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

SYSTEM ACTOR:

Health Systems

This document describes actions from the Birth Equity Action Map that health systems can take to advance birth equity, as well as potential partners and the barriers to change each action addresses. We define health systems as collective entitities that encompass multiple health care organizations (i.e., hospitals, physician practices, etc.) through shared ownership or contracting to deliver health services and public health interventions to communities. **Click here to explore these health system actions in the interactive Birth Equity Action Map.**

ACTION	DESCRIPTION	POTENTIAL PARTNERS	BARRIER(S) TO CHANGE BEING ADDRESSED
Address biases system-wide and advance cultural humility[1,3]	Enhance commitment, create accountability for, and support the practice of cultural humility and awareness/ improvement of workforce biases. Specifically, this might look like: ▪ Provide health care staff and providers with education on cultural humility and birth equity to grow their empathy and understanding of the need for equitable, trauma-informed, culturally competent care. ▪ Recognize and raise awareness of learning and action opportunities available (i.e., the Racial Equity Institute) to organizations. ▪ Inform and activate leadership champions to communicate the need for cultural humility to providers and health care staff, including stories from people with lived experience	National non-profits, Federal agencies, Private funders, Hospitals, Academic institution, Birth equity advocates, 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

ACTION	DESCRIPTION	POTENTIAL PARTNERS	BARRIER(S) TO CHANGE BEING ADDRESSED
Advance policies to support families' basic needs[1,2,3,4]	Educate/advocate for and advance policies at the state and federal level to protect and provide for basic human needs such as food, shelter, and childcare. Apply Black feminist praxes and Indigenous knowledge to policy and program development, implementation, and analysis at every level of government. Specifically, advance policies including: ▪ Raising the minimum wage ▪ Federal laws for paid family leave, paid sick leave ▪ Increasing EBT/WIC allocation and benefit period ▪ Increasing the supply of affordable housing ▪ Enacting progressive policies to support families basic needs at the state and local level ▪ Enacting the Black Maternal Health Momnibus Act. Center and defer to Black-led and centered, community-based organizations in implementing and evaluating Momnibus policies and programs. ▪ Offering evening and weekend appointments. ▪ Offering telehealth visits, in-home visits, mobile clinics, and other options for expanding access to care. ▪ Co-locating laboratory, imaging, mental and behavioral health, and other services to facilitate one-stop prenatal and postpartum visits. ▪ Ensuring the accessibility of exam rooms and other service areas. ▪ Making translators available and ensure signage and websites are available in priority languages. ▪ Removing work requirements ▪ Expanding Child Tax Credit ▪ Ensuring affordable and accessible childcare ▪ Targeting resources to families living in climate-affected areas	Federal agencies, State and local health agencies, Birth equity advocates, Legislators	System Structure: Inconsistent investment in providing equitable access to basic health, social, and economic services and supports

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	Community-based organizations, State and local health agencies, 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	Community-based organizations, State and local health agencies, Hospitals, Birth equity advocates, Legislators	Mental Model: Resistance to collaboration across sectors

ACTION	DESCRIPTION	POTENTIAL PARTNERS	BARRIER(S) TO CHANGE BEING ADDRESSED
Collaborate across silos to provide continuous care[1,2,3,4]	Commit to ongoing communication and collaboration among healthcare providers and birth workers to eliminate silos, strengthen the continuum of care while implementing evidence-based practices, and ensure warm handoffs across transitions (e.g., from pregnancy to postpartum). Specifically, this can look like: ▪ Provide postpartum services for at least 12 months ▪ Optimize the current two postpartum visits recommended by the American College of Obstetricians and Gynecologists ▪ Report the nationally endorsed Contraceptive Care-Postpartum performance measure ▪ Provide affordable and accessible childcare during perinatal appointments ▪ Provide mobile health services to families in rural areas ▪ Collaborate across health systems and payers to align and expand covered services	Hospitals, Legislators	System Structure: Health insurance and payment systems create and maintain inequitable access to health care and holistic perinatal care
Combat bias through training, education, and policy[3,4]	Combat bias through workforce training, education, and hospital-level policy change. Specifically, this might look like: ▪ Updating nursing and medical school curriculum ▪ Offering trainings (in medical schools and to current providers) that focus on protecting birthing parent autonomy, addressing racial biases, and promoting respectful maternity care	Hospitals, Professional medical associations, Medical and health education programs	System Structure: Lack of support for diverse birthing workforce Mental Model: Persistent implicit bias among providers and lack of empathy towards pregnant people with systemically marginalized identities
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, Community-based organizations, Hospitals	Mental Model: Resistance to collaboration across sectors

ACTION	DESCRIPTION	POTENTIAL PARTNERS	BARRIER(S) TO CHANGE BEING ADDRESSED
Develop and support an organizational growth culture[3]	Grow and support organizational commitment and capacity for adaptive leadership, including a growth and transformative mindset. This includes building organizational cultures that support a true commitment to psychological safety to unleash the potential for meaningful improvement, courageous creativity, human connection, and grace towards oneself and each other; mandatory/strongly encouraged paid time off; and instilling and welcoming a deep commitment to speaking truth to power, while also recognizing that strategic decisions need to inevitably play a role when navigating different settings, spaces, and audiences.	National non-profits, Federal agencies, Private funders, State and local health agencies, Hospitals, Birth equity advocates, Academic institutions	Mental Model: Resistance to embracing a transformative mindset
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	Community-based organizations, National non-profits, State and local health agencies, 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

ACTION	DESCRIPTION	POTENTIAL PARTNERS	BARRIER(S) TO CHANGE BEING ADDRESSED
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 ▪ Seeking out, disseminating, and supporting 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 inviting and integrating diverse and underrepresented perspectives in collaborative and policymaking spaces ▪ Creating and supporting dedicated spaces to bring community voices and experiences to policymakers and legislative staff ▪ Developing a patient- and community-led governing and 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	Community-based organizations, National non-profits, State and local health agencies, 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.	Community-based organizations, National non-profits, State and local health agencies, 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
Ensure equitable, trauma-informed, patient-centered care[1,3,4]	Ensure equitable, trauma-informed, patient-centered care is provided and rooted in reproductive justice. Specifically, this might look like: ▪ Develop community-led governance structures within health systems ▪ Invest in reproductive justice informed peer-to-peer, and community health worker programs ▪ Train providers to deliver respectable maternity care, including respect for the full range of birthing options and patient autonomy ▪ Provide access to peer counselors and lactation specialists to support human milk feeding ▪ Establish breastfeeding-friendly spaces and adhere to the 10 Steps to Successful Breastfeeding.	Hospitals, Payer, Medical and health education programs	System Structure: Extent to which federal and state governments prioritize maternal and infant health equity System Structure: Extent to which federal and state governments prioritize maternal and infant health equity System Structure: Hospital systems based on the "average" individual, not taking into account the diverse needs and wants of individual families Mental Model: The focus on individual care, rather than in the family/community context
Expand innovative care models[1,4]	Health systems should develop and evaluate innovative care delivery models to expand and improve options for birthing parents and families. Specifically, this can include: ▪ Midwifery-led prenatal care ▪ Group prenatal care options ▪ Telehealth and home monitoring programs. ▪Establishing Medicaid demonstration projects to test payment models for maternity care ▪ Assessing the impact and opportunity for developing birth centers within the Federally Qualified Health Center model.	Federal agencies, Hospitals, Academic institutions, Payers	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: Practice and research focus on the problem and not the solution

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	Community-based organizations, Federal agencies, Private funders, State and local health agencies, 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.	Community-based organizations, 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 Mental Model: Resistance to including doulas and midwives in care teams
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.	Community-based organizations, National non-profits, Federal agencies, State and local health agencies, 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
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.	Community-based organizations, Federal agencies, Private funders	System Structure: Inconsistent investment in providing equitable access to basic health, social, and economic services and supports

ACTION	DESCRIPTION	POTENTIAL PARTNERS	BARRIER(S) TO CHANGE BEING ADDRESSED
Implement and strengthen team-based care approaches[3,4]	Implement and strengthen team-based care approaches in order to provide cohesive, collaborative care to birthing people and their families. This should include OBGYNs, doulas, midwives, mental health professionals, pediatricians, community health workers, community nurses, home visitors, etc.	Hospitals, Payers, Professional medical associations	System Structure: Lack of support for diverse birthing workforce Mental Model: Resistance to collaboration across sectors
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.	Community-based organizations, Hospitals, State and local health agencies	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
Improve care for people in the justice- and immigration-system[1]	Advocate, build coalitions, and pass policies at the federal, state, and local level to ensure the delivery of equitable, trauma-informed, patient-centered care for justice- and immigration-system involved individuals and families. Specifically, this might look like: ▪ Establish federal guidelines for trauma-informed care in correctional and detention facilities ▪ Guarantee access to respectful, comprehensive, and quality maternal, sexual, behavioral, and reproductive healthcare, including abortion care, in correctional and detention facilities and hold staff accountable for denial of care, sexual and gender-based violence, and other human rights abuses ▪ Establish provider exchange service programs to increase access to perinatal health workers like doulas, counseling, reentry assistance, and maternal-infant bonding opportunities ▪ Mandate access to menstruation products and contraception ▪ Eliminate the use of protective restraints for pregnant incarcerated persons ▪ Explore alternative placement and secure housing options for incarcerated persons during the perinatal period ▪ Establish correctional policies that support family video conferencing, parenting resources, family visitation, and overnight visiting	Federal agencies, State and local health agencies, Professional medical associations, Legislators	System Structure: Criminalization of abortion care and non-hospital based birthing options Mental Model: Persistent implicit bias among providers and lack of empathy towards pregnant people with systematically marginalized identities Mental Model: Resistance to embracing a transformative mindset

ACTION	DESCRIPTION	POTENTIAL PARTNERS	BARRIER(S) TO CHANGE BEING ADDRESSED
Increase diverse labor and delivery care access[1,3,4]	Collaborate and innovate to increase access to diverse labor and delivery care (including birth centers) and connections/referrals between labor and delivery and other health care (e.g., emergency departments) and social services (e.g., transportation) to improve patient care and outcomes.	Legislators	System Structure: Inconsistent investment in providing equitable access to basic health, social, and economic services and supports System Structure: When referrals are made within clinical systems, there is no coordinated feedback structure to ensure services are received decision makers that it is not critical to invest in workforce, anti-racism, or service gaps
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.	State and local health agencies, Community-based organizations, National non-profits, Federal agencies, Private funders, Hospitals, Legislators	Mental Model: Resistance to public health, anti-racism, women's rights, and disability justice efforts Mental Model: Resistance to collaboration across sectors
Promote disaggregated data collection and sharing[3,4]	Enhance and financially support comprehensive, disaggregated data collection and transparent sharing from health systems in order to accurately understand and track inequities and allocate funding.	State and local health agencies, Hospitals, Payers	System Structure: Hospital performance data lacks disaggregation and structural measures
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.	Community-based organizations, Private funders, Hospitals, Medical and health education programs, Legislators	System Structure: Lack of support for diverse birthing workforce

ACTION	DESCRIPTION	POTENTIAL PARTNERS	BARRIER(S) TO CHANGE BEING ADDRESSED
Reform hospital accountability benchmarks[1,3,5]	Reform hospital accountability benchmarks to incentivize care delivery that is free from bias and medical error, based in equity, accounts for different provider types, and is patient-centered. This should also include incentivizing, measuring, and reporting on the frequency and quality of human milk feeding initiation and support in hospital obstetric units and scaling up measures like the Patient Reported Experience Measure of Obstetric Racism© (also called The PREM-OB Scale™ Suite) to increase hospital capacity for transformation.	National non-profits, Payers	System Structure: Hospital performance data lacks disaggregation and structural measures
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.	Community-based organizations, 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[1,4]	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	Community-based organizations, National non-profits, Private funders, Birth equity advocates	Mental Model: Resistance to collaboration across sectors

ACTION	DESCRIPTION	POTENTIAL PARTNERS	BARRIER(S) TO CHANGE BEING ADDRESSED
Strengthen facility and provider accountability for patient rights[3,4]	Assess and strengthen health system and hospital policies and insurance policies to ensure facility and provider accountability to patient rights and birthing autonomy. This could include implementing a consistent, streamlined process for accessing financial assistance or charitable care, within and outside the provider institution, that is not punitive or predicated on the existence of medical debt.	Hospitals, Payers, Legislators	System Structure: Inconsistent investment in providing equitable access to basic health, social, and economic services and supports System Structure: Hospital performance data lacks disaggregation and structural measures Mental Model: Persistent implicit bias among providers and lack of empathy towards pregnant people with systemically marginalized identities Mental Model: The devaluing of women and childbirth and intense focus on the newborn
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.	State and local health agencies, Community-based organizations, 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
Support patients in understanding and using insurance[3]	Those providing and accepting insurance need to strive to make information about insurance and coverage policies as transparent, accessible, and up-to-date as possible, and support community-level initiatives working to help patients obtain all supports they are eligible for (e.g., insurance, social services, etc.).	State and local health agencies, Hospitals, Payers	System Structure: Health insurance and payment systems create and maintain inequitable access to health care and holistic perinatal care

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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