AMCHP ASSOCIATION OF MATERNAL & CHILD HEALTH PROGRAMS | UNC GILLINGS SCHOOL OF GLOBAL PUBLIC HEALTH

SYSTEM ACTOR:

Community-Based Organizations

This document describes actions from the Birth Equity Action Map that community-based organizations can take to advance birth equity, as well as potential partners and the barriers to change each action addresses. We define community-based organizations as grassroots entity rooted in local communities, primarily focused on addressing health and social service needs. With a deep understanding of the cultural, social, and economic dynamics of their community, these organizations work to enhance health outcomes by leveraging local resources, knowledge, and networks. Click **here** to explore the community-based organization actions in the interactive Birth Equity Action Map.

ACTION	DESCRIPTION	POTENTIAL PARTNERS	BARRIER(S) TO CHANGE BEING ADDRESSED
Activate birth equity champions to influence policy[3,4,5]	Identify, inform, and activate champions who can influence legislators to direct funds where they need to go to support birth equity. Specifically, this might look like: ▪ Providing leadership and communication training to health department staff, community members, health care providers, doulas, and community health workers to advocate for equitable policies at the local/state level ▪ Using targeted messaging to transform mental models among policy and decision-makers ▪ Creating and supporting dedicated spaces to bring community voices and experiences to policymakers and legislative staff	Federal agencies, National non-profits, Private funders, State and local health agencies	Mental Model: Belief among decision makers that it is not critical to invest in workforce, anti-racism, or service gaps Mental Model: Persistent implicit bias among providers and lack of empathy towards pregnant people of color and others with systematically marginalized identities

ACTION	DESCRIPTION	POTENTIAL PARTNERS	BARRIER(S) TO CHANGE BEING ADDRESSED
Assess organization's current conditions and activities[4]	Assess organization's current conditions and activities informed by data. Results of the assessment should identify gaps and be actionable. Specifically, this can include: ▪ Latest maternal and infant health access, outcomes, quality, and experience data, stratified by self-identified race, ethnicity, limited English proficiency, disability, sexual orientation and gender identity, and type of coverage, with historical trends if available (CMO and/or Quality Improvement (QI) team). ▪ Inventory and assessment of clinical maternity and reproductive healthcare services (preconception, pregnancy, childbirth, and postpartum practices) through the lens of whole person care (CMO and/or QI team). ▪ Inventory and assessment of the intercultural competence of leaders and organization (CMO and/or QI team). ▪ Inventory and assessment of the capacity to support the mental health and social needs of diverse childbearing women and people (CMO and/or QI team). ▪ Assessment of the current capability to effectively and respectfully serve specific groups of people who wish to become pregnant, are currently pregnant, or recently gave birth (QI team, CMO, COO). These groups include: People from communities experiencing historical and ongoing racism. Immigrants, including those without legal status. People with limited English proficiency. People with disabilities. People with varied sexual orientations and transgender and gender-nonconforming people. ▪ Survey of current and potential birthing people about their expectations for and recommended improvements of maternity-related services, co-designed with service users (QI, patient experience, community health team). ▪ Hospital assessment of facility readiness to support breastfeeding using CDC's mPINC 10 Steps Assessment Tool	State and local health agencies, Health systems, Hospitals	System Structure: Hospital performance and readmission rates do not typically disaggregate data by race or center assessment of respectful care or other structural measures
Build local coalitions[1,3,4]	Build local coalitions to expand collective capacity to advance birth equity. Specifically, this might look like: ▪ Sharing resources and strategies among organizations for collective impact ▪ Investing in the development of cultural humility and empathy among coalition members ▪ Changing the traditional hierarchies to share power with community organizations, members, and patient representatives	State and local health agencies, Health systems, Hospitals, Birth equity advocates, Legislators	Mental Model: Resistance to collaboration across sectors
Create communication & coordination standards across sectors[3]	Create communication and coordination standards (e.g., shared vocabulary and data, warm handoff protocols, etc) and support healthy collaboration across sectors.	State and local health agencies, Health systems, Hospitals	Mental Model: Resistance to collaboration across sectors

ACTION	DESCRIPTION	POTENTIAL PARTNERS	BARRIER(S) TO CHANGE BEING ADDRESSED
Disseminate health education and birth rights information[3]	Develop and disseminate culturally relevant health education resources, including on birth choices and rights, acknowledging current system flaws, and suggested strategies for resiliency while pursuing community-driven systems change. Specifically, this might look like: ▪ Disseminating birth rights information to families and communities ▪ Assuring providers are knowledgeable on and held accountable to state-level and facility-level policies regarding patient rights	State and local health agencies, National non-profits, Health systems, Hospitals, Birth equity advocates	System Structure: Birthing individuals only have access to what their insurance is willing to pay for, setting a standard that doesn't allow choice Mental Model: The devaluing of women and childbirth and intense focus on the newborn
Elevate community voices for policy change[1,3,4]	Elevate and value diverse community voices in both governmental and organizational policy change efforts. Apply Black feminist praxes and Indigenous knowledge to policy and program development, implementation, and analysis at every level of government. Specifically, this might look like: ▪ Assess current relationships, initiatives, and reputation regarding community engagement ▪ Seek out, disseminate, and support insights shared from community members' lived experience including to inform on disaster and public health emergency response ▪ Dedicate staff hours to building and maintaining relationships with the community ▪ Actively invite and integrate diverse and underrepresented perspectives in collaborative and policymaking spaces ▪ Create and support dedicated spaces to bring community voices and experiences to policymakers and legislative staff ▪ Develop a community-led governing/decision-making board at a health system or hospital ▪ Provide opportunities for staff to learn from community leaders ▪ Join community leaders in community settings, for example, serving on community boards or attending community-led health events ▪ Require proportionate community representation – based on race and ethnicity, ability, and sexual orientation and gender identity in the service area population – on advisory committees and other governance bodies with meaningful decision-making roles	State and local health agencies, National non-profits, Health systems, Hospitals	Mental Model: The focus on individual care, rather than in the family/community context
Engage and compensate people with lived experience[2,3,4]	Recognize and create a structure for compensating the invaluable insights gathered from people with lived experience. Specifically, this might look like developing a mechanism to pay people with lived experience for serving on advisory boards or revising job descriptions to recognize lived experience as relevant job experience.	State and local health agencies, National non-profits, Health systems, Hospitals	System Structure: Funding systems perpetuate lack of accountability for funded programs to achieve results and/or meaningfully engage the impacted community Mental Model: The focus on individual care, rather than in the family/community context Mental Model: Belief among decision makers that it is not critical to invest in workforce, anti-racism, or service gaps

ACTION	DESCRIPTION	POTENTIAL PARTNERS	BARRIER(S) TO CHANGE BEING ADDRESSED
Expand maternal mental and behavioral health care[1,3]	Expand culturally competent maternal mental and behavioral health care to support families impacted by substance use disorders and mental illness. Specifically, this might look like: ▪ Address and strengthen systems for people with mental health challenges and/or substance use disorders, recognizing the unique needs of each and that care only partially overlaps ▪ Invest in community-based programs that provide mental and behavioral health treatment and support to birthing people with maternal mental health conditions or substance use disorder, including: group prenatal and postpartum care models; collaborative maternity care models; initiatives to address stigma and raise awareness about warning signs for maternal mental and behavioral health conditions; programs at freestanding birth centers; suicide prevention programs; and harm reduction services. ▪ Fill gaps in mental and behavioral health care provision by providing postpartum services and mental health care training and support to fathers, partners, and family members, incorporating screenings for postpartum depression into baby well-visits, and other methods. ▪ Increase access to maternal mental health services by increasing the number of mental health providers participating in Medicaid and other public and private insurance programs, increasing reimbursement rates, and covering nontraditional, alternative behavioral health therapies such as meditation or art therapy. ▪ Ensure and destigmatize access to medications for opioid use disorder (MOUD) for pregnant and postpartum people ▪ Expand access to peer support services for pregnant and postpartum people with substance use disorders ▪ Enact policies to increase access to harm reduction services, including syringe exchange services and naloxone distribution ▪ Implement targeted provider training that addresses stereotyping, implicit bias, social determinants of health, and shared decision making for pregnant and parenting people with mental health and substance use challenges ▪ Assess and change state policies to ensure birthing people are offered non-punitive, evidence-based support for substance use disorders, rather than approaches that punish or criminalize people for seeking treatment ▪ Implement the Perinatal Mental Health Conditions and Care for Pregnant and Postpartum People with Substance Use Disorder AIM Patient Safety Bundles	Federal agencies, Private funders, State and local health agencies, Health systems, Payers, Legislators	System Structure: Health insurance and payment systems create and maintain inequitable access to health care and holistic perinatal care Mental Model: The devaluing of women and childbirth and intense focus on the newborn Mental Model: Lack of appreciation for interconnected nature of maternal health, behavioral health, and health insurance policies

ACTION	DESCRIPTION	POTENTIAL PARTNERS	BARRIER(S) TO CHANGE BEING ADDRESSED
Fully integrate doulas and midwives into birthing care teams[1,3]	Fully integrate doulas and midwives into care teams by assessing and changing policies limiting their involvement, developing strong partnerships between health systems and community-based organizations, and supporting doula/midwife cooperatives and training programs. This must include attention to unintended consequences such as the prioritization of doulas and midwives associated with health systems over community-based doulas.	Health systems, Hospitals, Payers, Professional medical associations	System Structure: Lack of support for diverse birthing workforce System Structure: Birthing individuals only have access to what their insurance is willing to pay for, setting a standard that doesn't allow choice System Structure: Health insurance and payment systems create and maintain inequitable access to health care and holistic perinatal care Mental Model: Resistance to including doulas and midwives in care teams
Generate and disseminate evidence-based approaches[3]	Generate and disseminate evidence-based approaches to advance birth equity, including community-generated best practices. Specifically, this might look like: ▪ Create accessible forums to share evidence-based, community-generated approaches ▪ Support connections between funders and community-generated best practices and innovators ▪ Provide training and support (e.g., technical assistance, micro-grants to support staff time, etc.) to community-based organizations on documentation, scale-up, and dissemination of evidence-based approaches (as desired)	State and local health agencies, National non-profits, Academic institutions, Professional medical associations	Mental Model: Practice and research focus on the problem and not the solution
Grow public awareness of factors impacting birth equity[3,4]	Influential thought leaders and organizations should develop social media, mass communication content, and other strategies to grow public and cross-system (eg. among all other relevant organizations and providers) appreciation of the interconnected nature of maternal health, behavioral health, and health insurance policies along with their joint influence on birth equity. Specifically, this might include: ▪ Partnering with local media to raise awareness and create urgency around areas of needed systems change ▪ Focusing on informing and influencing youth mental models in partnership with schools, youth-led organizations, etc.	State and local health agencies, Federal agencies, National non-profits, Health systems, Birth equity advocates, Academic institutions, Professional medical associations	Mental Model: Lack of appreciation for interconnected nature of maternal health, behavioral health, and health insurance policies

ACTION	DESCRIPTION	POTENTIAL PARTNERS	BARRIER(S) TO CHANGE BEING ADDRESSED
Holistically support the existing birthing provider workforce[1,3,5]	Holistically support the existing birthing provider workforce to protect from burnout and attrition. Specifically, this might look like: ▪ Offer stipends to practicing clinicians of color to serve as mentors to nursing and midwifery students ▪ Offer holistic workplace pregnancy accommodations ▪ Research and support implementation of innovative approaches to end violence and harassment against providers, patients, and staff that do not involve policing ▪ Ensure living wage, workforce development opportunities, access to affordable, quality childcare, access to mental health and healing-centered services, access to retirement accounts, affordable housing, etc.	Federal agencies, Private funders, Health systems	System Structure: Inconsistent investment in providing equitable access to basic health, social, and economic services and supports
Implement collaborative knowledge sharing tools to support families[3,4]	Implement and disseminate approaches (e.g., collaborative knowledge sharing tools, websites, platforms like Unite Us) to efficiently provide up-to-date information about resources and wrap-around services that can support families.	State and local health agencies, Hospitals, Health systems	Mental Model: The focus on individual care, rather than in the family/community context System Structure: Extent to which federal and state governments prioritize maternal and infant health equity
Promote cross-sector dialogue[1,3,4]	Promote high-level dialogues across sectors at the community, state, and national levels to discuss critical sector impacts on maternal health and through this grow buy-in and inform action to increase collective impact.	Federal agencies, National non-profits, Private funders, State and local health agencies, Health systems, Hospitals, Legislators	Mental Model: Resistance to public health, anti-racism, women's rights, and disability justice efforts Mental Model: Resistance to collaboration across sectors
Provide cultural humility education to policymakers[3]	Provider policymakers and legislative staff with education on cultural humility and birth equity to grow their empathy and understanding of the need for equitable policies and inform their policy action.	National non-profits	System Structure: Inconsistent investment in providing equitable access to basic health, social, and economic services and supports Mental Model: Belief among decision makers that it is not critical to invest in workforce, anti-racism, or service gaps

ACTION	DESCRIPTION	POTENTIAL PARTNERS	BARRIER(S) TO CHANGE BEING ADDRESSED
Recruit, train, and support diverse provider workforce[2,3,5]	Recruit, train, and support a diverse community-based birthing provider workforce, including doulas, midwives, lactation consultants, and perinatal mental health specialists. This might include developing interdisciplinary clinical training models and empowering clients and community members to join the birth equity ecosystem through scholarship opportunities, training, and hiring.	Private funders, Health systems, Hospitals, Medical and health education programs, Legislators	System Structure: Lack of support for diverse birthing workforce
Reimagine and invest in housing programs[1]	Invest in innovative programs and partnerships that facilitate Black women and birthing people's access to housing and financial resources, including through housing cooperatives, community land trusts, managed care organizations, Section 1115 waivers, guaranteed income programs, and other methods. Include multigenerational families, families with multiple dependents, and other non-traditional family structures in these innovations.	Federal agencies, Private funders, State and local health agencies, Payers, Legislators	System Structure: Inconsistent investment in providing equitable access to basic health, social, and economic services and supports
Screen for needs throughout perinatal period[4]	Screen for physical and mental health and social needs at key points in pregnancy and the postpartum period using robust, culturally responsive screening tools. Co-create and consistently update care plans with the birthing person and facilitate access to the plan by all members of the care team.	Health systems, Hospitals	System Structure: When referrals are made within clinical systems, there is no coordinated feedback structure to ensure services are received System Structure: Extent to which federal and state governments prioritize maternal and infant health equity
Share resources to maximize impact[1,3,4]	Actors with institutional power can share non-financial institutional assets with other community partners. Specifically, this can look like in-kind donations of goods and services and pro bono support with professional services such as: ▪ Information technology infrastructure and support ▪ Data collection and management resources ▪ Financial, legal, and governance resources ▪ Emergency preparedness and response resources	National non-profits, Private funders, Health systems, Birth equity advocates	Mental Model: Resistance to collaboration across sectors
Support community engagement and staff retention[1,3,4]	Cultivate and implement strategies to support the wellness and restoration of staff and create accessible, inclusive environments that welcome family and community engagement in program and policy design.	Community-based organizations, Health systems, Hospitals	Mental Model: Resistance to public health, anti-racism, women's rights, and disability justice efforts Mental Model: The focus on individual care, rather than in the family/community context

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Sources

Actions were synthesized from a two-part Systems Mapping to Advance Birth Equity workshop with 48 diverse actors representing federal, state, local, community, and family birth equity partners as well as the following recommended recent sources that have called for specific actions to advance birth equity.

1. Black Mamas Matter Alliance (2023). Black Mamas Matter: In Policy and Practice: A policy agenda for the Black maternal health, rights, and justice movement.
2. Institute for Medicaid Innovation (2023). Innovation in Perinatal and Child Health in Medicaid.
3. National Birth Equity Systems Mapping Workshop (2023). AMCHP Virtual Workshop, May and June 2023.
4. National Partnership for Women and Families (2023). Raising the Bar for Maternal Health Equity and Excellence.
5. New Jersey Health Care Quality Institute and The Burke Foundation (2022). Delivering Better Care: Midwifery Practice in New Jersey.

Participating Organizations (in the workshop or feedback sessions)

- Alliance for Early Success
- Birthing Cultural Rigor, LLC
- BirthMatters
- Black Mamas ATX
- CityMatCH
- Family Solutions: A Program of the SC Office of Rural Health
- Funders for Birth Justice and Equity
- Georgetown University Center for Children and Families
- Giving Austin Labor Support
- Greater Newark Health Care Coalition
- Hand to Hold
- Healthy Mothers, Healthy Babies Coalition of Georgia
- HRSA's Maternal and Child Health Bureau
- Institute for Women and Ethnic Studies
- Intermountain Health RMOMS Program
- Mama Sana Vibrant Woman
- Mamatoto Village
- March of Dimes
- Maternal Health Equity Collaborative
- Maternal Mental Health Leadership Alliance
- Merck for Mothers
- Minnesota Indian Women's Resource Center
- National Healthy Start Association
- National Institute for Children's Health Quality
- National Partnership for Women & Families
- Our Journ3i
- Philadelphia Department of Public Health
- Preeclampsia Foundation
- Rhode Island Department of Health
- Sedgwick County Health Department
- St. Joseph County Department of Health
- Starting Out Right
- The BEE Collective
- The Reilly Group
- Trenton Health Team
- The U.S. Department of Agriculture
- U.S. Department of Labor
- Utah Pacific Islander Health Coalition
- University of Washington's Parent-Child Assistance Program