THE NATIONAL PERINATAL TASK FORCE

Building a Movement to Birth a More Just and Loving World

Commonsense Childbirth
because every woman deserves a healthy baby

MAMA SANA VIBRANT WOMAN

MARCH 2018

HAILE ESHE COLE,
PAULA X. ROJAS, AND
JENNIE JOSEPH

NATIONAL PERINATAL TASK FORCE

Building a Movement to Birth a More Just and Loving World

MARCH 2018

HAILE ESHE COLE, PAULA X. ROJAS, AND JENNIE JOSEPH

DESIGNED BY: CATHERINE CUNNINGHAM

Commonsense Childbirth
because every woman deserves a healthy baby

MAMA SANA VIBRANT WOMAN

ACKNOWLEDGMENTS

Special thanks to Groundswell Fund for supporting this effort. Also, special thanks to Victoria Muhammad, Kellee Coleman, Anna-Lisa Plant, and Jacqueline Smith for their generous support and time spent reading and reviewing this report.

STATEMENT ON GENDER

The National Perinatal Taskforce acknowledges that pregnant and parenting persons occupy a range of gendered identities, and that many do not identify as women or mothers. This report utilizes terms such as "woman" and "mother" as well as more gender inclusive language such as "pregnant person" or "parent," although we acknowledge that the report may do so inconsistently. We are in the process of transforming our language in order to fulfill our commitment of becoming fully inclusive and recognize that gender inclusivity is a learning edge for the National Perinatal Taskforce.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Maternal and infant health outcomes are key indicators for gauging the overall health and wellbeing of a population. The United States, despite monumental health care spending that outpaces other nations, underperforms when it comes to maternal and infant health. Globally, the United States ranks 57th in the world for infant mortality and 48th for maternal mortality.[1] While the U.S. has seen improvements in infant mortality rates and already achieved the Healthy People 2020 benchmarks, severe racial disparities in infant mortality persist. Recent data reveal significant differences in U.S. infant mortality rates categorized by race:

- Black non-Hispanic rate: 11.1 for every 1,000 births
- American Indian or Alaska Native rate: 7.6 for every 1,000 births
- White, non-Hispanic rate: 5.1 for every 1,000 births
- Hispanic rate: 5.0 for every 1,000 births
- Asian or Pacific Islander rate: 4.1 for every 1,000 births[2]

Researchers, medical providers, public health agencies, and community groups are now focusing on a life course perspective as well as the social determinants of health (SDOH) to find solutions. This approach acknowledges the impacts of racism and stress, which have been found to have lethal effects on maternal and infant outcomes, particularly in the Black community. This report calls for a nuanced understanding of the ways in which power, oppression, and the inequitable *conditions* of people's lives affect their health. Four primary areas of need are identified:

- **Models that provide community-located and culturally-based healthcare resources**
- **Increased social and community support as a means to mitigate the impacts of racism, stress, and other determinants that affect an individual's social conditions and, ultimately, health outcomes**
- **Models that promote self-determination and agency**
- **Movement-building efforts that shift cultural and social conditions**

In response to these needs, the National Perinatal Task Force (NPTF) was founded by midwife Jennie Joseph to begin addressing key issues. The task force operates as a grassroots movement whose primary objectives are to:

- Foster community-led **access** to quality, culturally-congruent health care and services
- **Connect** women and families to accessible and practical resources
- Share **knowledge** of best practices for mothers/parents and babies, and support informed choices
- **Empower** each woman/person to have agency in all of their decisions regarding themself and their baby's health

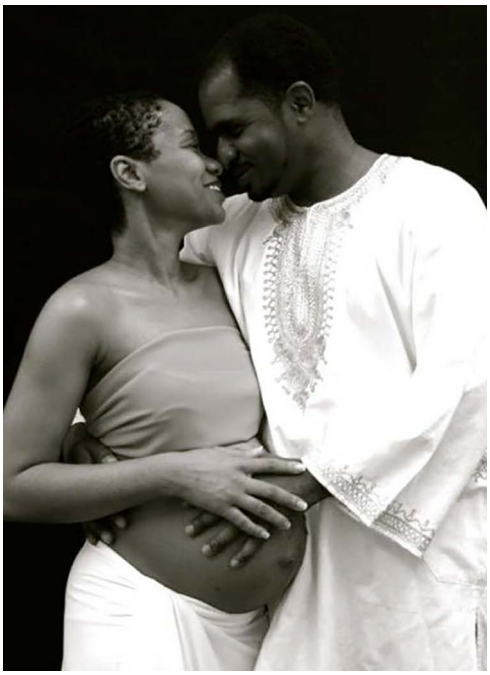
Specifically, the NPTF has developed Perinatal Safe Spots in order to 1) facilitate, engage, and support a national network of movement-building bodies, 2) provide examples of effective and innovative models, and 3) offer critical training and technical assistance to organizations looking to contribute to the movement of eradicating maternal and infant health disparities.

This report provides an in-depth overview of the Perinatal Safe Spots (PSS) network, introduces the National Association of Birth Centers and Clinics of Color (NABCCC), details the approaches of the JJ Way® and Maternal Justice Model, which serve as blueprints for organizations looking to

improve outcomes in their respective communities, and outlines important training opportunities provided by the NPTF.

In the end, the report also proposes the following overarching list of recommendations for all healthcare practitioners and agencies:

- **Participate in anti-oppression cultural and historical training that shifts organizational approaches from the individualistic nature of "cultural competency" to the systemic and institutional analysis of "structural competency" or "equity competency"**
- **Implement a "prenatal care plus" model to address critical social and economic concerns and incorporate "safety-net services" as a principal component of every care model**
- **Support the development of community-owned and -created Perinatal Safe Spots**
- **Advocate for public funding (city and state level) to resource community-based programs**
- **Increase efforts to remedy social inequities broadly**



INTRODUCTION: THE ISSUE OF U.S. MATERNAL AND INFANT HEALTH DISPARITIES

Maternal and infant health outcomes are key indicators by which to measure the overall health and wellbeing of a given community. Positive maternal and infant health outcomes have been found to have significant long-term implications not only for the pregnant person's life but also for that of the child. While the United States outspends other comparable high-income countries in healthcare expenditures, the amount of money spent does not correlate to positive returns in health outcomes.[3] In maternal and infant health, specifically, the United States ranks far below other countries in both maternal and infant mortality.

According to the Central Intelligence Agency World Factbook for 2016, the United States ranks 57th in the world for infant mortality rate and 48th for maternal mortality (see exhibits 1 and 2).[6] These dismal rankings persist despite considerable improvements to maternal and infant health outcomes nationally.

Recent data shows significant improvements in maternal and infant health outcomes across the nation.[7] Infant mortality rates decreased from 6.7 per 1,000 births in 2006 to 6.0 per 1,000 births in 2013.[8] While this mortality rate achieves the Healthy People 2020 goals, when broken down by race and ethnicity, the successes and improvements appear to serve some populations but not others.

Although the infant mortality[4] rate[5] has dropped nationally, the rates by race and ethnicity are as follows (see exhibit 3):

- Black non-Hispanic rate: 11.1 for every 1,000 births
- American Indian or Alaska Native rate: 7.6 for every 1,000 births
- White, non-Hispanic rate: 5.1 for every 1,000 births
- Hispanic rate: 5.0 for every 1,000 births
- Asian or Pacific Islander rate: 4.1 for every 1,000 births[9]

Along the same lines, the percentages of premature births by race also reveal clear discrepancies (see exhibit 4).[10] Babies who are born premature, or before 37 weeks of gestation, are more likely to experience short and long-term health problems, including but not limited to problems with brain and lung development, and digestive, vision, and hearing problems. In addition, when babies are born prematurely, approximately 16.9 billion dollars are spent for medical expenses for the babies, 1.9 billion dollars in costs for the mothers, and almost 611 million dollars for early intervention services from birth to age 3.[11]

A similar pattern can be seen with maternal mortality. When broken down by race and ethnicity, Centers for Disease Control data show that for Black women, maternal mortality was **40.4 deaths for every 100,000 live births** between 2011 and 2013. This is compared to **12.1 for white women** and **16.4 for women of other races**.[12] While the vast racial disparities exist in maternal mortality just as they do for infant mortality, unlike the latter, maternal mortality rates nationally have not been on the decline. In fact, an article published by the *New York Times* in 2016 stated that despite the global trend of falling rates of maternal mortality, the U.S. was one of the few wealthy nations to experience an increase in maternal mortality.[13] Data released by the Institute of Health Metrics and Evaluation reveals that maternal mortality in the U.S. increased from 23 per 100,000 births in 2005 to 28 in 2013.[14] Although the collection and accuracy of maternal mortality data is

often disputed due to inconsistent reporting standards and difficulty pinpointing pregnancy as a primary cause of death, researchers still conclude that the rates point to a longstanding issue.

The World Health Organization (WHO) has also called for increased attention to maternal morbidity, or as they define it, "any health condition attributed to and/or aggravated by pregnancy and childbirth that has a negative impact on the woman's well being." Morbidity can range from non-threatening to a more severe "near miss" where a woman survives a near death complication related to pregnancy or childbirth.[15] Like mortality, maternal morbidity has proven difficult to track. According to the CDC, maternal morbidity impacted 50,000 women between 2013 and 2014 and the numbers continue to rise.[16]

Exhibit 1. Maternal Mortality Rankings by Country

RANK	COUNTRY	RATE BY 1,000
1	Estonia	2
2	Singapore	3
3	Greece	3
4	Sweden	4
5	Italy	4
6	Belarus	4
7	Austria	4
8	Poland	5
9	Japan	5
10	Iceland	5
11	Finland	5
12	Czechia	5
13	Spain	6
14	Slovakia	6
15	Netherlands	6
16	Ireland	6
17	Qatar	7
18	Norway	7
19	Israel	7
20	Germany	7
21	Australia	7
22	Switzerland	8
23	Montenegro	8
24	Malta	8
25	France	8
26	Bosnia and Herzegovina	8
27	Belgium	8
28	Portugal	8

Exhibit 1. Maternal Mortality Rankings by Country, continued

RANK	COUNTRY	RATE BY 1,000
29	Lithuania	8
30	Kiribati	9
31	Macedonia	10
32	Cyprus	10
33	Bulgaria	11
34	Serbia	12
35	Canada	12
36	United Kingdom	12
37	United Arab Emirates	12
38	Slovenia	12
39	Denmark	12
40	Kuwait	14
41	New Zealand	15
42	Korea, South	16
43	Croatia	17
44	Turkey	20
45	Puerto Rico	20
46	Bahrain	20
47	Luxembourg	10
48	United States	21
49	Iran	21
50	Hungary	21

Data Source: Central Intelligence Agency. "Country Comparison. Maternal Mortality Rate." cia.gov. Central Intelligence Agency, n.d. Web. 04 Mar. 2017.

Exhibit 2. Infant Mortality Rankings by Country

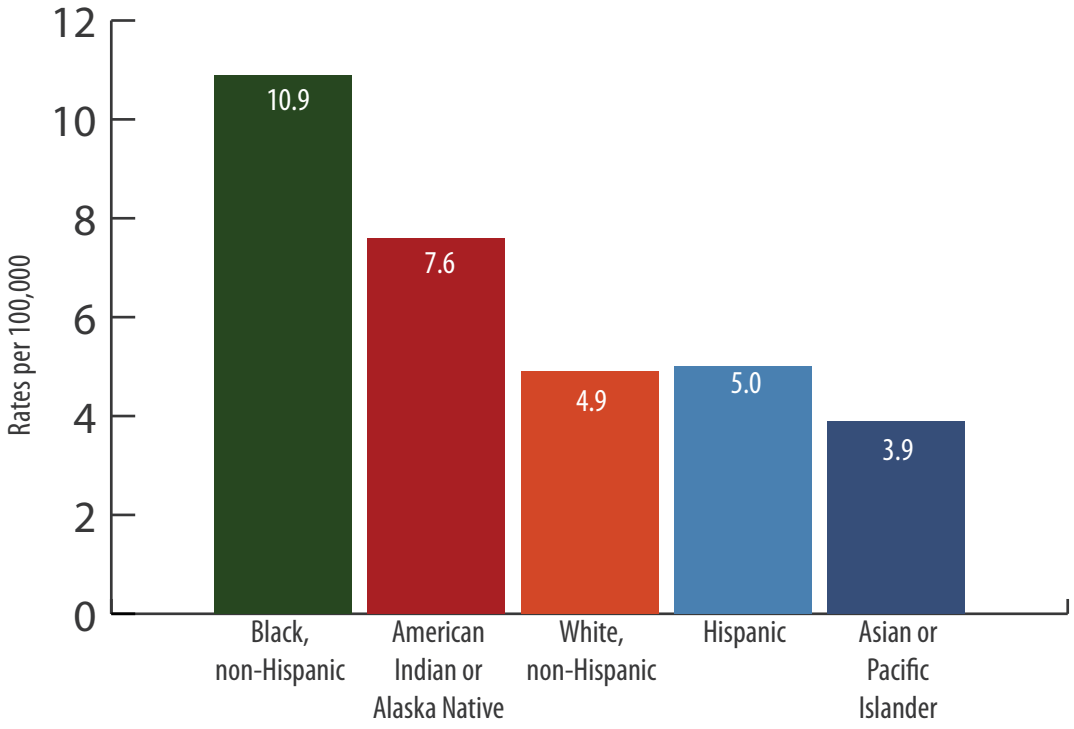
RANK	COUNTRY	RATE BY 100,000
1	Monaco	1.8
2	Japan	2
3	Iceland	2.1
4	Singapore	2.4
5	Bermuda	2.5
6	Finland	2.5
7	Norway	2.5
8	Czechia	2.6
9	Sweden	2.6
10	Hong Kong	2.7
11	Korea, South	3
12	Macau	3.1
13	Italy	3.3
14	France	3.3
15	Spain	3.3
16	Germany	3.4

Exhibit 2. Infant Mortality Rankings by Country, continued

RANK	COUNTRY	RATE BY 100,000
17	Guernsey	3.4
18	Belgium	3.4
19	Anguilla	3.4
20	Austria	3.4
21	Luxembourg	3.4
22	Malta	3.5
23	Israel	3.5
24	Switzerland	3.6
25	Belarus	3.6
26	Andorra	3.6
27	Netherlands	3.6
28	Ireland	3.7
29	Lithuania	3.8
30	Jersey	3.8
31	Estonia	3.8
32	European Union	4
33	Denmark	4
34	Slovenia	4
35	Isle of Man	4.1
36	Australia	4.3
37	Liechtenstein	4.3
38	United Kingdom	4.3
39	Wallis and Futuna	4.4
40	Portugal	4.4
41	Taiwan	4.4
42	San Marino	4.4
43	Cuba	4.5
44	Poland	4.5
45	New Zealand	4.5
46	Canada	4.6
47	Poland	4.5
48	French Polynesia	4.7
49	Hungary	5
50	Slovakia	5.2
51	Guam	5.3
52	Latvia	5.3
53	New Caledonia	5.3
54	Northern Mariana Islands	5.3
55	Faroe Islands	5.5
56	Bosnia and Herzegovina	5.6
57	United States	5.8

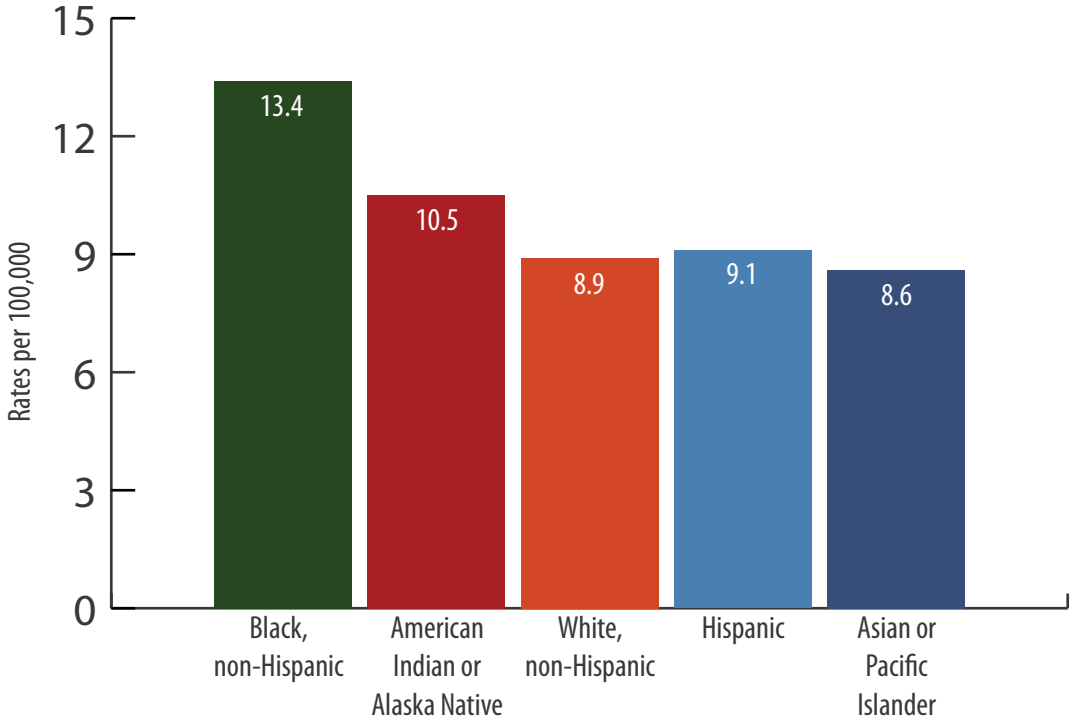
Data Source: Central Intelligence Agency. "Country Comparison. Infant Mortality Rate." cia.gov. Central Intelligence Agency, n.d. Web. 04 Mar. 2017.

Exhibit 3. U.S. Infant Mortality Rates by Race and Ethnicity (2014)[17]



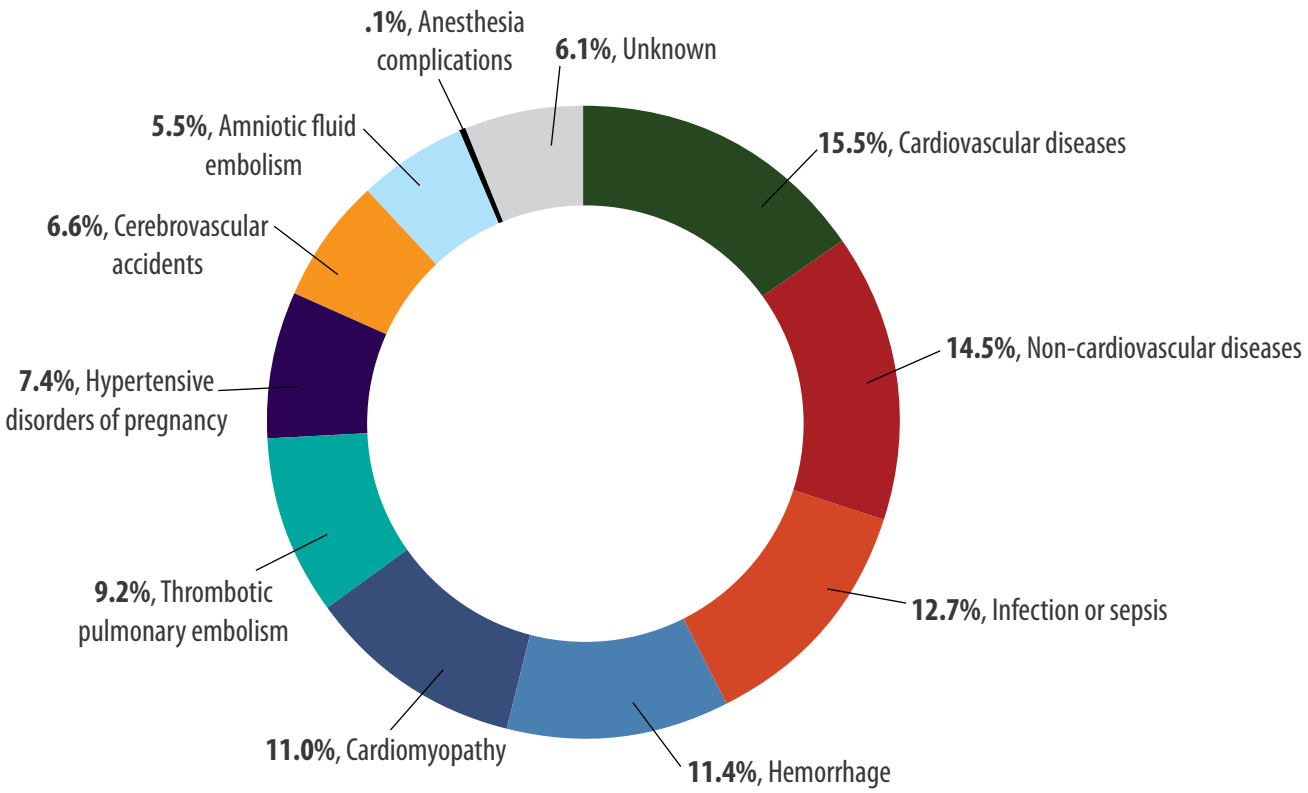
Data Source: Linked Birth/Infant Death Data Set, CDC/NCHS

Exhibit 4. Percentage of U.S. Premature Births by Race and Ethnicity (2015)



Data Source: National Vital Statistics System-Natality (NVSS-N), CDC/NCHS

Exhibit 5. Top Causes for Pregnancy-Related Death in the U.S.



Data Source: Centers for Disease Control and Prevention, "Reproductive Health. Pregnancy Mortality Surveillance System"

These persistent patterns, both in maternal and infant mortality and in rates of prematurity, indicate that, despite medical and technological advances, and despite national improvement, the question of how to eliminate the persistent racial gaps in maternal and infant health has yet to be answered.

To begin addressing this issue, researchers, medical providers, public health agencies, and community groups are increasing their emphasis on the life course perspective. While the life course perspective has now been well established, many healthcare institutions, providers, and researchers have yet to integrate this analysis into current models of care. Central to this approach is prioritizing the impacts of the social determinants of health. According to the World Health Organization,

"...The social determinants of health are the conditions in which

people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources and are mostly responsible for health inequities — the unfair and avoidable differences in health status seen within and between countries…"[18]

This framework seeks to incorporate social circumstances and the experiences of an individual over a lifetime into the overall understanding of health and well-being. Such an approach considers components such as education, environment, housing, income, geography, and even racism while exploring how these variables impact a person's health.

When examining the racial gaps that exist, incorporating an approach that considers the larger social context is key to assessing needs and developing solutions that adequately address root causes. Research has overwhelmingly identified stress as a marker for negative health outcomes. Consequently, researchers have also examined stress as an indicator for explaining the growing prevalence of low birth weight (LBW) and preterm birth. For example, Black women, whose instances of LBW, preterm birth, and infant mortality far exceed those of white women and other non-white groups, have been found to experience stress and racism over the life course that have detrimental and fatal impacts for them and their babies. Studies have found that:

- African-American women are more likely to experience stressful life events.[19]
- Some identified sources of stress for African-Americans include: socio-economic conditions, societal/institutional structures and pressures, neighborhood, intimate partner relations, and experiences of prejudice and discrimination.[20]
- Greater instances of perceived stress are associated with LBW.[21]

ALLOSTATIC LOAD

"Weathering," increased "stress age," and the "allostatic load" are terms denoting the continuous exposure to life stressors that subsequently and over time erode the overall health of the individual.

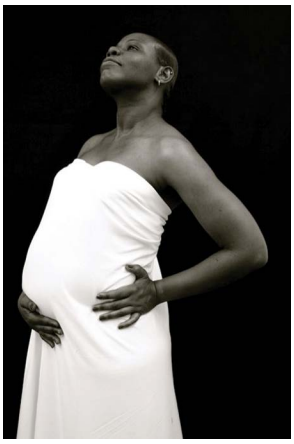
Research also acknowledges the particular role that racism-related stress plays in negative birth outcomes and the unique sources of stress experienced by African-American women. Experiences of racism and discrimination, particularly when introduced at a young age, were found to be associated with instances of LBW.[22] Central to this finding are the impacts of **weathering** and the burden of carrying what is called the **allostatic load**. "Weathering," increased "stress age," and the "allostatic load" are terms denoting the continuous exposure to life stressors that subsequently and over time erode the overall health of the individual. These terms have been used to describe the accumulation and impact of stress in the lives of women. This process then yields effects on pregnancy and has been found to contribute to negative birth outcomes, including LBW. The extent to which social determinants, and in particular race and experiences of racism, impact maternal and infant health outcomes is made abundantly clear in the following example. As described in a 2011 article in the *New York Times*, one study found that a Black woman with a graduate degree is more likely to have a negative birth outcome than a white mother *without a high school diploma*.[23] Stated another way, when all other things are equal, including access to prenatal care, income, education, health insurance status, and health behaviors, Black women still end up with the worst outcomes in the United States.

Outcomes for Native American women also reveal gross disparities in pregnancy and birth—only outpaced by Black American women. Similar to other communities of color, the legacies of historic trauma, violence, and discrimination inflicted on Native American communities has had long-lasting impacts on their health. Moreover, lack of access, distrust of medical institutions,

and lack of culturally congruent care are all significant factors that impact the overall wellness and ultimately birth outcomes of Native American women.[24]

Also, important to consider is the fact that Hispanic/Latina women, while experiencing generally positive birth outcomes, still face significant barriers accessing prenatal care as well as culturally and linguistically appropriate care services. While newly immigrated Hispanic/Latina women in the United States often experience what some have coined the "Hispanic paradox,"[25] studies have shown that the impacts of "weathering" is still seen to have impacts on Hispanic/Latina women.[26] In fact, U.S. born Hispanic/Latina women have an increased risk for preterm birth and other negative pregnancy-related outcomes when compared to newly immigrated Hispanic/Latina women.[27]

Again, focusing on the social determinants of health is an important step to addressing root causes for these unwavering gaps in maternal and infant health. Even the acknowledgment of racism as a root cause and key component of the social determinants is a significant stride towards creating a fuller understanding. Nevertheless, discussions around the social determinants must also be couched within a nuanced understanding of history, power, and intersecting arms of oppression. In this way, one must acknowledge the full spectrum of oppression, including not only the ways in which racism impacts health and well-being, but also factors such as sexism, classism, gender discrimination, homophobia, ableism, and xenophobia, to name a few. **Systemic inequities have deep historical roots stemming from hundreds of years of explicitly racist policies reinforced by de-facto practices that have persisted. The impact of this history on health in communities of color is profound.**



THE ANALYSIS: MORE THAN JUST HEALTHCARE

Considering the data as well as the depth of the issues at hand, one key takeaway becomes glaringly apparent. **Improving maternal and infant health outcomes and addressing root causes that speak to the social determinants of health is more than just an issue of prenatal care and requires more than a shift in our healthcare system.** If we know that health disparities are caused by more than differences in access and quality of healthcare, but also are largely influenced by the social conditions in which we live, then impacting these outcomes requires both innovative and proactive responses that move beyond traditional understandings of health care. Specifically, it requires:

A) in the short term, a means by which to mitigate and/or shield the vulnerable from the impacts of oppressive social conditions, and

B) in the long term, a broad and dramatic shift in those conditions.

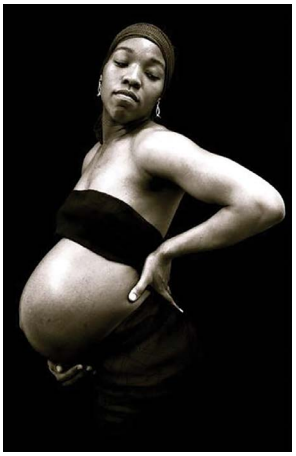
With these goals in mind, four primary areas of need are identified below:

- **Models that provide community-located and culturally-based health care resources.** While access to care and early access to prenatal care are crucial, the quality and type of care provided must be carefully considered. As previously noted, for certain populations, early access to prenatal care is not a guaranteed protection against negative maternal and infant outcomes. Prenatal care that does not also take into consideration the unique experiences of a woman/person, her/their community, and the specificities of her/their cultural background cannot produce the highest quality outcome.
- **Increased social and community support as a means to mitigate the impacts of racism, stress, and other determinants that affect an individual's social conditions and, ultimately, health outcomes.** Research has provided ample evidence of the benefits of social support during the antepartum, intrapartum, and postpartum periods. The presence of family support, intimate partner support, interpersonal support, and community and neighborhood contacts can help to 1) improve maternal satisfaction, 2) increase infant interactive behavior, 3) mediate the adverse effects of stress, 4) decrease the risk of postpartum depression, and 5) improve fetal weight.[28]

  Supportive presence during the labor process with a doula/birth companion, family member, or other support person has been shown to 1) reduce the use of pain medications during labor, 2) decrease the risk of cesarean section or other operative interventions, 3) increase maternal satisfaction, 4) increase the intent and early initiation of breastfeeding, and 5) decrease the likelihood of postpartum depression. Efforts to bolster established support networks and to reinforce the critical role of family, friends, and culturally congruent doulas/birth companions should be prioritized.[29] Culturally congruent support services in the postpartum period is key in a health system that sends mothers home after birth without any follow up until 6 weeks postpartum. Meaningful support during this critical period can impact breastfeeding, postpartum depression, and maternal mortality and morbidity.
- **Models that promote self-determination and agency.** Innovative models that impact health outcomes must also challenge historically rooted power dynamics that manifest in mechanisms such as racism, sexism, and classism, for example, and which impact an individual's social conditions and ultimately health. Community-based models that explicitly recognize and directly address structural inequities support pregnant

families to fully understand their social conditions and avoid self-blaming dynamics, both of which help to mitigate chronic stressors. Solutions to these important issues must be community-rooted, community-led, and self-determined by those groups and individuals directly impacted by such disparities.

- **Movement building efforts that shift culture and social conditions.** Improving care and health services is a critical component to impacting health outcomes. Nevertheless, unless the actual cultural and social conditions that create the disparities are transformed, changes to programming and care models will yield only a minimal effect. Thus, movement building efforts to change systems, institutions, and underlying ideologies are the only way to sustain any improvements in the long term. Instead of addressing the symptoms, or directing blame towards pregnant people, movement building efforts seek to impact and forever change the root causes of disparities.



THE RESPONSE: THE NATIONAL PERINATAL TASK FORCE (NPTF)

Founded by Florida-based midwife Jennie Joseph, a nationally recognized leader in the field, the National Perinatal Task Force (NPTF) was created as a response to the persistent disparities and abysmal maternal and infant health outcomes in the United States. Operating as an arm of her non-profit organization Commonsense Childbirth Inc. (CSC),[30] the NPTF is a virtual community of individuals, groups, and agencies working to improve and ultimately transform maternal and infant health outcomes in the U.S. The task force operates as a grassroots movement whose primary objectives are to:

- Foster community-led **access** to quality, culturally-congruent health care and support services
- **Connect** women and families to practical resources
- Share **knowledge** of best practices for mothers and babies, and support informed choice
- **Empower** each pregnant woman/person to have agency in all of her/their decisions regarding her/their self and her/their baby's health
- **Strengthen** local community efforts to advance social and racial justice and create equity

As an organizational entity, the NPTF serves to build and nurture a network of individuals committed to improving maternal health and providing support through useful tools, technical assistance, community- and capacity-building support, and mechanisms for training and development.

NPTF COMPONENTS

The work of the NPTF can be divided into three primary components: 1) building a network of movement building bodies, 2) disseminating innovative models of care, and 3) providing training, education, and technical assistance. These components work together to address key issues that impact women's experiences and ultimately their outcomes, while also aiding and supporting those who are working on the front lines to improve maternal and infant health in their respective communities.

MOVEMENT BUILDING BODIES

Central to the work of the NPTF is the development of an expanding network of Perinatal Safe Spots (PSS). Perinatal Safe Spots are key elements of the NPTF network and can be virtual, geographic, or physical locations. These safe spots are meant to evolve and change to fit the needs of their respective communities while also fulfilling the NPTF mission of providing immediate and judgment-free access to care, connection to resources, knowledge of best practices, support for informed choice, and agency in healthcare decision-making.

PERINATAL SAFE SPOTS (PSS)

Key elements of the NPTF network and can be virtual, geographic, or physical locations

Currently, there are 31 PSS in the task force. The hope is that this network continues to grow. The vision for the NPTF is to ensure access to a Perinatal Safe Spot in every materno-toxic

MATERNO-TOXIC AREA

Is any area where it is unsafe to be pregnant or parenting

area in the U.S. As defined by the NPTF, a materno-toxic area is any area where it is unsafe to be pregnant or parenting. Historically, materno-toxic areas traditionally face birth outcomes that are worse than those in adjacent zip codes and suffer an increased risk for premature birth, low-birth weight, and infant and maternal morbidity and mortality.

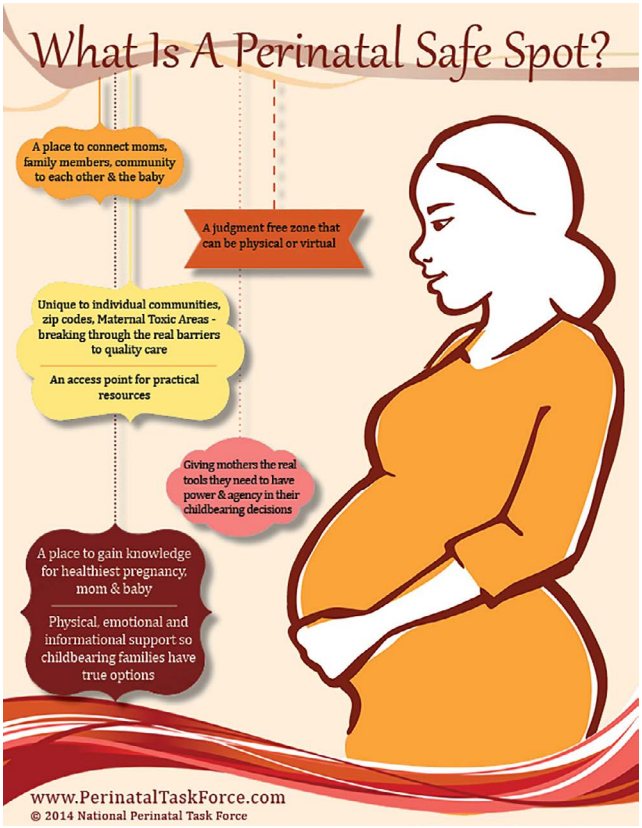
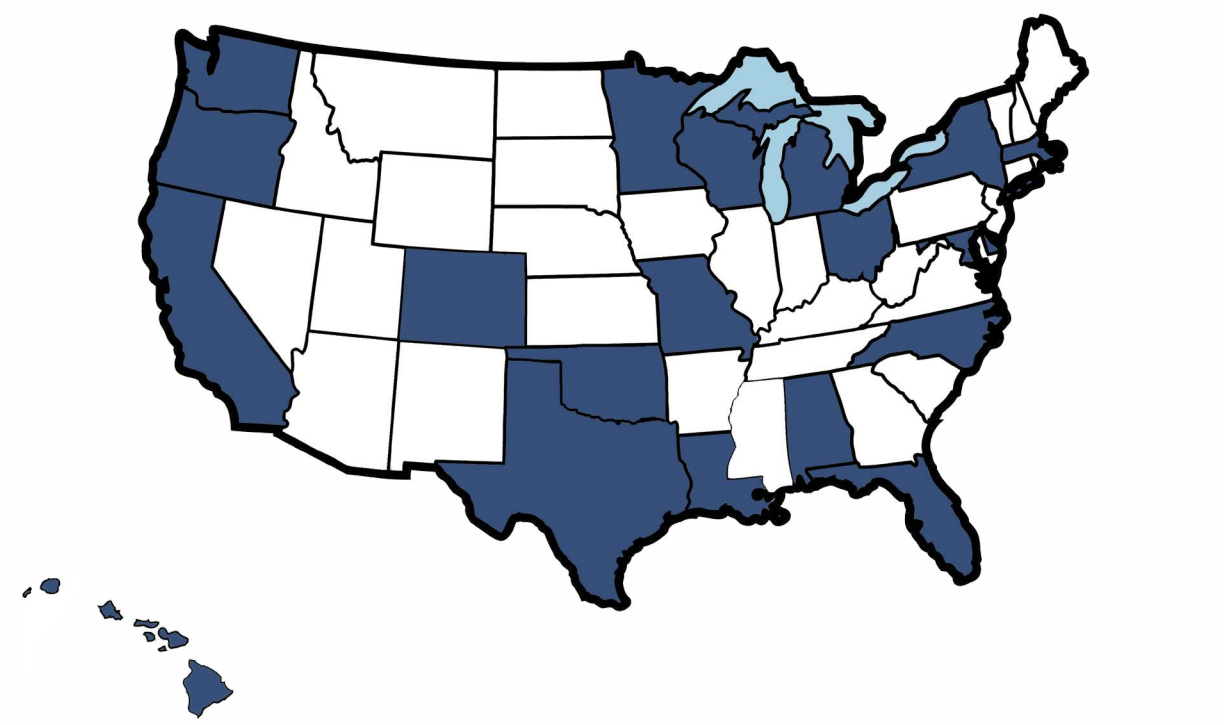


Exhibit 6. States with an Existing Perinatal Safe Spot



Full list and locations of existing PSS can be found in appendix A.

The National Association of Birth Centers and Clinics of Color (NABCCC) also serves as a key movement building body in the NPTF. Established in 2014, the NABCCC vision states that their primary aim is for all communities of color to have access to perinatal care at maternity clinics or birth centers that are owned and operated by practitioners of color. This movement building body provides a communal space for organizations owned and operated by practitioners of color and also provides mentoring, training, peer review, professional development, and malpractice insurance.

MODELS

In addition to the movement building bodies, the NPTF provides examples of existing innovative models that seek to improve maternal health disparities and also address the identified key areas of need. Currently, the two models endorsed by the NPTF are The JJ Way® and the Maternal Justice model. Both serve as blueprints and are meant to be adapted to fulfill the unique needs of a local community.

THE JJ WAY®

The JJ Way® is a community-based model of healthcare delivery featuring innovative but adaptable components. Developed by Jennie Joseph ("JJ"), the primary purpose of the model is to ensure that every woman has a full-term, healthy, and positive pregnancy experience and baby, and in turn, sees dramatically improved maternal and infant outcomes. Developed over the span of 25 years, the JJ Way® provides wrap-around care that allows pregnant women, family, and friends to participate fully in a woman's care.

Approach

The JJ Way® utilizes a trauma-informed approach that prioritizes four main tenets: *access*, *connections*, *knowledge*, and *empowerment*. These tenets are central to the model and embedded in every aspect of the JJ Way®.

> *"When the front desk operates as an 'open-door triage' there is no barrier to prenatal care. You are eligible for all services simply because you are pregnant and you have expressed a need. NO ONE IS TURNED AWAY regardless of ability to pay."*
>
> ***-Jennie Joseph***

Access to evidence-based prenatal care services immediately, preferably in the first trimester.

- A friendly receptionist elicits trust and relaxation so that the patient can open up and share. Known patients are always greeted by name; children and partners are welcomed too.
- Pregnancy tests and assistance negotiating an unwieldy and bureaucratic Medicaid system is offered. Patients are reassured that they will be seen while they are waiting for insurance, not after they receive it.
- Each patient will leave on the day of that first visit having had a full prenatal visit, lab work, education, and referrals—and with the knowledge that she has established a maternity medical home.
- In turn, the staff now has access to any medical records already generated during the current pregnancy via Emergency Room visits, has a thorough and relevant history, and can triage based on both medical and social risk status for the patient and liaise with collaborating agencies.

Connection to the developing baby as an impetus for behavioral change, close monitoring, and self-care.

- The prenatal bonding of the mother with the baby is impacted by encouraging the patient to be the primary protector of her growing child.
- Family and friends become team members through techniques such as placing comfortable sofas in exam rooms, encouraging hands-on tummy checks (with mom's permission), and videotaping or recording baby's heartbeat.
- Staff builds close relationships with individuals as they too become connected to their babies. The team approach builds the social capital of each woman, ensuring success beyond her pregnancy and delivery.
- Perinatal partners/providers connect to the work as community relationships and awareness of the barriers improve. This increases the motivation to work together for the individual baby, mother, and family.

Knowledge provided in practical, non-judgmental, clear way and in an understandable language.

- Peer-led group education takes place in the waiting area and is fluid and pertinent to the patients and family who are waiting. Emphasis is placed on answering any and all questions at a level that can readily be understood. Ample opportunities are afforded to talk to each staff member in person as a patient navigates through the clinic during the course of her visit.
- Culturally appropriate phrases and catchy colloquialisms are a trademark educational tool of The JJ Way®, which elicits a fun approach to learning and remembering information. Information about racial disparities in outcomes can be shared with family and friends in the same way.

Empowerment is achieved when an informed, confident mother has a healthy full-term pregnancy.

- The mother participates as an equal partner, recognized throughout as completely capable of fulfilling the role of motherhood.
- Each patient carries her own mini-health chart so that she has full charge of her records.
- Women have the freedom to choose between a birth center birth with a midwife or a hospital birth with a physician.

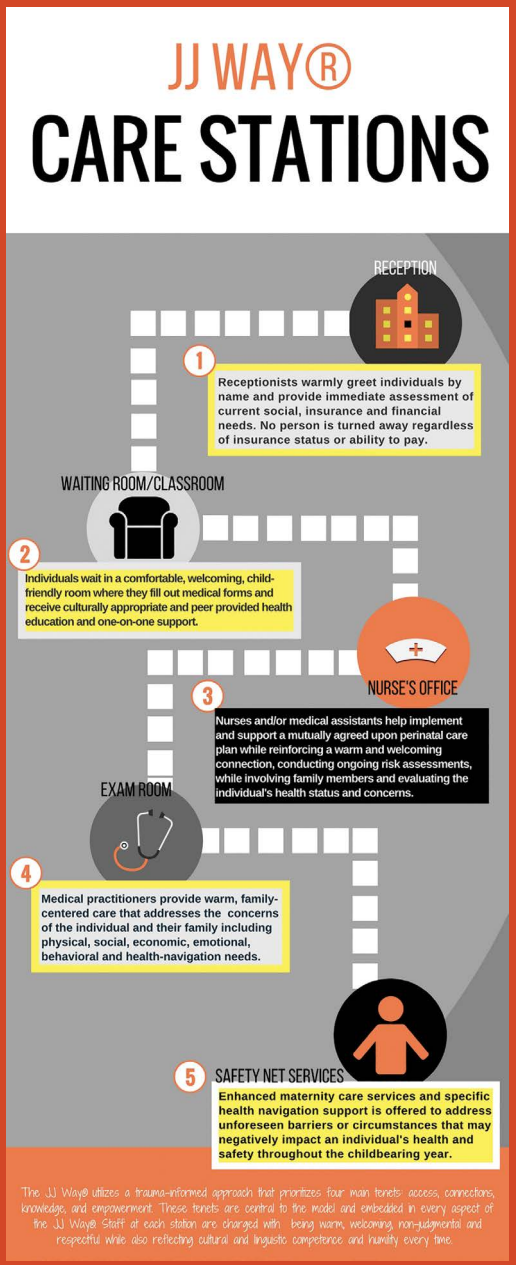
Components

Also, central to the JJ Way® are key components that prioritize and incorporate Jennie Joseph's four overarching tenets. **Any practice can adopt and implement the JJ Way®**. The primary components consist of the following:

- **Easy Access Clinic Model**: The 'Easy Access' prenatal care clinic is a key component of the JJ Way® in that it ensures early and easy access to care. The clinic specifically removes the traditional barriers experienced by disenfranchised women, increases access to first-trimester entry into prenatal care, creates an immediate maternity medical home, and traditionally serves uninsured, indigent, low-income women of color, and undocumented women. Creatively incorporated into existing care services, the clinic is cost effective in that it utilizes existing staff and resources while saving countless dollars by preventing preterm and low birth weight babies. The staff may consist of peer-educators, administrative staff, medical assistants, licensed midwives, nurse midwives/nurse practitioners, physicians, as well as student midwives/nurses, interns, and volunteers. All staff work together as an integrated TEAM to provide educational and social support

EXPERIENCING THE JJ WAY®

Experiencing the JJ Way® in its original implementation encompasses progressing through a series of stations. Again, each station invokes all of the four tenets.



services and referrals, and to improve quality and satisfaction with care.

- **Education and Support Services**: Throughout an individual's interaction with the JJ Way® system, intentional and culturally appropriate health messaging is provided - during each visit, at every 'station,' and in the group setting by peer educators. Topics reflect the interests and needs of the individual and focus largely on preparing families to navigate and manage the healthcare system.
- **Birth Center Model**: The Birth Center Model operates as a freestanding birth center that provides full service midwifery care and women's health services. Utilizing the "Midwifery Model of Care,"[31] the Birth Place prioritizes a woman-centered, comprehensive, and caring approach. Extensive evidence documents excellent outcomes of midwifery for the poor in urban and rural settings over the past 75 years.[32]

Exhibit 7. JJ Way® vs. Traditional Prenatal Care Comparison Table

JJ WAY® SYSTEM	REGULAR PRENATAL CARE
Access: emphasis placed on expediting entry into care by granting instant access and by identifying immediate gaps, obstacles, and barriers. The outreach component and word-of-mouth is also key to directing newly pregnant women into the clinic for care. Staff recognize the importance of "easy access" and the impact on perinatal outcomes. NO ONE IS TURNED AWAY!	Access: difficulty may be experienced, even over the phone, due to lack of insurance or under-insurance, unfriendly or unhelpful staff, lack of current or accurate referral information, lack of understanding of local or state system of applying for aid. Staff are not charged with having to be able to problem solve for patients' financial needs.
Connections: encouragement for prenatal bonding begins from the first visit. The baby and mother are acknowledged as a unit and the focus is on connecting her with her baby, her supporters and the JJ Way® TEAM. The TEAM in turn connects her to outside resources and services as needed.	Connections: busy prenatal clinics focus on providing medical care first and supportive care if time and resources allow. Individual practitioners work inside their specific job descriptions, generally, taking care not to overlap responsibilities, with the hope that colleagues will provide other resources as necessary.
Knowledge: continual education is provided on a one-on-one, individualized basis with the same messages being delivered consistently by different TEAM members at different times. Group education takes place in the waiting area and is fluid and pertinent to the patients that are present. Regular structured classes are also available as requested. The patient understands at all times that she is the decision maker and has the full support of the TEAM to advise her. The TEAM avails itself and each other of information pertinent to improving patients' knowledge.	Knowledge: one-on-one education may be limited due to time constraints and patients' individual questions are answered only as posed. Group education is accessed through structured, scheduled classes only.
Empowerment: Mom is supported in becoming her own best resource, respected and encouraged to be responsible for her own care. FOB, family, and supporters are integral to the optimal health of the mother and baby and are offered the opportunity to fully participate as TEAM members.	Empowerment: approach in general allows for patients and families to participate, but can be paternalistic and/or intimidating with an expectation that patients just relax and trust the experts.

The Impacts

A 2007 evaluative study conducted by the Health Council of East Central Florida found that overall, preterm birth rates for women at the Easy Access clinic were significantly lower than preterm birth rates for the county and the state of Florida. **When broken down by race, the study found that Black and Hispanic women in the clinic had 0% preterm births**.[33] An additional study conducted in 2012 found similar results. When outcomes were compared against those listed in the Florida Vital Statistics records, non-white women who participated in the JJ Way® model were found to have higher gestational ages as well as no recorded preterm births.[34] The most recent study, released in 2017, examined the outcomes for 256 women receiving care under the JJ Way® between February 2016 and February 2017. The results again revealed a reduction in both preterm birth and low birth weight for women across race when compared to rates for the county and the state.[35]

Exhibit 8. Percent of Preterm Births Comparison Chart (2007)

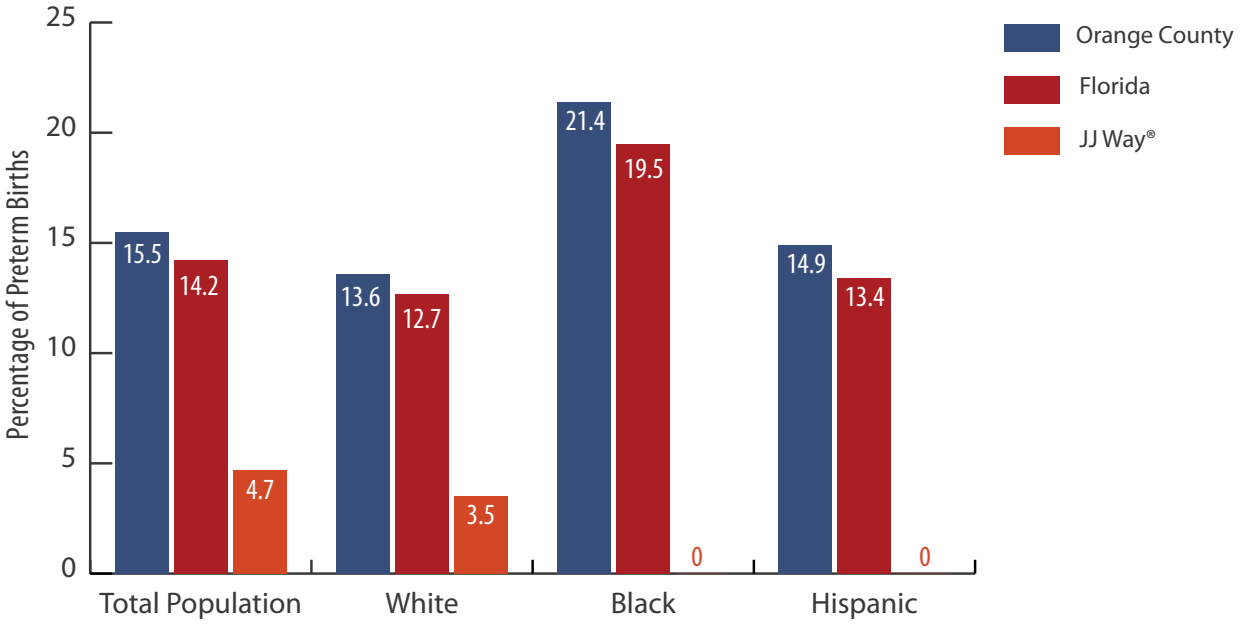


Exhibit 9. Percent of Preterm Births Comparison Chart (2012)

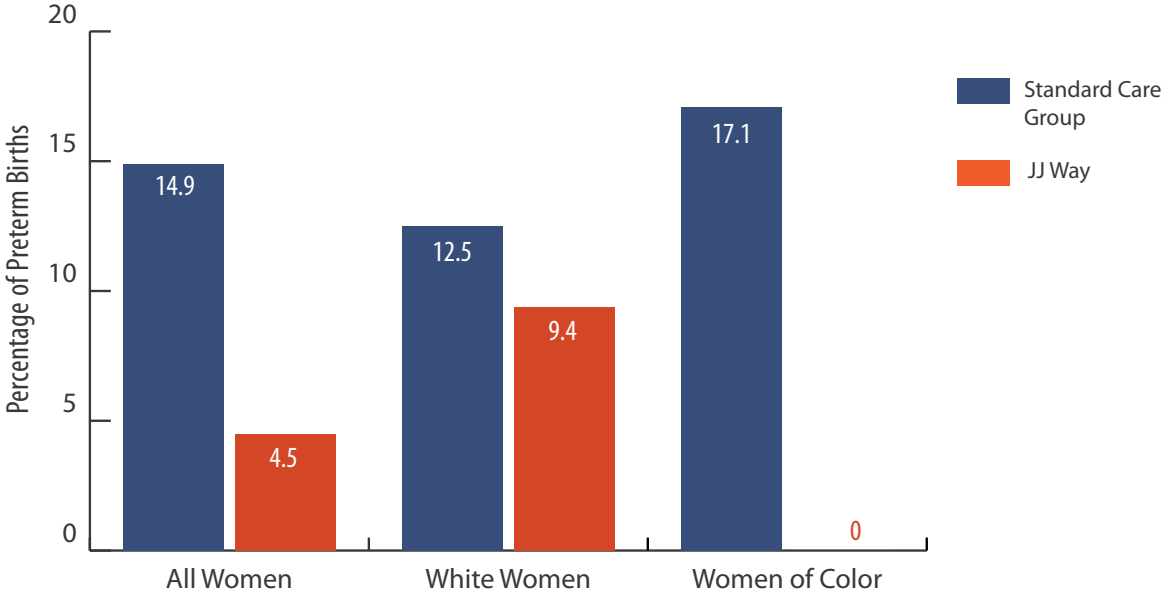


Exhibit 10. Percent of Preterm Births Comparison Chart (2017)

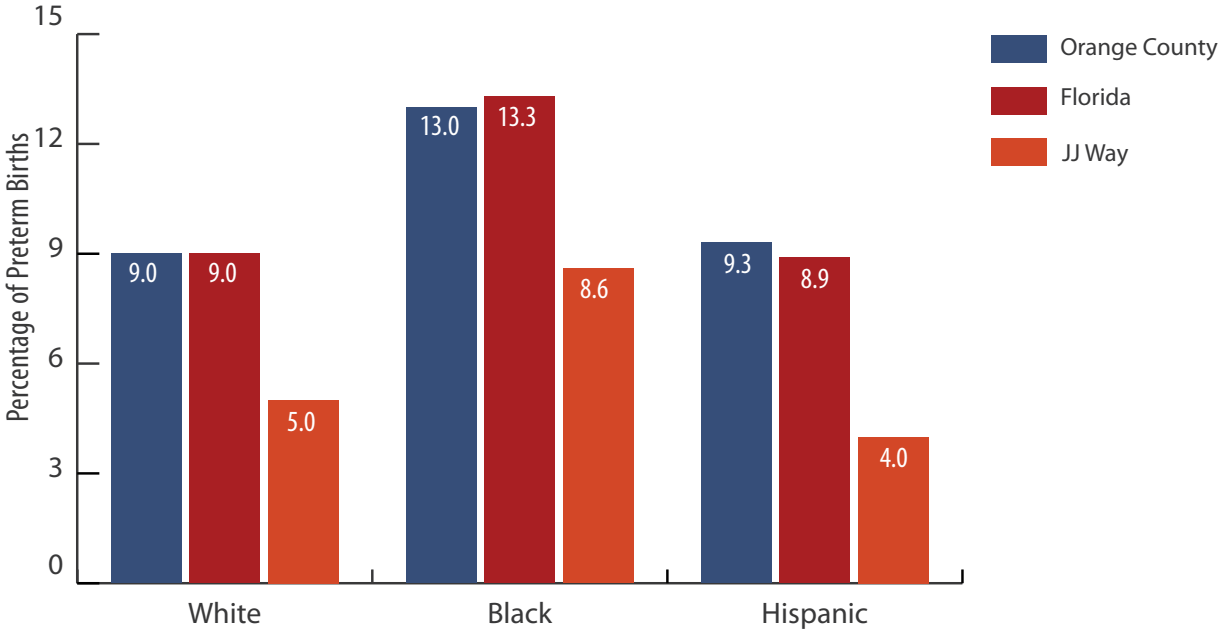
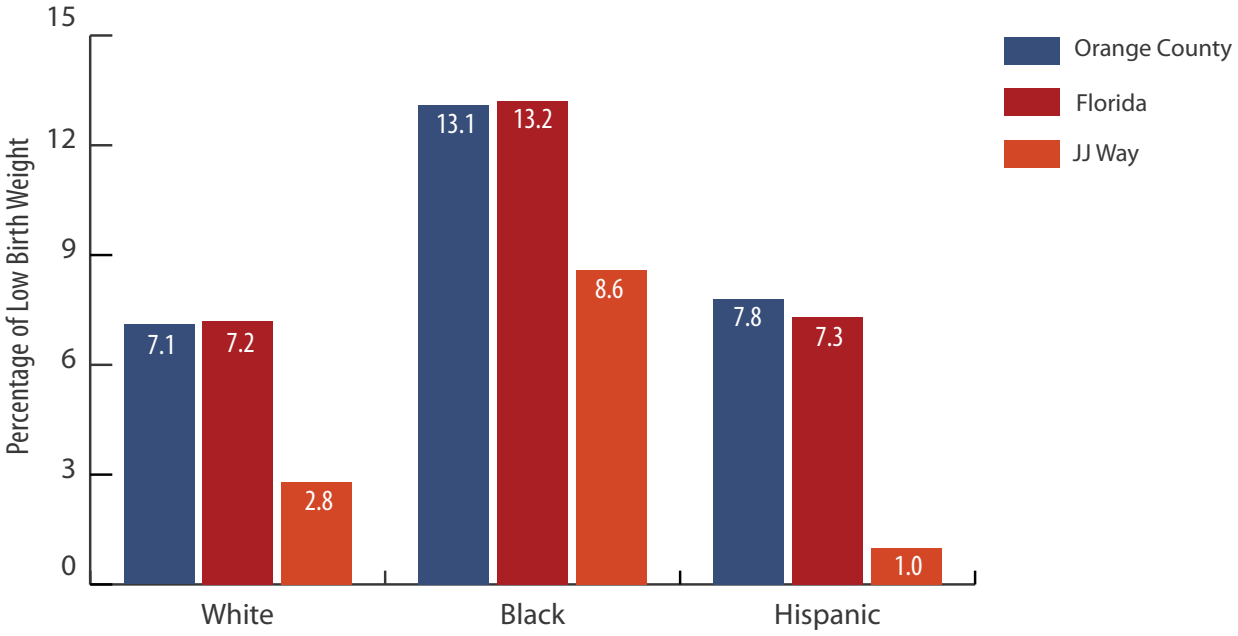


Exhibit 11. Percent of Low Birth Weight Comparison Chart (2017)



Training and Education

A long-term goal of the JJ Way® is that the model, its components, and its approach will be replicated and adapted to fit the needs of various communities. To facilitate this process and support improved maternal and infant health outcomes, Commonsense Childbirth Inc., within the activities of the NPTF, offers the following training and educational opportunities:

JJ WAY® TRAINING	DESCRIPTION
Easy Access Clinic	This training provides an overview of the Easy Access Clinic structure as well as step-by-step instructions on how to implement or incorporate its model into existing services.
Maternal Child Health Specialist (MCHS)	**The Maternal Child Health Specialist (MCHS)** is a training and certification program that equips health navigators, community health workers, outreach personnel, care coordinators, home visitors, doulas, childbirth educators, lactation educators, nurses, midwives, and physicians to understand their local and regional resources. This training provides the ways to negotiate and navigate through the systems that provide perinatal health care for women and babies who are at particular risk for poor outcomes.
Certified Childbirth Consultant Program (CCC)	This program is designed for those who desire to work towards becoming a midwife and/or to work professionally with women throughout the childbearing year. The course consists of 3 perinatal courses (Doula, Childbirth Educator, & Lactation Educator) and those who complete this Mini-Program will be designated as a Certified Childbirth Consultant (CCC).
Certified Doula	A doula is a healthcare professional who provides **non-medical support and care** through education, guidance, and counseling for pregnant and parenting women and families.
Certified Lactation Educator	This course teaches the anatomy and physiology of the breast and relevant changes during pregnancy and lactation, and it prepares the student to assess and provide anticipatory guidance regarding maternal nutrition, initiating and establishing successful breastfeeding, recognizing and managing common breastfeeding problems, and referral to community resources and breastfeeding products.
Certified Childbirth Educator	This course provides the basics of childbirth education and prep. Childbirth Educators are responsible for providing evidence-based information and teaching in a non-biased manner.
Community Outreach Perinatal Educator (COPE)	The Community Outreach Perinatal Educator or COPE training provides community-based MCH practitioner and para-professional training, education, and consultation, focused on care coordination and health navigation for vulnerable communities. Participants who complete the training become either Certified Perinatal Educators (CPE) or Community-Based Lactation Educators (CBLE). Training includes key topics that prepare participants to provide perinatal education, breastfeeding support, and family and birth support through all states of the pregnancy and birth process.
Commonsense Childbirth School of Midwifery (CCSM)	The Commonsense Childbirth Midwifery School provides training, mentorship, and guidance to aspiring midwives. CCSM offers the Three-year Program for non-nurse or direct-entry midwives and the Four-Month Pre-licensure Program for foreign-trained and out-of-state licensed or certified midwives.

THE MATERNAL JUSTICE MODEL (MJM)

As a result of 25 years of community-based organizing and a decade of birth justice work, Paula X. Rojas, community organizer and midwife, developed the Maternal Justice Model of care. This model, currently being implemented by Mama Sana/Vibrant Woman in Austin, TX, is interdisciplinary. Its goals and objectives address individual, community, and system level issues that are influenced by social determinants of health disparities. This approach is used to affect individual as well as collective empowerment, while at the same time improve health outcomes.

Components

The framework of the Maternal Justice Model builds upon the midwifery model of care and incorporates: an understanding of systemic power differentials; a popular education methodology

for learning that emphasizes the power of personal stories in collective work; and a focus on the allostatic load and the Social Determinants of Health. The primary components of the model include:

Approaches:

- **The Life Course Perspective**: Addresses the importance of overall health throughout all phases of an individual's life. In reproductive health, this perspective prioritizes the importance of pre- and inter-conception health.
- **Cultural/Racial Congruence and Specificity**: Culturally/racially specific health interventions have been linked to higher participation rates and better outcomes. Patients with same-race providers are more likely to seek medical care and attend their appointments, while less likely to postpone care. These patients also report higher levels of trust, respect, and overall ratings of satisfaction with care. Given this, the MJM prioritizes cultural congruence and facilitators and staff reflect the culture of the participants.[36]
- **Quality Relationships/Social Networks**: Quality relationships are a powerful mediator of positive health outcomes and a key predictor of longevity and immune function. They increase the brain's resilience and capacity to handle stress effectively, and they generate a cohesive narrative for participating women (which is the best predictor of a mother's capacity to form a healthy attachment to her infant).[37] The MJM model strategically helps build relationships/social support networks between the women, staff, and birth companions.
- **Health Choices and Praxis**: Structures, habits, and systems support healthy behaviors. As opposed to an emphasis on providing education about healthy nutrition and exercise, though that is included in the curriculum, the focus of the MJM model is on providing free access for developing healthy practices. Behavioral economics demonstrates that our behaviors are primarily mediated by our social conditions and access to resources versus our individual knowledge or willpower.[38] The MJM stresses the use of "praxis = theory and practice" as a way of improving health and wellness. As opposed to just learning about healthy nutrition and exercise, actually practicing with onsite exercise classes and nutrition groups makes it possible for pregnant persons to improve their health.
- **Self-Assessment**: Strategies include stress self-assessment exercises, follow-up stress management, and social support mechanisms embedded throughout the model. There is evidence that self-assessment, self-tracking, and practicing healthy routines have significant impacts on health and changing habits.[39]
- **Horizontal and Intentional Community Building and Engagement**: This component promotes meaningful relationships and trust between staff and program participants and amongst program participants. Additionally, engagement with the broader community incorporates creative outreach strategies with culturally and linguistically specific media.
- **Leadership Development**: The MJM encourages the use of incentives for participants who want to volunteer time to support the work. It incorporates intentional leadership development in which participants are invited to become advocates and leaders to advance maternal and infant health and join in community organizing projects to advance social justice for all.

Practices:

- **Co-location of services**: The variety of support and healthcare services - including

nutrition group, prenatal yoga and fitness, and prenatal education - are all provided in one location with on-site free childcare. For example, at Mama Sana/Vibrant Woman, three community based sites, located in the section of the city with a concentration of low-income communities of color, operate simultaneously.

- **Walk-in Prenatal appointment**: Participants without insurance or access to care receive immediate prenatal appointments on-site while their coverage applications may be in process. Additionally, assistance negotiating the complicated and bureaucratic Medicaid/Children's Health Insurance Program (CHIP) system is offered.
- **Immediate Referrals**: The MJM prioritizes immediate access to care with a first appointment within 10 days of initial phone contact. A 24-hour call-line is also available.
- **Group Prenatal Education**: The MJM encourages culturally and linguistically specific, on-going group prenatal education. Group sessions are based on a curriculum using popular education pedagogy that engages participants in creating collective knowledge beginning with their personal stories.
- **Birth Companions/Community Health Workers**: Free, culturally congruent, and trained companions offer emotional, physical, and logistical support to the participant during pregnancy, at birth, and in the first 3 months postpartum.
- **Intraprofessional Collaboration**: The MJM is based in the midwifery model of care with continuity of care and home visiting during the postpartum period combined with referrals and relationships with doctors and clinics that have been vetted by the program to insure quality experiences with respect to dignity and cultural competency.

The primary aspect of the Maternal Justice Model that is integrated into the work of the National Perinatal Taskforce is the focus on systems level change. The Model addresses social and racial justice issues that create barriers to prenatal care for women of color. This sociological and historic lens allows for a better understanding of key issues and how they play out in local communities. This includes the impact of institutional racism, economic disenfranchisement, and social isolation. The leadership development and community organizing components address the full range of social determinants of health in a community. Inspired by a vision of a more just AND loving world, the model holistically addresses the individual, community, and systemic levels concurrently.

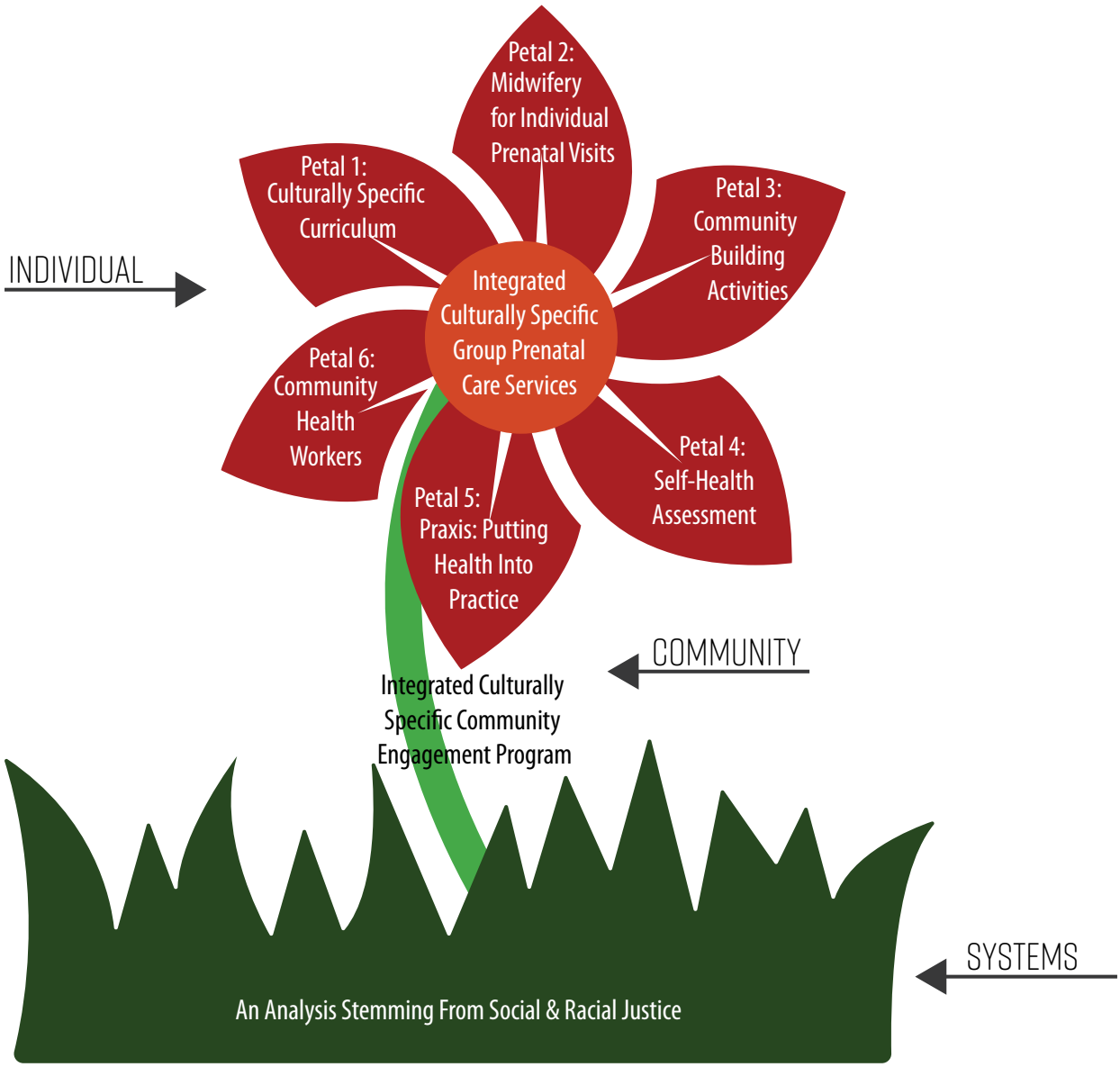
Individual Level

Individual level work in the MJM prioritizes self-determination, education, and full agency in healthcare decision making while also

MJM DEFINITION OF COMMUNITY ORGANIZING

the process of building collective power by people directly impacted by inequity and injustice in order to make systemic change. Beginning with building community and connection to then identify shared problems and envision both short and long term solutions to those problems. The process creates structures and organizations to harness the collective power, create spaces for collective self-care and support the leadership of the most directly impacted. Steps include

- identifying the people and systems that can make short term solutions possible;
- interacting with those targets to advance tangible changes via policy or resource allocations using media work, public hearings, negotiation and/or confrontation and pressure when needed.
- throughout the process, there is intentional building of an institution that is participatory and non-hierarchical that can develop the capacity to take on further problems while embodying the larger long term vision of the just and loving world we want to create.



supporting the practice of positive healthy behaviors. Time is created to collectively prepare and enjoy healthy meals, exercise, and build social networks and relationships with others. Additionally, participants' needs and interests inform the structure and content of group prenatal education. All activities operate to ensure that participants have a positive, healthy, and empowering pregnancy and birth experience. All activities are free of cost at convenient locations with on-site childcare, transportation support and food for the pregnant woman/person and her/their children.

Community Level

Community level work in the MJM begins with a deep understanding of why people of color do not fully trust the healthcare system. With this in mind, program staff not only reflect the community culturally/racially, with shared lived experiences, but they also work to build genuine relationships and trust with the pregnant women/persons. The model incorporates community organizing techniques to build community awareness and to recruit participants, birth

"In the Mama Sana prenatal groups I found new friends and felt so much support from the staff to deal with stress and take better care of myself. During the birth and afterwards, my birth companion and midwives were there with me at every step and came to me, at my house. Later, I even went back to the prenatal groups with my baby just to stay connected. Now I am giving back, gaining confidence and participating in a different way. I testified at city hall, and even spoke about the needs of my community at a meeting with the mayor."

-Paty, mother of a 9 month old

companions, and staff to mirror the community being served. Ongoing community building work is equally as important as the prenatal care services when attempting to improve outcomes in a community. This, of course, is long-term work with tangible impacts on health and wellness that may not be evident until years of active engagement have occurred.

Systems Level

The MJM program's impact on a systemic level is rooted in an analysis of social and racial justice. Specifically, the model is based on the assumption that systemic change occurs over time as a result of deliberate community organizing work for social change aimed at accomplishing institutional/policy changes "from above," in partnership with cultural changes "from below." In the model, staff serve as liaisons to the systems level, identifying, documenting, and addressing the systemic barriers to care, while support individuals or companions are trained to navigate institutional levels of access and services. Birth companions support pregnant women/people to navigate their individual issues within an institutional context parallel to work advocating for changes within the system. The community organizing work that runs alongside the programmatic work is focused on identifying levels within systems and institutions, including local governments, whereby policy changes and reallocation of resources towards more just and equitable systems can concretely impact the social determinants of health.

Outcomes

Mama Sana Vibrant Woman (MSVW) in Austin, TX is a powerful illustration of the rapid results of the Maternal Justice Model of Care. The program has a small but mighty staff, providing holistic group prenatal care, birth companions and postpartum home visits to Black and Latina pregnant women/persons. Though outcome data is still being gathered and the organization recently transitioned from an all volunteer collective to being staffed, the results are promising. These results are especially encouraging in a state like Texas where racial health disparities in maternal and infant health are very stark. Parallel to the programmatic work, the organization helped to launch city-wide racial justice community organizing and policy work. These efforts have created a focus on equity at the city government level, in budgeting and public allocations, in order to address the larger social determinants of health. This combined strategy that addresses the individual, community and systemic level is synergistic in improving the health and wellness of pregnant families of color.

Training and Education

The MJM provides various trainings to support a local community working to impact maternal and infant health. They include:

MATERNAL JUSTICE TRAININGS	DESCRIPTION
Embodied Herstories Training	"Embodied Herstories: Race and Reproduction in the United States" critically examines the U.S. history of women's reproduction and women's relationship to their reproductive autonomy using a Popular Education methodology and an Anti-Racist, Feminist intersectional framework. Participants will develop a shared language and analysis of reproductive history in the U.S. This history will include the "untold" stories of many pregnant women, beginning with colonization and slavery. The process will define institutional racism and identify how it impacts the state of pregnancy and birthing in the U.S., past and present. The workshop will explore the issues of individual "choices" and public policies related to pregnancy, birthing, and reproductive autonomy. Together, participants will "connect the dots" between U.S. history and current health outcomes and will identify how to apply this analysis to the current maternity care issues being faced.
Strategies for Social Change Training	This training begins by attempting to answer the following questions: A) What is social justice and how do people collectively work towards it? B) What are the different strategies used in working for social change? C) What is the difference between advocacy, activism, and organizing? D) What are the basic steps in community organizing as a method? This interactive training answers these key questions with a lens focused on the intersections of race, class, gender, sexuality, and gender identity, prioritizing the experiences of women and gender non-conforming people of color. It provides an overview of the underlying causes of inequality in the U.S. and reviews various systems of oppression and how they operate. In the end, participants will arrive at a better understanding of the legacies and histories of social movements and the various ways in which social change can occur in our current context. This training also provides concrete policy and community organizing case studies to be used as potential models. Examples include projects and campaigns currently being practiced in other cities to advance a more equitable distribution of resources that impact the social determinants of health and begin to address root causes of maternal and infant health inequities.
Maternal Justice Model Implementation Training	In the Maternal Justice Model Implementation training, participants learn about implementing the programmatic model that combines work on the systemic, community, family, and individual levels to support pregnant families of color and improve maternal and infant health outcomes. The training provides an overview of the model and its key components, including sections on the group prenatal education curriculum, midwifery model, and community organizing embedded with racial and social justice principles and practices. The training covers the programmatic and staffing components needed to start a project using the MJM model. The training also covers all aspects of curriculum implementation.
Maternal Justice Birth Companion Training and Certification	This training combines the historical context, critical analysis and content of the Embodied Herstories training (see description above) with the skills and education needed to holistically support pregnant women/people of color through all stages of the pregnancy, birth and postpartum period. This training develops culturally congruent birth companion's (doula's) ability to provide emotional, physical, and logistical support and education during the childbearing year. Participants will "connect the dots" between U.S. history and current health outcomes, identify how to apply this analysis to current maternity care issues, and walk away with the practical skills needed to provide non-medical support and care to pregnant families of color.

All MJM trainings are available in English, Spanish or bilingually

RECOMMENDATIONS

In addition to the NPTF and its ongoing work to impact maternal and infant health disparities, the task force proposes the following far-reaching recommendations:

- **All practitioners and health care agencies be required to participate in anti-oppression based cultural and historical training that shifts organizational approaches from the individualistic nature of "cultural competency" to the systemic and institutional analysis of "structural competency" or "equity competency."**

  In a 2014 report released by the NIH and entitled "Structural Competency: Theorizing a New Medical Engagement with Stigma and Inequality," the authors call for an approach that centers the understanding of the ways in which structural, institutional, social, and economic factors produce symptoms and impact health.[40] The article defines "cultural competency" as

  > *"…the trained ability to identify cross-cultural expressions of illness and health, and to thus counteract the marginalization of patients by race, ethnicity, social class, religion, sexual orientation, or other markers of difference." (Metzel and Hanson, 2)*

  On the other hand, "structural competency" encompasses five core components that include: 1) recognizing the structures that shape clinical interactions; 2) developing an extra-clinical language of structure; 3) rearticulating "cultural" formulations in structural terms; 4) observing and imagining structural interventions; and 5) developing structural humility. (Metzel and Hanson, 1)

  Similarly, becoming an "equity competent" organization necessitates the development of the following:

  1. **Historical context**: Knowledge, awareness, and understanding of U.S. history and the evolving policy environment that created past and current legal and social constructs for the privilege and oppression of certain populations. This model highlights the impact of those evolving policies on current social conditions (e.g., the impact of redlining on the inability to accumulate wealth from generation to generation and its relationship to health inequities in infant mortality).
  2. **Common language**: The organization uses clear and universally accepted concepts and definitions to discuss issues of equity, systemic power, and oppression along the various axes of race, class, gender, sexuality, ability, and age, amongst others. This enables the organization to exchange knowledge and information based on shared meaning in ways that are easily understood to support collaboration and communication among colleagues, partners, and stakeholders.
  3. **Privilege and oppression**: Knowledge, awareness, and understanding of the effect of privilege and oppression at a personal, community, and systemic level.
  4. **Equity lens**: Understanding the social, political, and environmental contexts of a program, policy, or practice in order to evaluate and assess the unfair benefits and burdens within a society or population.
  5. **Policy**: Knowledge and understanding of policy making, analysis, and implementation with a focus on equity impact.

     and finally,

  6. **Commitment to ongoing learning**: Expansion of knowledge, skills, and understanding through engagement in a culture of inquiry and continuous learning.

The NPTF recommends "structural competency" and "equity competency" as useful frameworks for addressing not only the social determinants of health, but also the ways in which institutions (including health agencies and hospitals) inadvertently fail to address - and also perpetuate - the oppressive structures that impact and ultimately cause health disparities. These frameworks should not only be incorporated into medical training, but also into organizational structure, policy, and process.

- **Practitioners and health care agencies implement a "prenatal care plus" model that seeks to address critical social and economic concerns and incorporates "safety-net services" as a principal component of its care model.**

  "Prenatal care plus" encompasses a model that provides the necessary medical services while simultaneously providing education, support, and social and economic provisions, as needed, in a culturally rooted, respectful, and appropriate manner. This approach builds on the assertion that prenatal care, in and of itself, will not result in the desired and overarching impacts on disparities. Instead, "prenatal care plus" seeks to address the "broader conditions" of one's life that can serve as barriers to health and negatively impact outcomes. This includes mechanisms that empower, explicitly address stress, provide avenues for social support and connection, and incorporate "safety-net services" that address non-medical issues such as housing, finances, employment, food insecurity, transportation, childcare, instances of interpersonal violence, and much more.

- **Support the development of community-owned and -created Perinatal Safe Spots.**

  Perinatal Safe Spots (PSS), as defined by the NPTF, do not have to be clinics, hospitals, or even physical locations. PSS can be virtual, community-based, or set up in any other configuration that provides needed services or support in or for a materno-toxic area. In this way, identifying, prioritizing, and supporting the further development of community-led PSS addresses the identified area of need around self-determination and leadership from groups directly impacted by those inequities. This recommendation also calls for creative and innovative extra-medical solutions that are culturally congruent, empower and build communities, raise awareness, and address the social determinants locally.

- **Increased efforts to shift and impact social inequities broadly.**

  While changes to health care systems and models of care are important, without the overall shift in the conditions that cause health inequities, many disparities will continue to exist. Transforming systems that have intentionally marginalized communities of color for centuries will take focused long-term work. Acknowledging this component is key to addressing the fundamental causes of the current health inequities. The development of innovative policies to advance equity in local communities - including public budget allocations, education and awareness, and community organizing work that supports the collective empowerment of the communities impacted by health inequities and shifts institutional power to eliminate ALL inequities - must take place alongside all other efforts.

CONCLUSION

While the persistence of maternal and infant health disparities in the United States may seem disheartening, there are many communities who understand the profound importance of addressing this issue and who are doing pivotal work in this area. Examples such as The JJ Way® provide evidence that positively changing these outcomes is indeed possible. Frameworks such as the Maternal Justice Model also provide a blueprint and a track record for self-determined communities and allied organizations and institutions to truly go "upstream" to organize and push towards the elimination of ALL inequities, health or otherwise. The NPTF is one example of the work that it takes to establish key networks to support this important endeavor, allowing groups to work together and maintain a clear historic and analytic frame guiding their work toward shared goals: that every pregnant woman/person experience a positive and healthy pregnancy and birth, and that maternal and infant health outcomes are improved overall.

While a larger social framework that includes a deep understanding of the social determinants of health informs the proposed models and practices, it is also imperative to intentionally address historic and systemic forms of oppression at every level. Current maternal and infant health outcomes in the U.S. are the cumulative result of ongoing systemic marginalization beginning with intentional laws and policies and continuing with default and de-facto practices in most current day institutions. Current systems and institutions that fail to address this issue head on will continue to perpetuate it. Addressing centuries of disenfranchisement and exclusion requires that we prioritize substantive reallocation of resources, creative interdisciplinary and innovative programs, and bold policies to advance us towards equity. Turning the Titanic or redressing the impacts of history, including economic exploitation and institutional racism, will require a difficult and courageous commitment. There is no better inspiration for this work than a vision of a just and loving world where every baby is born healthy, every mother receives quality attentive care, and all communities have equitable resources to care for their families.

ENDNOTES

1. Central Intelligence Agency. "Country Comparison. Infant Mortality Rate." cia.gov. Central Intelligence Agency, n.d. Web. 04 Mar. 2017; Central Intelligence Agency. "Country Comparison. Maternal Mortality Rate." cia.gov. Central Intelligence Agency, n.d. Web. 04 Mar. 2017.

2. Office of Disease Prevention and Health Promotion. "Maternal, Infant, and Child Health." Healthypeople.gov. n.d. Web. 04 Mar. 2017

3. E. H. Bradley and L. A. Taylor. "The American Health Care Paradox: Why Spending More Is Getting Us Less (New York: Public Affairs, 2013); Organization for Economic Cooperation and Development, OECD Health Data 2015 (Paris: OECD, June 2015); "U.S. Health Care from a Global Perspective: Spending, Use of Services, Prices, and Health in 13 Countries." The Commonwealth Fund. n.d. Web. 08 April 2017.

4. Infant Mortality is defined as the death of an infant before their first birthday.

5. Central Intelligence Agency. "Country Comparison. Infant Mortality Rate." cia.gov. Central Intelligence Agency, n.d. Web. 04 Mar. 2017.

6. Central Intelligence Agency. "Country Comparison. Maternal Mortality Rate." cia.gov. Central Intelligence Agency, n.d. Web. 04 Mar. 2017.

7. Office of Disease Prevention and Health Promotion. "Maternal, Infant, and Child Health." Healthypeople.gov. n.d. Web. 04 Mar. 2017

8. Ibid.

9. Ibid.

10. Ibid.

11. March of Dimes."Long term health effects of premature birth." http://www.marchofdimes.org/complications/long-term-health-effects-of-premature-birth.aspx.n.d. 28 June 2017.

12. Center for Disease Control and Prevention. "Reproductive Health. Pregnancy Mortality Surveillance System." Cdc.gov. n.d. 04 Mar. 2017.

13. Grady, Denise. "Maternal Deaths Decline Sharply Across the Globe." New York Times. n.p. 13 April 2010. Web. 08 April 2017; Tavernise, Sabrina. "Maternal Mortality Rate in U.S. Rises, Defying Global Trend, Study Finds." New York Times. n.p. 21 Sept. 2016. Web. 08 April 2017.

14. Ibid.

15. World Health Organization. "Measuring maternal health: focus on maternal morbidity." http://www.who.int/bulletin/volumes/91/10/13-117564/en/. n.d. 28 June. 2017.

16. Center for Disease Control and Prevention. "Severe Maternal Morbidity in the United States." Cdc.gov. n.d. 28 June. 2017.

17. This report references maternal and infant mortality data that utilizes racial and ethnic categories as defined by the U.S. Census. Nevertheless, this report would like to complicate these categories by acknowledging that racial identification is both fluid and subjective. The processes by which an individual self-identifies racially/ethnically are complex and multi-layered. This should be taken into consideration when considering the racial gaps in health and the significance and impacts of the potential overlaps in these ascribed categories.

18. World Health Organization. "Social Determinants of Health." Who.int. n.d. 08 April 2017.

19. Lu, Michael C., and Belinda Chen. "Racial and Ethnic Disparities in Preterm Birth: The Role of Stressful Life Events." American Journal of Obstetrics and Gynecology 191.3 (2004): 691–699. ScienceDirect. Web. 29 July 2013; Parker-Dominguez, Tyan et al. "Stress in African American Pregnancies: Testing the Roles of Various Stress Concepts in Prediction of Birth Outcomes." Annals of Behavioral Medicine 29.1 (2005): 12–21. link.springer.com.ezproxy.lib.utexas.edu. Web. 29 July 2013.

20. Holland, Margaret L., Harriet Kitzman, and Peter Veazie. "The Effects of Stress on Birth Weight in Low-Income, Unmarried Black Women." Women's Health Issues 19.6 (2009): 390–397. ScienceDirect. Web. 29 July 2013; Rich-Edwards, Janet et al. "Maternal Experiences of Racism and Violence as Predictors of Preterm Birth: Rationale and Study Design." Pediatric and Perinatal Epidemiology 15 (2001): 124–135. Wiley Online Library. Web. 29 July 2013; Rosenthal, Lisa, and Marci Lobel. "Explaining Racial Disparities in Adverse Birth Outcomes: Unique Sources of Stress for Black American Women." Social Science & Medicine 72.6 (2011): 977–983. ScienceDirect. Web. 29 July 2013.

21. Caldwell, Cleopatra Howard et al. "Racial Identity, Maternal Support, and Psychological Distress Among African American Adolescents." Child Development 73.4 (2002): 1322–1336. Wiley Online Library. Web. 29 July 2013; Parker -Dominguez, Tyan et al. "Racial Differences in Birth Outcomes: The Role of General, Pregnancy, and Racism Stress." Health Psychology 27.2 (2008): 194–203. APA PsycNET. Web. 29 July 2013; Sable, Marjorie R., and Deborah Schild Wilkinson. "Impact of Perceived Stress, Major Life Events and Pregnancy Attitudes on Low Birth Weight." Family Planning Perspectives 32.6 (2000): 288–294. JSTOR. Web. 29 July 2013.

22. Carty, Denise C. et al. "Racism, Health Status, and Birth Outcomes: Results of a Participatory Community-Based Intervention and Health Survey." Journal of Urban Health 88.1(2011):84–97. link.springer.com.ezproxy.lib.utexas.edu. Web. 29 July 2013; Dominguez, Tyan Parker, Emily Ficklin Strong, et al. "Differences in the Self-Reported

Racism Experiences of US-born and Foreign-born Black Pregnant Women." Social Science & Medicine 69.2 (2009): 258–265. ScienceDirect. Web. 29 July 2013; Parker-Dominguez, Tyan, et al. "Racial Differences in Birth Outcomes: The Role of General, Pregnancy, and Racism Stress." Health Psychology 27.2 (2008): 194–203. APA PsycNET. Web.; Giscombé, Cheryl L., and Marci Lobel. "Explaining Disproportionately High Rates of Adverse Birth Outcomes Among African Americans: The Impact of Stress, Racism, and Related Factors in Pregnancy." Psychological Bulletin 131.5 (2005): 662–683. APA PsycNET. Web; Hogue, Carol J. Rowland, and J. Douglas Bremner. "Stress Model for Research into Preterm Delivery Among Black Women." American Journal of Obstetrics and Gynecology 192.5, Supplement (2005): S47–S55. ScienceDirect. Web. 29 July 2013; Jackson, Fleda Mask et al. "Examining the Burdens of Gendered Racism: Implications for Pregnancy Outcomes Among College-Educated African American Women." Maternal and Child Health Journal 5.2 (2001): 95–107. link.springer.com.ezproxy.lib.utexas.edu. Web. 29 July 2013; Parker-Dominguez, Tyan et al. "Stress in African American Pregnancies: Testing the Roles of Various Stress Concepts in Prediction of Birth Outcomes." Annals of Behavioral Medicine 29.1 (2005): 12–21. link.springer.com.ezproxy.lib.utexas.edu. Web. 29 July 2013; Rich-Edwards, Janet et al. "Maternal Experiences of Racism and Violence as Predictors of Preterm Birth: Rationale and Study Design." Pediatric and Perinatal Epidemiology 15 (2001): 124–135. Wiley Online Library. Web. 29 July 2013; Rosenthal, Lisa, and Marci Lobel. "Explaining Racial Disparities in Adverse Birth Outcomes: Unique Sources of Stress for Black American Women." Social Science & Medicine 72.6 (2011): 977–983. ScienceDirect. Web. 29 July 2013.

23. Williams, Timothy. "Tackling Infant Mortality Rates Among Blacks." New York Times. 14 Oct. 2011. Web. 08 April 2017.

24. Raglan, G.B., Lannon, S.M., Jones, K.M. et al. Matern Child Health J (2016) 20: 16. https://doi.org/10.1007/s10995-015-1803-1

25. Powers, Daniel A. "Paradox revisited: A further investigation of racial/ethnic differences in infant mortality by maternal age." Demography 50, no. 2 (2013): 495-520.

26. Ibid.

27. Landale, Nancy S., R. Salvador Oropesa, and Bridget K. Gorman. "Immigration and infant health: Birth outcomes of immigrant and native-born women." Children of immigrants: Health, adjustment and public assistance (1999): 109.

28. Buka, Stephen L. et al. "Neighborhood Support and the Birth Weight of Urban Infants." American Journal of Epidemiology 157.1 (2003): 1–8.aje.oxfordjournals.org.ezproxy.lib.utexas.edu. Web. 29 July 2013; Campbell, Della et al. "Female Relatives or Friends Trained as Labor Doulas: Outcomes at 6 to 8 Weeks Postpartum." Birth 34.3 (2007): 220–227. Wiley Online Library. Web. 29 July 2013; Carty, Denise C. et al. "Racism, Health Status, and Birth Outcomes: Results of a Participatory Community-Based Intervention and Health Survey." Journal of Urban Health 88.1(2011):84–97. link.springer.com.ezproxy.lib.utexas.edu. Web. 29 July 2013; Collins, Nancy L. et al. "Social Support in Pregnancy: Psychosocial Correlates of Birth Outcomes and Postpartum Depression." Journal of Personality and Social Psychology 65.6 (1993): 1243–1258. APA PsycNET. Web; Crnic, Keith A. et al. "Effects of Stress and Social Support on Mothers and Premature and Full-Term Infants." Child Development 54.1 (1983): 209–217. JSTOR. Web. 29 July 2013; Hoffman, Susie, and Maureen C. Hatch. "Stress, Social Support and Pregnancy Outcome: a Reassessment Based on Recent Research." Paediatric and Perinatal Epidemiology 10.4 (1996): 380–405. Wiley Online Library. Web. 29 July 2013; Mottl-Santiago, Julie et al. "A Hospital-Based Doula Program and Childbirth Outcomes in an Urban, Multicultural Setting." Maternal and Child Health Journal 12.3 (2008): 372–377.link.springer.com.ezproxy.lib.utexas.edu. Web. 29 July 2013; Oakley, Ann. "Social Support in Pregnancy: The 'soft' Way to Increase Birthweight?" Social Science & Medicine 21.11 (1985): 1259–1268. ScienceDirect. Web. 29 July 2013; Oakley, Ann, Lynda Rajan, and Adrian Grant. "Social Support and Pregnancy Outcome." BJOG: An International Journal of Obstetrics & Gynaecology 97.2 (1990): 155–162. Wiley Online Library. Web. 29 July 2013; Sauls, Donna J. "Effects of Labor Support on Mothers, Babies, and Birth Outcomes." Journal of Obstetric, Gynecologic, & Neonatal Nursing 31.6 (2002): 733–741. Wiley Online Library. Web. 29 July 2013; Turner, R. Jay, Carl F. Grindstaff, and Norman Phillips. "Social Support and Outcome in Teenage Pregnancy." Journal of Health and Social Behavior 31.1 (1990): 43–57. JSTOR. Web. 29 July 2013.

29. Ibid.

30. Commonsense Childbirth Inc. (CSC) is a 501(c) 3 non-profit organization that was formed in 1998 by Jennie Joseph to enhance women's experience of childbirth and improve perinatal outcomes using a midwifery model of care. CSC;s vision is that all women have a healthy pregnancy, birth and baby and a key principle is that no one is turned away. It's mission is to ensure access to timely maternity health care particularly for minority, low-income, uninsured, and underinsured women; and to provide practical, social, educational and emotional support, resources and referrals as a means to improving the chances for a positive outcome.

31. According to the Midwifery Task Force, Inc., the Midwives Model of Care is based on the fact that pregnancy and birth are normal life processes. The Midwives Model of Care includes: 1) Monitoring the physical, psychological, and social well-being of the mother throughout the childbearing cycle, 2) Providing

the mother with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support, 3) Minimizing technological interventions, and 4) Identifying and referring women who require obstetrical attention. The application of this woman-centered model of care has been proven to reduce the incidence of birth injury, trauma, and cesarean section.

32. Raisler, J, Kennedy, H. "Midwifery care of poor and vulnerable women, 1925 – 2003." Journal of Midwifery Women's Health. 2005. Mar – Apr; 50(2):113-21.

33. Health Council of East Central Florida. Commonsense Childbirth, Inc. Program Evaluation. August 2009.

34. Sarah J. Day et al. The JJ Way®: Reducing Perinatal Outcome Disparities. A Retrospective Matched Comparison Group Study on Birth Outcomes in At-Risk Populations. Poster Presentation. 2012.

35. Visionary Vanguard Group, Inc. JJ Way® Community-Based Maternity Center Final Evaluation Report. 2017.

36. Gaston, M., Porter, G. K., & Thomas, V. G. (2007). Prime Time Sister Circles™: Evaluating a gender-specific, culturally relevant health intervention to decrease major risk factors in mid-life African-American women. Journal Of The National Medical Association, 99(4), 423-438; Prevention interventions need to be culturally relevant, gender specific. (2009). DATA: The Brown University Digest of Addiction Theory & Application, 28(10), 1-6.; Goicoechea-Balbona, A. (1997). CULTURALLY SPECIFIC HEALTH CARE MODEL FOR ENSURING HEALTH CARE USE BY RURAL, ETHNICALLY DIVERSE FAMILIES AFFECTED BY HIV/AIDS. Health & Social Work, 22(3), 172-180.; UNGAR, M. (2010). Families as Navigators and Negotiators: Facilitating Culturally and Contextually Specific Expressions of Resilience. Family Process, 49(3), 421-435.

37. Siegel, D.J. (2012) The Developing Mind, Second Edition: How Relationships and the Brain Interact to Shape Who We Are. New York: Guilford Publications.; Siegel, D.J. (2010) The Mindful Therapist: A Clinicians Guide to Mindsight and Neural Integration. New York: W.W. Norton & Company, Inc.; Siegel, D. J. (2004). Attachment and self-understanding: Parenting with the brain in mind. In M. Green, M. Scholes (Eds.) , Attachment and human survival (pp. 21-35). London England: Karnac Books.; Cohen, S., & Janicki-Deverts, D. (2009). Can We Improve Our Physical Health by Altering Our Social Networks?. Perspectives On Psychological Science (Wiley-Blackwell), 4(4), 375-378. doi:10.1111/j.1745-6924.2009.01141.x; Uchino, B. N. (2004). Social support and physical health : understanding the health consequences of relationships / Bert N. Uchino. New Haven : Yale University Press, c2004.

38. Thorgeirsson, T., & Kawachi, I. (2013). Behavioral economics: merging psychology and economics for lifestyle interventions. American Journal Of Preventive Medicine, 44(2), 185-189. doi:10.1016/j.amepre.2012.10.008; Duhigg, C. (2012). The power of habit : why we do what we do in life and business / Charles Duhigg. New York : Random House, c2012.; S.D. Halpern, P.A. Ubel, D.A. Asch. (2007) Harnessing the power of default options to improve health care. N Engl J Med, 357, pp. 1340–1344; F.J. Zimmerman (2009) Using behavioral economics to promote physical activity. Prev Med, 49 (4) pp. 289–291; Ariely, D. (2008). Predictably irrational: The hidden forces that shape our decisions. New York, NY US: HarperCollins Publishers.

39. Norris, Jeffrey. "Self-tracking may become key element of personalized medicine." UCSF News (2012).

40. Metzl, Jonathan M., and Helena Hansen. "Structural competency: Theorizing a new medical engagement with stigma and inequality." Social Science & Medicine 103 (2014): 126-133.

APPENDIX A: LIST AND LOCATIONS OF CURRENT PERINATAL SAFE SPOTS

NAME	LOCATION
Nurture Root to Fruit	Oakland, CA
Birth and More Wellness	Farmington Hills, MI
Alba Birth Center	Appleton, WI
Uzazi Village	Kansas City, MO
Community Birth Companion	Opelousas, LA
Kathi Barber	Baltimore, MD / Oakland, CA
Laoch Midwifery	Tacoma, WA
Mamas on Bedrest and Beyond	Austin, TX
Mothering the Mother, Inc.	Milwaukee, WI
Mamatot Village, Inc.	Washington, DC
Open Circle	Providence, RI
Tribe Midwifery	Los Angeles, CA
Selah Doula Services	Greensboro, CA
Bold Doula	Beacon, NY
The Cultural Wellness Center	Minneapolis, MN
Birthwell Partners	Central Alabama
Co-Mothering CNY	Syracuse, NY
Roots and Wings	Arlington, TX
Sista Midwife Productions	New Orleans, LA
BirthWellness	Reading, PA
Postpartum Recovery	Baltimore, MD
Birth Roots	Chula Vista, CA
Roots Community Birth Center	Minneapolis, MN
A Mother's Choice	Colorado Springs, CO
Mana Sana Vibrant Woman	Austin, TX
Intune Mother	Oklahoma City, OK
Grace Carr	Hamilton, OH
Aloha Hawaii	Honolulu, HI
Community Birth & Wellness Center	Ferguson, MO
Mosaic Midwifery	Oklahoma City, OK Metro and surrounding areas
Ashland Birth Center	Ashland, WI
Birth Choice Midwifery	Fort Mill, SC
New Creation Childbirth	Greenfield, MA
Easy Access Women's Health Clinic	Orlando, FL
The Birth Place	Winter Garden, FL
Birthing Hands of DC	Washington, DC
International Center for Traditional Childbearing (ICTC)	Portland, OR

NOTES

THIS REPORT HAS BEEN ENDORSED BY:

MomsRising.org
MamásConPoder.org

FOR MORE INFORMATION, PLEASE CONTACT:

Jennie Joseph: jennie@commonsensechildbirth.org

or

Paula X. Rojas: Paulax@mamabaila.com

Commonsense Childbirth
because every woman deserves a healthy baby

MAMA SANA VIBRANT WOMAN

NATIONAL PERINATAL TASK FORCE

Building a Movement to Birth a More Just and Loving World

MARCH 2018