by ROOTT has been overall favorable with an additional need for clarity regarding benefits, and outcomes. Those outcomes were clearly realized by maintaining a 0% Black Maternal and Infant Mortality rate, 19% overall cesarean rate, 7.2% preterm rate, 5.6% low birth weight rate with all cases correlating to preterm births, and a 98% breastfeeding initiation rate.

IMPACT

ROOTT and its partners provided information and services to hundreds of Black women and families in Ohio as well as provided education and anti-racist training to thousands of interdisciplinary professionals.

CORE INDICATORS FOR ROOTT AND PARTNERS

3

Number of counties Perinatal Support Program direct services were provided to Ohio

187

Women expressing better perinatal and postpartum experiences through ROOTT's Perinatal Support Program model

113

Clients and greater community provided with information regarding family planning, inclusive of contraception options, in order to facilitate informed and respectful decision making

3,000

Individuals received education regarding the Structural and Social Determinants of Health, inclusive of anti-racist implicit bias training

Detroit, Michigan

PROJECT NAME

Project Detroit: Voices for Life

ORGANIZATION NAME

Southeast Michigan Perinatal Quality Improvement Coalition

PROJECT OVERVIEW

The Southeast Michigan Perinatal Quality Improvement Coalition (SEMPQIC) seeks to reduce the disparity between Black and White adverse maternal, perinatal and infant outcomes, including infant and maternal mortality, by creating a coordinated, equitable and sustainable network for perinatal care based on best practices, evidence based and innovative community solutions that will result in system changes and improved birth outcomes for all babies born in southeast Michigan. SEMPQIC partnered with the Detroit Health Department, Henry Ford Health, Black Mothers Breastfeeding Association to launch *Project Detroit: Voices For Life* (VFL). VFL was established to build on existing community assets to examine and replicate circumstances and conditions where Black mothers thrive, empowering Black women to advocate for the best perinatal care experiences, and lead care providers to reach their full potential in providing respectful and equitable care for Detroit women. VFL established a Maternal Mortality and Vitality Review Team, unconscious bias training, doula training and 100 Voices Storytelling.

KEY ACCOMPLISHMENTS

SEMPQIC and its partners accomplished the following during the grant period:

1. **The Maternal Mortality and Vitality Review Board published a comprehensive report** outlining key recommendations based on maternal mortality cases reviewed in Detroit through the comparative lens of "vitality".
2. **With storytelling training from Detroit Health Department/SisterFriends, Focus: HOPE and Black Mothers Breastfeeding Association, 15 women were videotaped and 22 videos were produced as a part of the "Our Births, Our Voices: Hear Us! Detroit Mothers Speak" campaign.** The videos and a "Tool Kit: What Black Women Should Know" are available on the SEMPQIC website (https://www.sempqic.org/hear-us-campaign).
3. **Henry Ford Health provided unconscious bias training to over 500 HFH and non-HFH healthcare professionals.**
4. **Black Mothers Breastfeeding Association graduated 18 doulas in December 2023 totaling 42 doulas trained and graduated over the last 3 years.**

CHALLENGES AND LESSONS LEARNED

The persistent impact of COVID-19 in the City of Detroit has presented ongoing challenges, necessitating the continuation of virtual trainings for programs like Storytellers and Doula, rather than in-person sessions. This shift has prompted adaptations to ensure continued program accessibility. Recognizing the diverse needs of women participating in the Storyteller training, adjustments were made to the schedule to accommodate those unable to attend daytime sessions, including the addition of evening hours. While the transition to virtual platforms allowed for flexibility, the importance of in-person Storyteller and Doula trainings were reaffirmed in 2022, highlighting the value of interpersonal interactions.

IMPACT

SEMPQIC strengthened health facilities, trained providers and doulas, and provided women with a variety of services and programming in Detroit.

CORE INDICATORS FOR SCC INITIATIVE AND PARTNERS

62

Facilities strengthened to provide quality care

347

Providers trained at Henry Ford Health System and number of Doulas trained

103

Women receiving Doula services, Storytellers trained, women responding to HFH Respectful Care Survey indicating empowerment, and number of women participating in MMVRT process

1

Districts/regions with MfM-supported programs (City of Detroit)

Jackson, Mississippi

PROJECT NAME

Jackson Safer Childbirth Experience

ORGANIZATION NAME

Mississippi Public Health Institute

PROJECT OVERVIEW

Mississippi Public Health Institute (MSPHI) is dedicated to developing partnerships committed to program innovation, the increase of health resources, education, health awareness, and applied research and policy. MSPHI spearheaded an initiative focused on mitigating unnecessary cesarean sections and enhancing community-based support for pregnant and postpartum women. The initiative sought to safely reduce cesarean rates among women in Jackson, MS by increasing provider and community awareness of the health risks associated with cesarean birth and elevating the acceptance and utilization of community-based support doulas by both health care providers and the priority population (i.e., African American women of childbearing age, specifically those between the ages of 18 and 44).

KEY ACCOMPLISHMENTS

MSPHI accomplished the following during the grant period:

1. **Provided training to enhance doulas' ability to support expectant mothers;**
2. **Implemented a self-reporting doula data collection system for more efficient and accurate information gathering;**
3. **Tailored programs to address community-specific concerns on preeclampsia and postpartum care; and**
4. **Organized bi-weekly yoga and Lamaze classes for Black women.**

CHALLENGES AND LESSONS LEARNED

MSPHI grappled with several challenges while attempting to bridge the gap between doulas and health care providers in Mississippi. While some health care providers embraced additional support for birthing persons, a significant number remain hesitant due to negative encounters, limited understanding of the doula role, and sparse interactions with doula integration. Ongoing commitment from doulas was hindered by unavailability and burnout, impacting participation in training and recruitment as well as metric tracking for project assessment. Despite these challenges, contracted doulas are working to impact the health care system, emphasizing the need for sustained efforts to establish procedures, addressing biases, and building partnerships.

IMPACT

MSPHI enhanced the empowerment and capabilities of contracted doulas by providing comprehensive training to over 800 individuals in Jackson and the surrounding areas.

CORE INDICATORS FOR MISSISSIPPI PUBLIC HEALTH INSTITUTE AND PARTNERS

6
Districts/regions covered (metro birthing hospitals)

822
Doulas and hospital staff trained by JSCE sponsored activities

27
Labor and delivery units contacted and communicating with JSCE

New Orleans, Louisiana

PROJECT NAME
New Orleans Respectful Motherhood Initiative

ORGANIZATION NAME
Institute of Women and Ethnic Studies

PROJECT OVERVIEW

The Institute of Women and Ethnic Studies (IWES) is a national non-profit health organization domiciled in New Orleans dedicated to improving the mental, physical and spiritual health and quality of life for women, their families and communities of color, particularly among marginalized populations, using community-engaged research, programs, training and advocacy. IWES in collaboration with its partners in the "New Orleans Respectful Motherhood Initiative," addressed unmet health needs and provided support to birthing individuals who may be disconnected from quality care and policy solutions. IWES conducted Perinatal Community Health Worker (PCHWs) training and empowered individuals with the skills to address the unique challenges faced during the perinatal period. Drawing inspiration from the Black Maternal Health Momnibus Act of 2020, the group developed a draft of a Louisiana plan seeking to establish a coalition involving New Orleans' top industries and organizations, with a specific focus on advocating for maternal wellness and family health. Lastly, IWES engaged the Local Maternal Mortality Review Task Force, aiming to comprehensively analyze maternal mortality cases to identify areas for improvement in care and policy. IWES's partners included 504HealthNet, George Washington University, Institute for health care Improvement Birth Equity Lab, New Orleans City Council, New Orleans Health Department, New Orleans Maternal and Child Health Coalition, NOLA4Women, NOLA Baby Café, Saul's Light, Touro Maternal and Child Health Task Force, TrainingGrounds Inc., and Xavier University of Louisiana.

KEY ACCOMPLISHMENTS

IWES and its partners accomplished the following during the grant period:

1. **Provided services to thousands of women and birthing people through doulas, perinatal community health workers, and social workers;**
2. **Onboarded 59 PCHWs,** reflecting a commitment to building a robust support network;
3. **Conducted focus groups and in-depth interviews** involving both community members and healthcare professionals shedding light on the model of respectful motherhood; and

4. **In partnership with the Louisiana Department of Health, published the *Louisiana Perinatal Mental Health Task Force Policy Brief* with recommendations for improving maternal mental health services.** The recommendations include incorporating universal perinatal mood and anxiety disorder screening into key care systems, expanding direct access to mental health services, optimizing and expanding care coordination systems, and ensuring the mental health provider network meets the needs of pregnant and postpartum individuals, with a focus on the needs of Black and Brown women.

CHALLENGES AND LESSONS LEARNED

The ongoing COVID-19 pandemic exposes centuries of health disparities, with heightened mortality and morbidity among people of color, the economically disadvantaged, and those with limited health care access. Addressing these challenges requires innovative, focused approaches. Louisiana faced additional disruptions from hurricane storms, leading to evacuations and shortages, adding complexity to health care provision. Community engagement and inclusivity were pivotal in the initiative's strategy.

Active involvement of all community members, including women with diverse experiences, and collaboration with PCHWs were crucial. Securing support from diverse stakeholders, such as hospital administrators, policymakers, and researchers, remains an ongoing priority, emphasizing inclusivity in shaping maternal health care solutions. Recognizing the urgency of addressing racial equity and biases, the initiative hosts dedicated training sessions, showcasing a proactive commitment to dismantling systemic biases. Valuable insights are gained from prioritizing specific demographics, like native New Orleanians, people of color, and Spanish speakers, in selecting Perinatal CHWs, ensuring cultural competence and addressing community needs effectively. In navigating these challenges, the initiative underscores the importance of adaptability, inclusivity, and a holistic health care approach that considers broader social determinants impacting maternal health.

IMPACT

IWES and its partners conducted trainings with over 2,000 providers and provided services to thousands of birthing people in New Orleans and the surrounding areas.

CORE INDICATORS FOR THE INSTITUTE OF WOMEN AND ETHNIC STUDIES

2,226
Providers received training through presentations/trainings from partner organizations

59
Birthmark/ Building Perinatal Community Health Workers

48
Parishes in the area served by partner organizations

Newark, New Jersey

PROJECT NAME

Reducing Maternal Mortality and Severe Maternal Morbidity in Newark, NJ

ORGANIZATION NAME

Greater Newark Health Care Coalition

PROJECT OVERVIEW

The Greater Newark Health Care Coalition (GNHCC) works collaboratively to improve systems and community and individual conditions for optimal health and well-being. GNHCC addressed the following aims to comprehensively address maternal health in Newark as a Safer Childbirth City: implementation of a community-based participatory research study (CBPR) and the subsequent development of a robust public education campaign, exploration of a severe maternal morbidity surveillance system, and collective impact implementation of the Alliance for Innovation on Maternal Health Community Care Initiative (AIMCCI) bundles with community care service providers and Newark's labor and delivery hospitals. Collectively, these aims represented a holistic approach to maternal health, incorporating surveillance, community engagement, and improvements in clinical care to address disparities and promote maternal well-being in Newark.

KEY ACCOMPLISHMENTS

GNHCC accomplished the following during the grant period:

1. **Created and distributed 1,000 new mom kits,** providing essential resources and support for new mothers during the COVID-19 Public Health Emergency;
2. **Implemented and hosted 8 training opportunities** with 90+ attendees via ReachOne Health Equity Training, a racial sensitivity and implicit bias training, emphasizing a commitment to fostering a more equitable and culturally competent approach to maternal health;
3. **Successfully created a series of Medicaid maternal care** shedding light on maternal care trends and outcomes for women Medicaid recipients of childbearing age including severe maternal morbidity;
4. **Collaborated with Rutgers School of Public Health on a CBPR project** on a community based participatory research project aiming to comprehensively examine Black women's experiences with maternal health care via 6 Newark women with lived expertise trained as IRB Community Researchers who interviewed 31 Black women resulting in four main research themes and corresponding recommendations; and

5. **Utilized research findings to develop an online public education campaign, *Hear Her,*** to elevate awareness about serious complications associated with pregnancy and the postnatal period, with a specific focus on the experiences of Black birthing people.In its early days, the campaign reached over 116,000 people across various platforms including https://www.newarkmom.org/.

CHALLENGES AND LESSONS LEARNED

GNHCC faced challenges and learned valuable lessons during the grant period. GNHCC had to overhaul its educational materials to ensure health literacy and cultural competence. It also translated materials into multiple languages, recognizing the importance of accessibility for diverse populations. Ensuring diversity among community workers and spokespeople, with a focus on including immigrants, became a vital aspect of GNHCC's strategy. This effort aimed to authentically represent the communities served, recognizing the significance of diverse perspectives in shaping maternal health initiatives. Additionally, the COVID-19 pandemic necessitated adapting recruitment strategies for the CBPR focus groups. Initially recruiting directly from the Health Information Exchange, the strategy shifted to prioritize safety and avoid invasiveness.

IMPACT

GNHCC and its partners provided communities in Newark and the surrounding areas with comprehensive maternal health initiatives.

CORE INDICATORS FOR GREATER NEWARK HEALTHCARE COALITION

14

Zip codes in catchment area of participating hospitals, and zip codes covered by CHW program

2

Number of non-hospital maternal safety bundles implemented by Newark maternal health service providers during the SCC grant period

Norfolk, Virginia

PROJECT NAME
Project ReByrth

ORGANIZATION NAME
Urban Baby Beginnings

PROJECT OVERVIEW

Urban Baby Beginnings® (UBB) is a non-profit providing community support services for pregnant and parenting families in Virginia. UBB introduced the Rebyrth program, an initiative aimed at establishing meaningful connections for expectant clients of color seeking perinatal support. The program collaborates with birth and postpartum specialists of color who are not only highly skilled but are also from the communities they serve to provide culturally competent doula support, peer-based maternal mental health support, and lactation counseling. Recognizing the importance of accessible information, Rebyrth also provided online educational resources, ensuring that expectant clients have a wealth of knowledge at their fingertips.

KEY ACCOMPLISHMENTS

UBB's ReByrth Program accomplished the following during the grant period:

1. **Accepted 3,307 calls from members of the community in need of support;**
2. **ReByrth Norfolk provided 873 doula consultations,** offering personalized support to clients during a crucial period;
3. **Successfully enrolled 98 clients in birth and postpartum services,** including home visiting and doula support services;
4. **Credentialed and onboarded 14 Medicaid doula providers,** poised to accept 6 Medicaid plans in the state of Virginia pending acceptance;
5. **Interviewed 76 key stakeholders in the community,** fostering a deep understanding of the diverse needs and perspectives within the community; and
6. **Presented at the Virginia Neonatal Perinatal Collaborative (VNPC) conference in March 2023,** where ReByrth was introduced as a viable model of care through the Alliance for Innovation on Maternal Health—Community Care Initiative (AIM CCI).

CHALLENGES AND LESSONS LEARNED

UBB's ReByrth Program encountered a few challenges during the grant period, which included concerns about the long-term sustainability of both the Rebyrth project (e.g., funding, infrastructure) and the lack of community-based services in the community. This prompted the organization to build a new system to address data-related issues and work with state and local partners to build a long-term sustainability plan, indicating the organization's proactive response to evolving circumstances.

IMPACT

UBB's ReByrth Program trained health workers and community-based providers and provided thousands of women with services and digital support during the grant period.

CORE INDICATORS FOR URBAN BABY BEGINNINGS REBYRTH PROGRAM

2,100
Women who have received perinatal or postpartum services at UBB through the ReByrth project

1,875
Women who have received reproductive health counseling services at UBB through the ReByrth project

2,100
Women who have received digital support and CHW services at UBB through the ReByrth project

79
Health workers who have received training through the ReByrth project

7
Community- based partners who have been strengthened to provide quality care through the ReByrth project

1,973
Women/providers who reported 0 adverse events related to the lack of quality care in health facilities/hospital systems

Philadelphia, Pennsylvania

PROJECT NAME

Maternal Mortality Review Community Action Team

ORGANIZATION NAME

Health Federation of Philadelphia

PROJECT OVERVIEW

Health Federation of Philadelphia (HFP) is a network of Community Health Centers as well as the broader base of public and private-sector organizations that deliver health care, public health and human services to vulnerable populations. HFP, in collaboration with its partners, worked to strengthen surveillance and reporting, improve clinical care, integrate community voices in developing solutions, address racial disparities in maternal health outcomes, and increase community-based support for childbearing women through development of a maternal mortality community action team. HFP and its partners built out the infrastructure for the Philadelphia Maternal Mortality Review Community Action Team (the OVA—Organizing Voices for Action) and strengthened the following existing maternal health projects: Heart Safe Motherhood, Access Matters, Perinatal Opioid Use Disorder (OUD) Training, Early Warning Signs Implementation team and Strategy Arts. The Heart Safe Motherhood initiative aims to improve hypertension surveillance in the postpartum period. Access Matters contributes through Implicit Bias and Postpartum Doula Accessibility Trainings, while Perinatal OUD training and the Early Warning Signs Implementation team further enrich the initiative's holistic strategy. The involvement of Strategy Arts emphasizes the thoughtful and collaborative approach taken by the Health Federation of Philadelphia and its partners in tackling critical issues in maternal and child health. Notably, the establishment of a Community Action Team, named Organizing Voices for Action (OVA), underscores the initiative's dedication to amplifying community-based support for childbearing women.

KEY ACCOMPLISHMENTS

HFP and its partners accomplished the following during the grant period:

1. **Prevention Point health educators and navigators achieved significant milestones through the provision of health education sessions;**
2. **Released the 2022 Annual Early Warning Signs Evaluation Report** and provided a comprehensive assessment of the program's efficacy and reach;
3. **Established a diverse advisory board** emphasizing inclusivity and varied perspectives, enabling a comprehensive approach to address unique community needs;
4. **Developed an equity tracker** to monitor practices aligning with equity principles, fostering a more inclusive and fair approach; and
5. **Collaborated with Lived Experience Experts** to underscore the significance of firsthand experiences in shaping the initiative authentically.

CHALLENGES AND LESSONS LEARNED

The OVA initiative faced challenges with retention due to the impact of the COVID-19 pandemic. The disruptive nature of the pandemic affected the ability to maintain consistent engagement and participation in the OVA initiative. For example the tracking of core indicators encountered difficulties as various metrics underwent substantial changes. The altered landscape made it challenging to monitor and assess key performance indicators effectively, posing a hurdle in evaluating the initiative's progress. In response to pandemic challenges, the OVA initiative addressed retention issues with adaptable strategies to navigate and mitigate COVID-19's impact on participant engagement. Additionally, implementing a strategic language shift to "mothers and birthing people" demonstrates a commitment to inclusivity, ensuring a welcoming environment for all individuals with the ability to give birth, irrespective of gender identity, and reflecting sensitivity to diverse experiences in maternal health.

IMPACT

HFP provided thousands of women with valuable health education and assessment in Philadelphia and the surrounding areas. Individuals participating in the Early Warning Signs (EWS) training completed a pre- and post-test and the qualitative portion revealed the following emergent themes: the training being perceived as informative, instilling confidence, having an effective presentation approach, and being relevant and familiar to participants.

CORE INDICATORS FOR HEALTH FEDERATION OF PHILADELPHIA

2,254
Women enrolled in the Heart Safe Motherhood Initiative

845
Number of communications received by provider from patients

17
Philadelphia zip codes with MfM-supported programs

ADDITIONAL INDICATORS

390	Number of women receiving services from Prevention Point
190	Number of women receiving family planning services via Prevention Point
182	Number of doulas who attended professional development workshops
35	Number of providers who attended Brunch and Learn educational workshops
505	Number of participants for Implicit Bias Training
601	Number of providers x-waivered and trained via Perinatal OUD training
6	Number of institutions who hosted Implicit Bias training

6	Number of organizations represented via attendance at Implicit Bias conference
198	Number of women served at Prevention Point Ladies Night
64	Number of women scheduled follow up appointment to start contraceptive
30	Number of women receiving doula services in the postpartum period via Maternity Care Coalition
390	Number of women receiving services from Prevention Point
190	Number of women receiving family planning services via Prevention Point
182	Number of doulas who attended professional development workshops

Pittsburgh, Pennsylvania

PROJECT NAME
Pittsburgh:
A Safer Childbirth City

ORGANIZATION NAME
Jewish Healthcare Foundation

PROJECT OVERVIEW

The Jewish Healthcare Foundation (JHF) is an activist and grantmaking foundation working to advance health care innovation, advocacy, collaboration, and education in the interest of better population health. It has three operating arms: the Pittsburgh Regional Health Initiative (PRHI), Health Careers Futures (HCF), and the Women's Health Activist Movement Global (WHAMglobal). In partnership with other organizations across the region, JHF created Pittsburgh: A Safer Childbirth City to reduce racial/ethnic disparities in maternal mortality and morbidity rates across the city. Many of these partners are birthing-focused and prioritize Black birthing people and their support systems across the Pittsburgh region as well as offer training courses and skills-building opportunities, bolstering the maternal health workforce and assisting parents-to-be. The project worked to engage communities in maternal health improvements and address the social determinants of health, and work with doulas and perinatal support workers to bolster the care support system around women and families during pregnancy, childbirth, and the months after.

KEY ACCOMPLISHMENTS

JHF's Pittsburgh: A Safer Childbirth City accomplished the following during the grant period:

1. **Created a Community Advisory Board (CAB) in partnership with Healthy Start, Inc.** to ensure diverse community voices were represented in decision-making, bolstering community engagement and advocacy efforts;
2. **Community Advisory members completed the Community Health Advocate training.**
3. **The Community Fund, made up of five Black-led organizations focused on maternal health, completed separate projects as well as a collective impact training and eventually formed a Shared Resource Hub,** allowing them to pool resources such as administrative assistants and grant writers each individual organization would not have been able to access individually.
4. **The Perinatal Health Equity Champion program paired community health workers with hospital-based maternal health workers** to go through a 6-month quality improvement training followed by one year of community-led QI projects with intensive coaching and peer support.
5. **The Smart Start program combined parental volunteers with traditional case management** to provide support to newly arrived pregnant and postpartum refugees.
6. **Held a sustainment-focused Finale event** to highlight the work of partners and gain valuable support from regional stakeholders for ongoing work.

These accomplishments underscore the initiative's commitment to inclusive community engagement, knowledge dissemination, and capacity building in addressing maternal health disparities.

CHALLENGES AND LESSONS LEARNED

The disruptive impacts of COVID-19 and systemic racism have significantly affected the community advocates involved in the Safer Childbirth Cities Initiative. These external challenges have presented considerable hurdles, causing interruptions and constraints to their engagement. In many ways, these unforeseen changes have highlighted the acute relevance and urgency of the Safer Childbirth Cities' work amidst the ongoing global health crisis and persistent systemic inequalities.

Additionally, the initiative successfully engaged a diverse array of community partners with distinct goals and catered to different key populations. While this extensive engagement was a positive outcome, it posed a challenge in clearly defining and articulating the major aims of the study. The multiplicity of partners and their varied objectives slightly complicated the identification and alignment of primary study objectives. This broad engagement signifies the initiative's commitment to inclusivity and collaboration with various stakeholders, contributing to a more comprehensive and diverse approach in addressing maternal health disparities.

IMPACT

JHF and its partners provided training and skills-building opportunities to people across the Pittsburgh region and engaged thousands of community members in collaboration with local doulas and community health workers.

CORE INDICATORS FOR JEWISH HEALTHCARE FOUNDATION

52

Participants trained through all Pittsburgh Safer Childbirth City projects

11

Health facilities, Regional PA PQC sites and Community Based Organizations, participating and strengthened through Pittsburgh Safer Childbirth City initiative

11

Sites and community based organizations participating in perinatal quality collaborative quality improvement projects and reporting outcomes

230

Neighborhoods in Pittsburgh impacted or receiving service provided by MFM-supported programs

3,332

People that interact with MfM-supported projects including all sub-contracted projects and the women served by those agencies and through the project.

3,332

Participants interacting with doula community health workers through the volunteer program, Community Fund participating groups, and Community Health Advocates program as reported by the Moms Advisory.

San Francisco, California

PROJECT NAME
SisterWeb: San Francisco Community Doula Network

ORGANIZATION NAME
SisterWeb

PROJECT OVERVIEW

SisterWeb is a network of culturally congruent community doulas and birth workers from and for Black communities working to dismantle racist health care systems, strengthen community resilience, and advance economic justice for birthing families and doulas in San Francisco. SisterWeb has been instrumental in bolstering access to culturally responsive doula care for Black, Latinx, and Pacific Islander women within the San Francisco community. This project focused on the following programs from SisterWeb: Kindred Birth Companions, Semilla Sagrada, and Champion Dyad Initiative. Kindred Birth Companions is a doula program specifically designed and run by Black Doulas who serve the needs of Black families residing in San Francisco. Complementing this, Semilla Sagrada operates as a direct service program, initiated by Latinx doulas from diverse national backgrounds. This program is dedicated to providing essential support to Latinx families and birthworkers in the region. Additionally, the Champion Dyad Initiative (CDI) strategically fosters the role of designated "champions" at each hospital, collaborating closely with SisterWeb staff members, and has been implemented across all five sites/hospitals equipped with labor and delivery units in San Francisco. Together, they function to improve the quality of care within these health care facilities, aiming to ensure fair and equitable treatment for all women of color during their pregnancies and births.

KEY ACCOMPLISHMENTS

SisterWeb's initiatives provided community-based doula care and doula training opportunities to women of color in San Francisco. **It accomplished the following during the grant period:**

1. **Provided comprehensive perinatal doula care and health advocacy services** by culturally congruent doulas to over 269 mothers, which was pivotal in addressing their unique needs and challenges;
2. **Partnered with Health Connect One to offer and facilitate a comprehensive "Train the Trainer" program,** empowering SisterWeb to oversee their community doula program more effectively and create pathways for women interested in pursuing careers as professional birthworkers.

CHALLENGES AND LESSONS LEARNED

The COVID-19 pandemic's unprecedented circumstances, coupled with hospital regulations and the comfort levels of both patients and doulas, imposed notable constraints on traditional in-person support methods. As a result, doulas were compelled to innovate and adapt, resorting to alternative methods to provide assistance and support to mothers remotely, often leveraging technology such as tablets or other digital devices. Despite these challenges, doulas persevered and demonstrated remarkable resilience by embracing innovative means to provide continuous support to mothers amid these unprecedented circumstances.

IMPACT

The impact of SisterWeb's initiatives has been profound, particularly in the support and care extended to Black and Brown mothers in San Francisco. The tailored support ensured that mothers received personalized care throughout their perinatal journey, addressing their unique needs and challenges. This initiative not only provided crucial support to birthing families but also created pathways for women aspiring to pursue careers as professional birthworkers.

The impact of these efforts is powerfully expressed in the words of a Kindred Birth Companions (KBC) Doula, who shared a heartfelt sentiment about the support received: "I feel so lucky to be at SisterWeb because I don't think I got the support outside. I didn't really know what support meant until I came to SisterWeb, and I think one of the most recent memories was not feeling alone being a doula too and knowing that I also can rely on other doulas." This testimonial resonates with the positive impact of SisterWeb's initiatives, highlighting the transformative effect on the lives of doulas and the invaluable support extended to mothers from marginalized communities.

CORE INDICATORS FOR SISTERWEB

269

Black and Brown mothers receiving perinatal doula care and health advocacy from a culturally congruent doula

269

Black and Brown mothers reported via a survey that their doulas helped them use their voice, assert their own wishes, and ask for a moment when they needed time to think over a decision

10

Black and Brown doulas provided professional training, support, and wages and benefits.

6

Hospitals where SW doulas regularly support clients during births and work with via Champion Dyads

St. Louis, Missouri

PROJECT NAME
St. Louis 360 Doulas Initiative

ORGANIZATION NAME
Jamaa Birth Village

PROJECT OVERVIEW

Jamaa Birth Village is a pioneering Black Maternal Health organization in Ferguson, MO providing culturally congruent traditional midwifery and community-based doula care, with wraparound holistic care support to Saint Louis area families. One year after the Michael Brown Jr. uprising in the birthplace of Jamaa Birth Village, reports indicated systemic and structural racism as the root cause of inequities and disparities plaguing Black families, increasing the preventable causes of complicated pregnancies, premature births, low birth weight newborns, and negative birthing and postpartum outcomes for Black mothers. A maternal health care analysis led by Jamaa Birth Village in 2015, proved a stark disparity gap in community-based maternity care providers, reporting zero Black certified community based & hospital Midwives in the State of Missouri, less than 10 Black practicing doulas in the Saint Louis metropolitan area, a lack of culturally congruent maternal health care and a void and disregard of Black community voices regarding maternal health care inequities and solutions.

Jamaa Birth Village created the STL 360 Doula Initiative to enhance access to culturally congruent holistic maternal health services for Black women, establish a sustainable doula workforce, and integrate doula care into the existing health and hospital systems. The project's broader vision encompassed a fundamental restructuring of the maternal care ecosystem, seeking to pivot it towards centering and addressing the unique requirements of Black St. Louisans throughout the prenatal, perinatal, and postpartum periods. Through this multifaceted approach, Jamaa Birth Village has been instrumental in fostering systemic changes in maternal healthcare provision. Their comprehensive strategy not only focuses on doula training but also emphasizes the pivotal role of culturally congruent care within the broader healthcare framework.

KEY ACCOMPLISHMENTS

Founded in 2015, Jamaa Birth Village closed the disparity gap in access to Black Doulas in the St. Louis region through Okunsola's Community Doula Training©, St. Louis's first Black licensed community-based doula training, growing the STL doula community from less than 10-Black practicing doulas, to over 91 Black practicing doulas between the years of 2016 and 2020. Under the umbrella of the STL 360 Doula Initiative, Jamaa Birth Village spearheaded efforts to further scale the local doula movement through providing services to women in St. Louis. . It accomplished the following during the grant period:

1. **Integrated 363 local doulas into the maternal health ecosystem in St. Louis.** By fostering a deeper appreciation and readiness for doula services, the initiative significantly contributed to enhancing the respect and acknowledgment of doulas' vital roles in supporting expectant and new mothers within these communities.
2. **Enrolled and provided comprehensive doula services throughout the pregnancy and postpartum periods to over 217 women in the St. Louis metro area, Kansas City metro area, and Greene County.** The program's offerings included various facets of support, ensuring holistic care for expectant and new mothers and included face-to-face visits during the pregnancy period, continuous 1:1 birthing support during labor and delivery, on-call availability throughout both the pregnancy and postpartum stages, and post-birth education.
3. **Provided enrollees with referrals to childbirth classes and various community resources, enriching the overall support system available to these women.**
4. **Co-authored the Medicaid Doula Reimbursement policy brief.**

5. **Collaborated with Missouri HealthNet and the Missouri Department of Health and Senior Services in amending the State Plan Amendment for Medicaid doula reimbursement.**
6. **Collaborated with state legislators adding $500,000 into the Missouri state budget f**or doula training, doula train the trainer, and hospital doula education workshops in the legacy of the late Cora Faith Walker, a Jamaa Birth Village supporter.
7. **Collaborated with state legislators in advancing doula Medicaid and private insurance reimbursement.**
8. **Provided doula training and certification to the City of St. Louis Department of Health, Affinia Health, Parents as Teachers, and the Ferguson-Florissant School District.**
9. **Collaborated with Missouri Baptist Hospital during the COVID-19 pandemic,** advocating for doulas to be allowed in L & D and postpartum units as care providers with hospital badges.
10. **Partnered with the BJC Hospital Network across 4-hospitals, the Goldfarb School of Nursing, and the Washington University OB residency program to provide doula education workshops and CEU's.** Partnered with BJC and March of Dimes for the Hospital Doula Friendly action team.
11. **Influenced the SSM Hospital system to integrate Doulas as a part of the care team.**
12. **Collaborated with the Mercy Hospital system to integrate cultural congruency across their maternity care provider, executive and administrative teams.**
13. **Co-created the Missouri Community Doula Council—a coalition of Doula training organizations.**

CHALLENGES AND LESSONS LEARNED

Jamaa Birth Village completed project deliverables during the grant period and developed a partnership covenant and goals for the leadership structure that would allow for multiple perspectives and leadership from all team members that reflected the community that was being served. The STL 360 Doula Initiative was initially co-led with Generate Health STL and Jamaa Birth Village. The co-led framework transitioned to being led solely by Jamaa Birth Village to remove historical inequities Black CBOs like Jamaa Birth Village experience in leading and disrupting systemic and structural change in tandem with white led institutions. Beyond this, the ongoing COVID-19 pandemic led to unexpected delays in the project. It exposed centuries of health inequities, with heightened mortality and morbidity among people of color, the economically disadvantaged, and those with limited healthcare access. Addressing these challenges requires innovative, focused approaches.

IMPACT

The impact of the 360 Doulas Project has been substantial. This initiative extended beyond the immediate scope of training licensed doulas and providing doula care, aiming to ensure a robust infrastructure for culturally aligned doula care specifically tailored to the needs of Black pregnant individuals in St. Louis.

CORE INDICATORS FOR JAMAA BIRTH VILLAGE

28
St. Louis Promise Zone municipalities with MfM programs

363
Doulas trained in total as part of the STL 360 Doula Initiative

115
Doulas trained with mentor as part of STL 360 Doula Initiative

81
Pregnant women served in the Healthy Blue Doula Care pilot

10
Doula training scholarships provided through the Healthy Blue Doula Care pilot

Tampa, Florida

PROJECT NAME
Improving Equity in Perinatal Mental Wellness

ORGANIZATION NAME
REACHUP, Inc.

PROJECT OVERVIEW

REACHUP, Inc. advocates for and mobilizes resources to help communities achieve equality in health care and positive health for families. REACHUP, Inc. and its partners embarked on a mission aimed at enhancing perinatal mental wellness while simultaneously addressing and diminishing racial and ethnic disparities prevalent in perinatal health outcomes. Central to this initiative was the facilitation of comprehensive and inclusive access to a continuum of care tailored to women and their families. At the core of this effort stood the Perinatal Wellness Coalition, a strategic endeavor geared towards augmenting maternal health and wellness. The coalition expanded its doula services, seeking to provide enhanced support to pregnant individuals and new mothers. A significant aspect of this expansion included the introduction of weekly peer support groups, designed to prioritize mental wellness. These support groups not only catered to the needs of their clients but were also extended to the broader community, aiming to create a supportive environment that emphasized mental well-being during the perinatal period. This effort by REACHUP, Inc. and its partners showcased a holistic approach towards perinatal health. By prioritizing mental wellness and inclusivity within their continuum of care, they addressed critical disparities in perinatal health outcomes while providing vital support to women and families throughout their perinatal journey.

KEY ACCOMPLISHMENTS

REACHUP, Inc. accomplished the following during the grant period:

1. **Created an informative video spotlighting several facets of their doula program,** underscoring its direct and tangible impact on the clients it served, for a Community Counsel presentation. Through this medium, the organization successfully shared the invaluable contributions and outcomes arising from their doula services, shedding light on the transformative influence on their clientele.
2. **Created and implemented a novel support group named "Infant Feeding Fridays."** This initiative took the form of interactive question-and-answer-based Zoom sessions, extending an open invitation to all clients served by REACHUP and the wider community. These sessions covered an array of critical topics encompassing breastfeeding, bottle feeding, formula safety, pumping, and solid foods.

These achievements by REACHUP, Inc. underscored their commitment to empowering their clientele and fostering an inclusive environment for shared knowledge and experiences. The initiatives not only provided essential information but also facilitated a collaborative space where clients could actively contribute, ensuring that their voices were not only heard but also celebrated and valued within the community and the organization's doula program.

CHALLENGES AND LESSONS LEARNED

Navigating team building and establishing partnerships for home visitations has persistently posed as one of the most significant challenges for REACHUP, Inc., particularly in the context of perinatal and postpartum care. The COVID-19 pandemic's disruptive influence has significantly exacerbated these difficulties, presenting formidable obstacles primarily due to the constraints imposed on physical meetings and in-person interactions.

IMPACT

REACHUP, Inc. and its partners provided doula training and care to pregnant and postpartum people in Tampa. Through the "Infant Feeding Fridays" sessions a trend emerged: clients with prior breastfeeding experience actively engaged and shared invaluable insights, contributing substantially to each discussion. This dynamic was particularly heartening for the doulas involved, as it aligned with their fundamental goal of not being the sole voice but rather amplifying the voices of their clients. REACHUP made it a priority to hire and train staff from the community, not only to build community capacity, but also to ensure representation throughout the project.

CORE INDICATORS FOR REACHUP, INC.

1

Counties with MfM-supported programs

17

Health workers (facility and community-based) trained by MfM-supported programs

3

Health facilities strengthened to provide quality care and/or contraception

Trenton, New Jersey

PROJECT NAME
Reducing Perinatal Health Risks in the Greater Trenton Area

ORGANIZATION NAME
Trenton Health Team

PROJECT OVERVIEW

Trenton Health Team (THT) is an innovative, multi-sector partnership dedicated to the health and well-being of the greater Trenton community. THT prioritizes bringing maximum impact and improvement to greater Trenton and worked in collaboration with Central Jersey Family Health Consortium (CJFHC), Children's Futures (CF), Children's Home Society of New Jersey (CHSofNJ), and Capital Health (CH) to deepen the understanding of maternal health challenges, particularly focusing on high-risk pregnancies prevalent among Black, Latinx, and immigrant communities. Through this endeavor, THT and its partners worked to provide enhanced and tailored doula services to offer comprehensive support to women navigating high-risk pregnancies within these vulnerable communities. The initiative introduced the Family Connects Mercer County program, a pivotal resource offering cost-free, in-home nurse visits to all families residing in Mercer County and delivering babies at Capital Health – Hopewell. The program extended its services regardless of income levels or socio-cultural backgrounds, striving to provide essential care and support to new families during the crucial postpartum phase. Additionally, the initiative dedicated efforts to bolster doula services, provide crucial support to both prenatal and postpartum patients at Capital Health OB/GYN and ensure comprehensive care and guidance for expectant and new mothers to enhance their overall maternal health experiences.

KEY ACCOMPLISHMENTS

THT provided doula care and the necessary resources to vulnerable families and communities in New Jersey.
It accomplished the following during the grant period:

1. **Successfully launched Family Connects,** a postpartum nurse home visiting program for new families in Mercer County;
2. **Nurse Case Managers conducted diabetes education and distributed more than 70 glucose monitor kits to patients;**
3. **Introduced Lyft services as a crucial support system for patients attending the Trenton Clinic and provided over 200 rides to patients,** highlighting the significance of transportation assistance in ensuring access to essential prenatal care;

4. **Orchestrated a Food Drive during Hispanic Heritage Month in October 2022** to address the prevalent food desert challenges within the Trenton community; and
5. **Launched a Disparities Dashboard,** a groundbreaking tool designed to raise awareness and address the stark racial and ethnic disparities in adverse birth outcomes as well as actively work towards diminishing these gaps and fostering more equitable birth outcomes for marginalized communities.

CHALLENGES AND LESSONS LEARNED

The Capital Health OBGYN-Trenton Clinic witnessed ongoing systemic changes coupled with staff turnover during the inception of the initiative. The operational capacity of the primary prenatal care provider encountered unforeseen hurdles due to unexpected departures of key staff members, leading to disruptions and adjustments in the planned priorities for the second year. Additionally, the outreach and engagement efforts targeting African American patients/clients in Trenton was also a challenge, resulting in limitations in effectively reaching and serving this community within the health care system..

IMPACT

THT and its partners provided families and communities in Trenton and the surrounding areas with the care and resources needed for their health and well-being.

CORE INDICATORS FOR TRENTON HEALTH TEAM

1

Number of districts/ regions with MfM-supported programs (Greater Trenton Area)

200

Birthing people with doula assisted births supported by SCC funding and birthing people supported with necessary medical supplies

6

Providers equipped to offer improved non-clinical services and supports or referrals to community partners

Tulsa, Oklahoma

PROJECT NAME
Tulsa Birth Equity Initiative

ORGANIZATION NAME
Tulsa Birth Equity Initiative

PROJECT OVERVIEW

Tulsa Birth Equity Initiative (TBEI) empowers families within the Tulsa community, ensuring that every birth is a healthy and dignified experience while actively working to diminish maternal health disparities. Collaborating closely with local partners, TBEI focused on harnessing the collective influence, expertise, and experiences of various organizations in the region to enact substantial improvements within maternal health policies, data systems, and service delivery frameworks. Their aim was to address the needs of marginalized groups, including Black, Indigenous, Latinx, and justice-involved women and teens. A pivotal component of TBEI's strategy involved establishing a pathway for local women to become Community-Based Doulas (CBDs). This initiative included an educational continuum, providing ongoing education and training to equip women within the community with the necessary skills and knowledge. Additionally, TBEI introduced a spoke-and-hub system, a structured network facilitating the referral of women to available CBDs—either within organizational staff or within the broader community. This innovative system was designed to ensure accessible and quality support for expectant mothers, enhancing the overall birthing experience for marginalized communities within Tulsa.

KEY ACCOMPLISHMENTS

TBEI and its partners accomplished the following during the grant period:

1. **Formed a community advisory committee** consisting of seven Black women that served as a platform to identify opportunities and viable solutions to enhance the maternal health care experiences of Black women in the local community;
2. **Implemented an ongoing series of doula training cohorts, totaling seven cohorts consisting of 10 to 20 individuals;**
3. **Increased total number of staff from five with three full-time doulas in February 2021 to 21 staff in January 2024 with eight full-time and four part-time doulas**
4. **Initiated a doula hub program** that provides trained doulas with opportunities to operate as part-time employees and established an online doula directory to connect community members to non-staff doulas;
5. **Advocated for state doula Medicaid reimbursement and served on the committee establishing reimbursement in Oklahoma;**
6. **Established contracts with two hospitals** to gather and analyze data to improve transparency and aid in quality improvement; and
7. **Collaborated with Emergency Infant Services and the Historic Vernon A&M Church to distribute 5,000 diapers to families across Tulsa.**

CHALLENGES AND LESSONS LEARNED

TBEI and its partners encountered several challenges during the grant period. The ongoing impact of the COVID-19 pandemic restricted the availability of doulas to physically serve families, presenting a considerable challenge in providing comprehensive and direct support during such crucial times.

Additionally, TBEI and its partners faced specific difficulties in engaging Native communities in the opportunities for doula training. To address these gaps and ensure inclusive and community-aligned services, they conducted focus groups within the Native community to gather insights and better understand the unique needs of the Native community regarding maternal health services. By actively engaging in these dialogues, TBEI and its partners gleaned valuable information to shape future strategies and ensure that any forthcoming doula services are responsive, culturally sensitive, and aligned with the needs of Native communities.

IMPACT

TBEI and its partners provided needed training, care and support to families in Tulsa. Testimonials from doula training program participants underscored the profound impact of these training sessions, describing them as life-changing and empowering. Participants expressed gaining a deeper understanding of pregnancy and childbirth, fostering a strong sense of community and sisterhood within their training groups. The doula hub program extended its reach and expanded access to doula services and resources for more families in Tulsa, contributing to improved birthing experiences across the state.

CORE INDICATORS FOR TULSA BIRTH EQUITY INITIATIVE

8
Counties served

46
Zip codes served

373*
Women receiving doula services through TBEI doula program

139
Women receiving contraception consultation through TBEI services

117
Doulas trained

50
Doulas certified

670**
Health workers trained by TBEI at OSU, Hillcrest Medical Centers, Tulsa Community College Nursing Program, and other institutions

2
Health facilities receiving Hospital QI support/ training

**Includes 16 repeat clients who have had at least two pregnancies supported by TBEI **Includes some duplicates*

Washington, DC

PROJECT NAME

Mamatoto Village Safer Childbirth Cities Washington, DC Initiative

ORGANIZATION NAME

Mamatoto Village

PROJECT OVERVIEW

Mamatoto Village is devoted to serving Black women through the creation of career pathways in maternal health and providing accessible perinatal support services designed to equip women with the necessary tools to make the most informed decisions in their maternity care, parenting, and lives. Mamatoto Village and its partners created an all-encompassing coalition of stakeholders, advocating for systemic and policy reforms, and extending accessible, high-quality perinatal support services. Additionally, the initiative implemented sustainable remedies to tackle homelessness and housing disparities that disproportionately affect communities, particularly at the intersection of birthing justice.

KEY ACCOMPLISHMENTS

Mamatoto Village accomplished the following during the grant period:

1. **Through the implementation of the Perinatal Community Health Worker Training and the Lactation Specialist Training, Mamatoto Village equipped its workforce with specialized skills and expertise, enhancing the quality of care provided;**
2. **Launched the Village Keepers Initiative** as a testament to the organization's proactive approach in fostering community involvement and support;
3. **Served over 1,300 people in their Maternal and Reproductive Health Village (MRHV) program;**
4. **Conducted an in-depth review of peer-reviewed and gray literature and a mixed-methods needs assessment** concerning housing injustices and its intersection with birth justice in the DC Metro Area; and
5. **Finalized a reporting template scrutinizing federal, state, and local housing policies and programs in order to develop focused and coordinated advocacy campaigns,** designed to elucidate clear policy recommendations and advocacy measures aimed at effecting tangible change in the intersecting realms of housing, reproductive, and birthing justice.

CHALLENGES AND LESSONS LEARNED

One primary challenge Mamatoto Village faced was outreach and recruitment efforts to former clients. The ongoing COVID-19 pandemic continues to be a challenge that the project team is experiencing. The pandemic exacerbated the ongoing housing crisis within the greater Washington region. Looking ahead, Mamatoto Village will continue to work towards its proposed objectives and activities, however, it is undetermined how the ongoing pandemic will continue to impact the team and its work. Mamatoto Village acknowledges the critical importance of adapting its strategies to navigate the persistent challenges posed by the pandemic and remains vigilant and prepared to respond flexibly to the ongoing and uncertain impacts of COVID-19 on its project's initiatives and operations.

IMPACT

Mamatoto Village has made significant strides in delivering impactful, evidence-based maternal health care services to women and birthing individuals across the greater Washington DC region.

CORE INDICATORS FOR MAMATOTO VILLAGE

2

Number of communities (by state)le served by the Maternal and Reproductive Health Village program

168

Number of womxn reporting contraceptive use following 6-week postpartum visit

97

Number of participants attending trainings conducted by Mamatoto village

16

Number of MCOs with clients receiving perinatal support services through Maternal and Reproductive Health Village program

Limitations

There are multiple limitations to this evaluation. The evaluation team, for example, encountered issues with the data available from SCC grantees, which presented challenges with reporting impact across sites and at the aggregate level when reporting the overall impact of the SCC Initiative. Additional challenges with the data included incomplete data, inconsistent data, and reporting of indicators, as well as conflicting definitions of indicators and data collected, i.e., indicator definition did not match the data that was collected. SCC grantees also experienced challenges due to the COVID-19 pandemic, which resulted in delays in implementation and required changes to planned in-person activities to adhere to social distancing guidance.

Recommendations

The following are recommendations to facilitate the implementation of the SCC Initiative program in the future:

- → **Standardize project indicators and definitions of indicators across sites,** which will allow the SCC Initiative to assess overall impact across sites.
- → **Provide training and technical support** across the development of any project-specific indicators and data collection.
- → **Develop a logic model for the SCC Initiative** that describes the overall program activities and anticipated outcomes.

In addition to these recommendations, future studies/ evaluations could explore the following evaluation questions:

- → **How well were grantees equipped to lead this work as CBOs and form partnerships?**
- → **What additional assistance was needed from the SCC Initiative to lead this work?**
- → **What were the grantees' experiences in the SCC Initiative?**

Conclusion

The SCC Initiative supported CBOs to implement evidence-based interventions and innovative approaches to reverse the country's maternal health trends and directly tackle racial and ethnic inequities in maternal health outcomes.

The most prevalent activities across grantees were training, programs and interventions, service delivery, resource development, and data collection and analysis. However, what truly fueled the success of these initiatives was the power of investing in, trusting, and elevating community-led solutions. Overall, SCC grantees provided care and services to thousands of people, including providing services to birthing people directly or connecting them to doula services. Grantees also provided training to hundreds of doulas and community health workers and thousands of health care providers to improve the access to and quality of care provided to Black women and birthing people. Furthermore, with SCC funding, grantees have worked toward major policy and sustainability wins. SCC grantees served as catalysts for passed legislation that extended postpartum Medicaid coverage from 3 to 12 months, expanded Medicaid coverage to include doula and home visiting services, required health care systems to provide information and support about postpartum depression, and standardized licensure for birthing centers. SCC grantees will be able to continue their work to improve the access to and quality of care to communities with the over $2 million in additional funding they secured. To effectively address the maternal health crisis, it is imperative that funding bodies prioritize investing in and resourcing community-based and community-centered maternal health initiatives, especially those led by women of color and people with lived experience. Community-led approaches bring invaluable insights and perspectives that can ensure the creation of equitable and effective solutions. Collaborative and inclusive community-based approaches are essential to addressing and ameliorating the maternal health crisis, ensuring that all birthing people receive comprehensive quality and respectful care and services.

What truly fueled the success of these initiatives was the power of investing in, trusting, and elevating community-led solutions.

Appendix

CORE INDICATOR DEFINITIONS

CORE INDICATOR	CORE DEFINITION
NUMBER OF DISTRICTS/ REGIONS COVERED	# of districts/regions with MfM-supported programs
WOMEN WITH IMPROVED QUALITY CARE	# of women receiving services (ANC, delivery, and/or PNC) from MfM-supported maternal health projects and beneficiaries of maternity waiting home users
WOMEN WITH ACCESS TO CONTRACEPTION	# of women receiving modern contraceptive products and services
WOMEN EMPOWERED TO DEMAND QUALITY CARE	# of patient-oriented digital innovation users, beneficiaries of community health worker programs
PROVIDERS EQUIPPED TO OFFER QUALITY CARE	# of health workers (facility and community-based) trained by MfM-supported programs;
FACILITIES STRENGTHENED	# of health facilities strengthened to provide quality care and/or modern contraception
PEOPLE WITH ACCESS TO QUALITY FACILITIES	# of people in MfM program affiliated health facilities' or pharmacies' catchment area

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