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Allegheny County BIRTH Plan for Black Babies and Families:

Battling Inequities & Realizing Transformational Health Outcomes



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In partnership with

Allegheny County Maternal and Child Health (MCH) Strategy Team

and

the Infant Health Equity (IHE) Coalition

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MESSAGE FROM THE CEO

Community is at the center and forefront of the Healthy Start model. While our geographic service footprint is localized, our community expands well beyond Pittsburgh and Allegheny County; it is inclusive of all folks who are inspired to work collectively toward a society where the color of our skin is not one of the greatest predictors of our health.

Although this work is not new, we are in the midst of a tipping point for birth equity. Celebrity birth stories are front and center, but how are we supporting women and birthing people in our own communities? Black women are increasingly being asked to weigh in, and at times lead, but is it tokenism or a sign of lasting change? More funding flows to maternal and child health initiatives, but are we seeing equitable prioritization of community-based interventions supporting social determinants? And some of our largest health institutions are still publicly identifying race–not racism–as a critical risk factor for poor health outcomes. This speaks for itself.

The development of this action plan holds significance for me as a marker of 30 years of Healthy Start Pittsburgh and five years in my role as chief executive officer. Most importantly, it highlights the fact that our rates of infant and maternal mortality are a community crisis requiring a community response. Although the work is intense and the progress over the years has been gradual, slow motion is in fact motion. But I believe we are poised to do better in Allegheny County. We have good data on collaborative, community-driven approaches that work and this plan lays that out for us. As doulas, nurses, parents, doctors, and concerned citizens, we have identified four maternal and child health priorities. We have our marching orders in the form of 16 concrete action items. We need to get in step.

Having a Healthy Start program in our community is an asset–something of which we should be tremendously proud. I've inherited this legacy and am honored to ensure that we continue to operate in the spirit of the Healthy Start movement to:

- Positively impact the health behaviors and experiences of pregnant women who are at elevated risk for poor birth outcomes by supporting increased access to prenatal care, providing culturally-responsive case management, reducing rates of smoking, and increasing rates of breastfeeding;
- Support improvement in birth outcomes such as reductions in the rate of premature and low birthweight births; and
- Collaborate on improvements in how providers organize and deliver services while driving innovative cross-sector, multi-systems initiatives that change the landscape of maternal and child health services and supports in our county.

Already, Healthy Start demonstrates positive impact in these areas. Families who receive our services show far better outcomes than the general population of Black women and babies in Allegheny County. Likewise, families who are connected to other home visiting and community-based supports have a higher likelihood of a positive trajectory. But we must reach farther, wider, and deeper. This action plan lays out for us how we can change the trajectory of our region by investing in the vitality of our babies through community, collaboration, and change.

This is the community's plan and, on behalf of its authors, I welcome your feedback and invite you to roll up your sleeves and join us!



Jada Shirriel, MS
Chief Executive Officer
Healthy Start, Inc.



EXECUTIVE SUMMARY

From decades of neighborhood displacement and gentrification, to the lack of paid leave, to the underrepresentation of Black Maternal and Child Health (MCH) workers, to disinvestment in community-based models of care, the region suffers from a range of forces working against the health and well-being of Black babies and families.

The disparities are striking. Black babies in Allegheny County die before the age of 1 at a rate over five times that of white babies. Black women and birthing people in Allegheny County have nearly twice the proportion of pre-term births and over twice the proportion of low birth weight babies compared to white women and birthing people. Black women in Pittsburgh die from pregnancy and childbirth related complications at a rate higher than 97 percent of similar cities.

Given these glaring inequities in maternal and child health built on a foundation of structural and systemic racism, an equity-centered, community driven approach to action is the only way to create meaningful and lasting change for Black women and birthing people and their babies and families.

This action plan centers the voices, experiences, and leadership of Black women and community members in the region. This planning process began with funding from the U.S. Department of Health and Human Services to the Pittsburgh Healthy Start program, enabling Pittsburgh Healthy Start to build upon an existing strategy process and existing core team – the Allegheny County MCH Strategy team. Pittsburgh Healthy Start and this core team convened a broader Infant Health Equity (IHE) Coalition, representative of a wide range of community perspectives and experiences, which then engaged in a series of six facilitated sessions (from January to March 2022) to develop this action plan.

Broader community input was sought and incorporated at multiple stages of the action planning process, including via five funded community-led research projects (through which 123 community members were surveyed or interviewed in individual or group settings) as well as a Town Hall to highlight Black woman-led and community-led innovative approaches to infant health equity in Allegheny County, an online input survey, and a public input session (166 community members were engaged through these three activities).

With guiding principles focused on listening, collaboration, and taking a strategic and actionable approach, the IHE coalition entered into this planning process using innovative data-driven policy and systems level strategies, to address the social and structural determinants of health and to improve infant and maternal mortality rates for Black babies, Black women and Black birthing people in Allegheny County.

The resulting action plan includes four key action areas, with structural determinants and racism (at structural, institutional, and interpersonal levels) addressed within each of these areas:

1. **Strengthen the MCH Workforce:** This action area focuses on strengthening the Maternal and Child Health (MCH) Workforce, which includes doulas, lactation support, childbirth educators, community health workers, midwives, mental health professionals, nurses, physician assistants, physicians, and other workers that support the health and well-being of birthing families throughout the continuum of the perinatal period. Key challenges identified by the IHE coalition and community members that the actions in this section attempt to address include: lack of Black MCH workers, lack of compassion and cultural sensitivity among the workforce, insufficient training for the workforce, barriers and limitations related to workforce pathways, and inadequate insurance coverage for care from doulas and mental health professionals.

2. **Strengthen Systems of Care:** This action area focuses on strengthening systems of care, including the healthcare system, public health system, social services, family support services, and other community supports and services that aid birthing families and families with children. Key challenges identified by the IHE coalition and community members that the actions in this section attempt to address include: the healthcare system's dependence on large health institutions as opposed to more community-based models of care, lack of high-quality hospitals and health centers in Black communities, the need for more affordable and flexible health insurance, and the need for more investment in strengthening family and community supports (e.g., home visits, family support centers, breastfeeding circles).

3. **Address Social Determinants of Health:** This action area focuses on addressing social determinants that impact infant and maternal health. Key challenges identified by the IHE coalition and community members that actions in this section attempt to address include a lack of: living wage, paid leave, employment opportunities, affordable and accessible childcare, affordable and accessible transportation, and access to affordable and healthy food.

4. **Coordinate and Streamline MCH Initiatives:** This action area focuses on reducing overlap and duplication of MCH initiatives; increasing effectiveness and efficiency of MCH initiatives; assessing and strengthening MCH organizations' and collaboratives' equity capacity; and increasing equitable funding for MCH initiatives in the region.

The specific action items within each area are outlined in the following table, along with icons indicating key stakeholder groups that can take action within a particular item. This does not imply that stakeholders not listed cannot take action or do not have a role within a particular action item. Rather, a selection of key stakeholders are identified to help readers of the action plan navigate to sections and items of most relevance to them.

While implementation of all the action items in this plan are crucial to improving maternal and child health, those marked with an asterisk (*) are more feasible to address immediately based on existing capacity in the community and will be included in a subsequent Year 1 implementation plan.

KEY

Policy makers | Government agencies | Funders

Healthcare (including healthcare systems, practices, payors, associations, and other entities)

Professional or licensing boards | Higher education institutions | MCH employers

Community organizations | Community members | Workplaces/employers

ACTION AREA 1: STRENGTHEN THE MCH WORKFORCE		
1.1	**Provide supports to retain Black and underrepresented MCH workers**	
1.1.1.	Ensure equitable pay and benefits.	
1.1.2.	Create standards for providing financial and professional support to Black and underrepresented MCH workers.	
1.1.3.	Establish regular support groups for Black professionals to connect professionally and socially.	
1.1.4.*	Provide mentorship to MCH workers from other underrepresented mentors.	
1.1.5.	Provide accessible professional development opportunities.	
1.1.6.*	Structure, strengthen and clarify career advancement pathways.	
1.2	**Implement efforts to recruit Black and other underrepresented MCH workers**	
1.2.1.	Diversify the make-up of program boards at higher education institutions and among MCH employers.	
1.2.2.*	Expand employment training and certification opportunities for community members.	
1.2.3.*	Offer paid shadowing, training, and fellowship opportunities.	
1.2.4.	Conduct proactive outreach campaigns to diversify and fill gaps in the MCH workforce.	
1.2.5.	Make it easier for members of the MCH workforce to continue working in the community in new or contract positions.	
1.2.6.	Provide clarity and transparency to the hiring process.	
1.3	**Support non-physician MCH workers**	
1.3.1.	Educate and advocate around the role of doulas, lactation support workers, and other non-physician MCH workers and why they are important.	
1.3.2.*	Support business development for doulas, lactation support workers, and other non-physician MCH workers.	
1.3.3.	Directly and fully reimburse doulas, lactation support workers, and other non-physician MCH workers equitably via insurance.	
1.3.4.	Diversify the Advanced Practice Providers (PAs and NPs) and Midwifery workforces (e.g., by advancing the work of the National Society for Black Physician Assistants).	
1.3.5.*	Enable community health workers and peer supporters to provide ongoing mental health screenings in the community.	
1.3.6.*	Expand basic mental health training so more MCH workers can provide mental health screenings, certain aspects of mental health counseling, referrals, resources, and other supports (which is particularly important given the dearth of mental health professionals and therapists, especially Black ones).	

1.4	**Establish standards, practices, and training that enable the MCH workforce to provide more compassionate, culturally competent, anti-racist, equitable care**	
1.4.1.	Create workforce policy, standards of practice and care, regular training and accountability systems and measures for physicians, nurses, and other MCH providers.	
1.4.2.*	Craft universal conversation scripts which take a trauma informed approach and can be utilized in clinic, home visiting, or other settings.	
1.4.3.	Equip Black women and birthing people with the information, skills, and resources they need to understand how racism might impact their pre- and postnatal care and how they can speak to their healthcare providers about it and advocate for themselves.	
1.4.4.	Reduce patient load so physicians, midwives, and advanced practice providers have more time with each patient.	
1.4.5.	Administer a quality of care survey after each visit with a MCH provider.	
1.4.6.	Replace or supplement paper mental health screenings/forms one-on-one conversations with trusted MCH workers.	
1.4.7.	Educate physicians, nurses, and other MCH providers about historical trauma and racism, healthcare providers' roles in it (including individual bias in their interactions with patients), and what needs to change.	
1.4.8.*	Review the diversity and bias training offered by large health systems and propose improvements.	
1.4.9.	Review existing curriculum around topics of diversity, bias, and social determinants (e.g., OB-GYN and Pediatric resident curriculum, Neonatal Advanced Practice Providers curriculum) and revise as needed to strengthen and scale what works.	
	ACTION AREA 2: STRENGTHEN SYSTEMS OF CARE	
2.1	**Increase connection to and collaboration with community-based care**	
2.1.1.*	Center and expand the work of trusted institutions and individuals with deep roots and ties to the communities they serve.	
2.1.2.	Bring care and health information into communities rather than making community members come to hospitals and clinics.	
2.1.3.	Employ a Trauma Informed Community Development framework.	
2.1.4.	Establish practices and structures that enable more open, inclusive communication and data sharing between larger health systems/organizations and community-level care/grassroots organizations.	
2.1.5.	Establish, expand, and transparently share with the community healthcare metrics (disaggregated by race/ethnicity and other key demographics) that capture aspects of the patient experience that go beyond patient satisfaction (e.g., trust, respect, medications prescribed, time to diagnosis).	
2.1.6.*	Conduct a statewide best practice analysis around collaboration between the state, Managed Care Organizations (MCOs), and Community Based Organizations (CBOs).	
2.1.7.	Make the case for community care directly to healthcare providers and trainees.	
2.2	**Invest in and strengthen key sources of community support in Black communities**	
2.2.1.*	Elevate the voices, stories, and leadership of community members – especially Black women and birthing people – in ways that enhance these individuals' agency, build community, catalyze advocacy, and directly connect to improving their health-related experiences and outcomes.	

2.2.2.*	Increase caregiver programming in Allegheny County, especially for Black fathers and partners.	
2.2.3.	Increase investment in and support for community-based programs.	
2.2.4.	Utilize the expertise residing in the community to plan for change.	
2.2.5.	Expand high-quality healthcare centers – with providers and staff that look like the families they serve – in Black communities.	
2.3	**Establish stronger care coordination and integration.**	
2.3.1.	Establish a robust county-level referral network across all healthcare and social service organizations.	
2.3.2.	Integrate existing mental health supports into primary healthcare in ways that improve access - including by enhancing affordability and reducing wait times.	
2.3.3.*	Train all healthcare staff to identify the signs of mental health concerns (including via direct conversations as opposed to paper screening forms, as noted in action item 1.4.6.) and connect individuals with relevant resources and referrals (through the robust network described in action item 2.3.1).	
2.3.4.	Craft care teams that include Community Health Workers, nutritionists, mental health professionals, social workers, and others to provide comprehensive and integrated care (spanning both physical and mental health and wrap-around services) and real-time conversations and consultations from prenatal through postpartum care.	
2.3.5.*	Equip care teams to co-create (alongside their clients and patients) a comprehensive and feasible care plan.	
2.4	**Improve MCH related policies and policy implementation in ways that reduce inequities.**	
2.4.1.	Establish multisector communication committees to analyze policies/procedures and provide clear communication to those implementing (e.g., state home visiting policy, which includes two prenatal visits, does not have enough guidance around it).	
2.4.2.	Expand health insurance coverage and strengthen Medicaid - including making it easier and more affordable for families to acquire insurance and use insurance to receive care from a wide range of providers; removing caps on mental health visits; and providing coverage for healthcare-related transportation.	
2.4.3.	Ensure consistency in the way Child Youth Family (CYF) regulations are applied to Black families compared to white families, as well as consistency in how any identified concerns are addressed.	
2.4.4.*	Strengthen the Women, Infants, and Children (WIC) program, including via more effective outreach and promotion (e.g., having applications for WIC and other benefits available at doctor's offices and other community locations), more comprehensive and culturally appropriate nutrition education and resources (e.g., around learning how to grow your own food/maintain a garden), providing a greater variety and quantity of fruits and vegetables to shop for, and increasing the availability of stores that accept WIC benefits in underserved communities.	

ACTION AREA 3: ADDRESS SOCIAL DETERMINANTS OF HEALTH		
3.1	**Transform Workplace Policies and Environments to be Supportive of Current and Future Parents.**	
3.1.1.	Increase wages by establishing a living wage and offering universal basic income.	
3.1.2.	Establish programs to help individuals as they try to enter the workforce or start a small business.	
3.1.3.	Provide paid leave for all parents.	
3.1.4.	Provide more workplace support for taking time off from work to care for children.	

3.1.5.	Increase recognition from employers that mental health is a concern.	
3.1.6.*	Provide a certification/designation for employers who undergo training to better support pregnant women in the workforce.	
3.1.7.*	Establish a stamp of approval for companies with good accommodations for moms and families that have recently given birth or had a child.	
3.1.8.	Hold employers accountable for supporting moms and families.	
3.2	**Improve Accessibility and Affordability of Child Care**	
3.2.1.	Expand employer-supported childcare.	
3.2.2.*	Strengthen the respite care system.	
3.2.3.*	Support and expand home-based child care.	
3.3	**Improve Access to Transportation**	
3.3.1.	Strengthen public transportation options for getting to work, healthcare, and other key locations, including by reestablishing local bus lines that have been removed.	
3.3.2.*	Provide insurance coverage for transportation to/from healthcare appointments and births.	
3.4	**Address Food Insecurity**	
3.4.1.	Partner with Black grocers to sustain them in the community.	
3.4.2.	Revisit land use practices, particularly vacant lots that can be used for local farming and support.	
3.4.3.	Expand options like mobile stores with fresh produce that accept food bucks (e.g., as Giant Eagle is doing).	
3.4.4.*	Explore additional options to make healthy foods accessible and affordable in Black communities (including by strengthening WIC as noted in Action 2.4.3).	
3.4.5.*	Equip the MCH workforce and healthcare providers to provide compassionate, culturally-sensitive nutritional information.	
3.4.6.*	Make meal trains and postpartum doulas a standard of care to support healthy nutrition during and after pregnancy.	
3.4.7.	Limit television and online commercials for unhealthy foods.	

ACTION AREA 4: COORDINATE AND STREAMLINE MCH ACTIVITIES		
4.1*	**Reduce Overlap and Duplication of MCH Initiatives.**	
4.2*	**Increase Effectiveness and Efficiency of MCH Initiatives.**	
4.3*	**Assess and Strengthen MCH Organizations' and Collaboratives' Equity Capacity.**	
4.4*	**Increase equitable funding for MCH initiatives in the region.**	

Ultimately, the IHE Coalition believes that this action plan is essential to establishing a common strategy and collective action to reduce the disproportionate rates of death and poor health outcomes experienced by Black families in Allegheny County, while centering the lived experiences of those most impacted.



MATERNAL AND INFANT HEALTH EQUITY IN ALLEGHENY COUNTY: URGENCY MEETS OPPORTUNITY

Despite Pittsburgh's many accolades as one of the most livable cities in the U.S. and being home to some of the top-ranked, Magnet-designated hospitals in the country, the region continues to face glaring inequities in maternal and infant health.

In particular, these accolades and rankings stand in sharp contrast to the experience of Black women and birthing people, as illustrated both in the data described below and the many personal stories shared by Black writers.

As of 2018 (the latest data available through the Allegheny County Birth Report), Black women and birthing people had the highest proportion of pre-term births in Allegheny County (15.1%, compared to 8.5% among white women and birthing people), meaning the rate for Black women is well above the Healthy People 2030 target of 9.4%. Black women and birthing people also experienced over twice the proportion of low birth weight (14.8% vs 6.8%) and very low birth weight (2.9% vs 0.9%) babies as white women and birthing people in Allegheny County.

The disparities in infant mortality are even more striking, with Black babies in Allegheny County dying before the age of 1 at a rate over five times that of white babies (16.2 per 1,000 births vs. 2.7 per 10,000 births in 2019, according to the Pennsylvania Department of Health's Enterprise Data Dissemination Informatics Exchange).

According to the Allegheny County Health Department's 2021 Perinatal Periods of Risk (PPOR) study results, the overall fetal mortality rate (fetal mortality refers to spontaneous intrauterine death at any time during pregnancy) in Allegheny County was 7.1 per 1,000 live births and fetal deaths, above the Healthy People 2030 target of 5.7 per 1,000. The Black fetal-infant mortality rate was over twice as high as the white rate and Black infants represented 80% of all excess infant deaths in Allegheny County, despite only representing 16% of total births.

According to Pittsburgh's Gender Equity Commission's 2019 report on inequality across gender and race in the city, "despite starting prenatal care earlier than Black women in similar cities and having lower rates of gestational diabetes, hypertension and infection,

Black women's maternal mortality is higher in Pittsburgh than 97 percent of similar cities. Moreover, the inequality between white and Black maternal mortality rates in Pittsburgh is greater than the inequality between white and Black maternal mortality rates in 84 percent of similar cities."

This report, which was completed by University of Pittsburgh researchers, further demonstrates that across a wide range of health, employment, and other indicators, Black women in Pittsburgh face worse outcomes compared not only to white women in Pittsburgh, but also Black women in most other U.S. cities - leading the report authors to note that "Pittsburgh is arguably the most unlivable for Black women".

While the Pittsburgh's Gender Equity Commission's 2019 report provides a solid quantitative context for gender- and race-based inequities in Pittsburgh, in a response to this report from a collective of Pittsburgh-based Black women and femmes, they note "this report has actually decentered the labor of Black women and femmes, exploited and ignored those same people, while centering white scholars as "validating" Black people's experiences, which is a manifestation of racism and the appropriation of knowledge and scholarship from Black women and femmes." This IHE action plan is led by and centers the work of Black women and birthing people, both in terms of the content and the make-up of the core team and coalition, while also being inclusive of a diverse range of stakeholders.

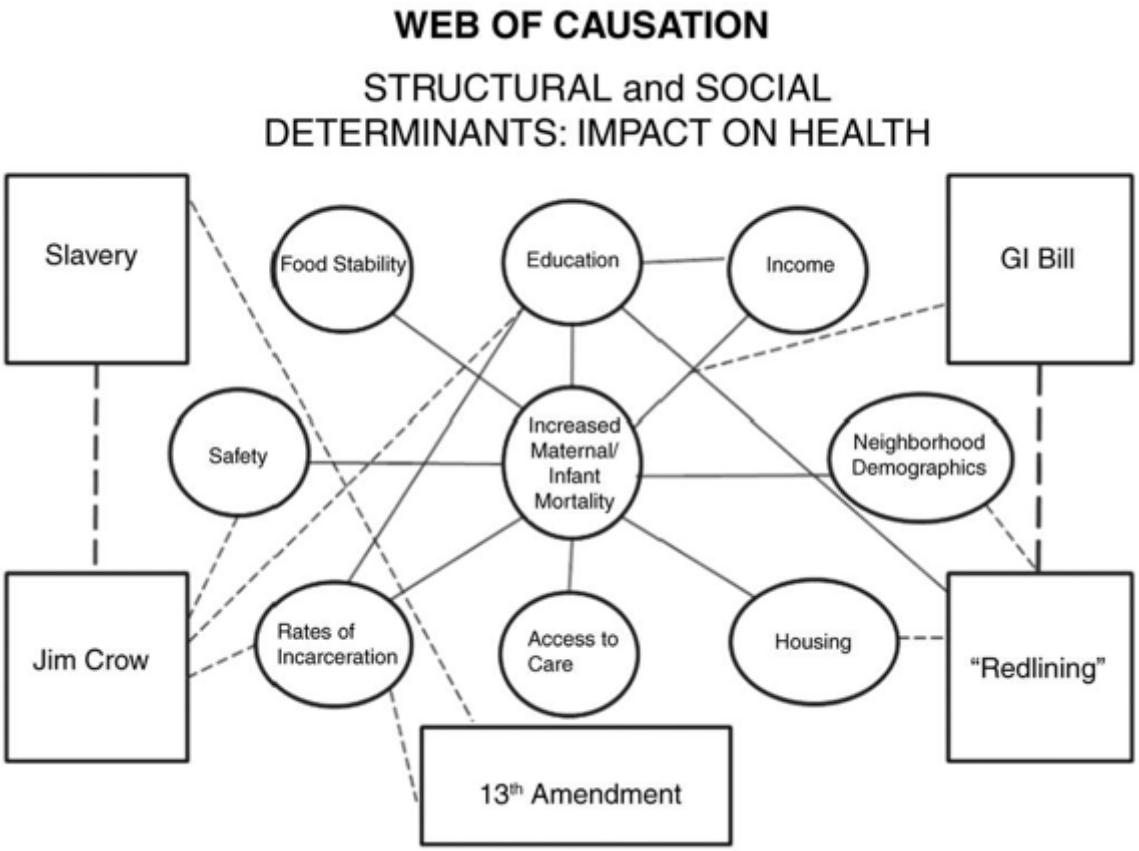
Understanding the aforementioned inequities in maternal and infant health--as well as the context in which Black lives are devalued--requires an exploration of structural and systemic racism and the social and structural determinants of health. The social determinants of health (SDOH) are defined by the World Health Organization as "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life". In their review of maternal health inequities in the U.S., Crear-Perry et al. describe the structural determinants of health as ***"cultural norms, policies, institutions, and practices that define the distribution (and maldistribution) of SDOH. These structures and systems date back to the founding of this nation and its economy on principles of racial, class, and gender hierarchy. They shape the distribution of power and resources across the population, engendering health inequities along racial, class, and gender lines and intersections."***

The authors of this review then proceed to root their discussion of maternal health inequities in the U.S. within the Restoring Our Own Through Transformation (ROOTT) theoretical framework, developed by Jessica Roach in 2016. Notably, ROOTT is a "Black women-led reproductive justice organization dedicated to collectively restoring our well-being...created by a collective who view the issues surrounding maternal and infant health

as a consequence of structural and institutional racism."

Crear-Perry et al. describe this framework (illustrated in the figure below) as follows:

> "This framework identifies the social determinants of Black maternal health—education, income, neighborhood characteristics, housing, access to care, safety, and food stability—and how their availability to Black families has been dictated by the very structure of American society from the time of slavery.
>
> Structural racism and institutional policies and practices— Jim Crow, the GI Bill, "redlining" (home mortgage denial on the basis of race and government-backed disinvestment in non-white neighborhoods), mass incarceration—are historically based features of an overtly oppressive U.S. society that have endured and adapted over time and continue to shape contemporary access to health-promoting resources and opportunities necessary for optimal Black maternal and infant health outcomes."



Source: ROOTT Theoretical Framework, as illustrated and described in Fig 1. of Crear-Perry et al.

This web of structural and social determinants of health is illustrative of the experience of Black women and birthing people, and their families, in Allegheny County. Predominantly

Black neighborhoods in Pittsburgh have significantly higher scores on the Neighborhood Distress Index (which includes indicators related to crime, housing sale prices, vacant land, and poverty rates). Moreover, demographic analysis illustrates a higher degree of residential segregation in Pittsburgh than in other areas and finds that Black residents are less likely than white residents to feel welcome in the city. All of this stems from a long history of discrimination and segregation in the city, ***"from the demolition of the Lower Hill District in the 1950s that displaced 8,000 residents and 400 businesses, to current displacements and gentrification in neighborhoods across the city,"*** in the words of Deesha Philyaw, artist, author and Pittsburgh transplant.

As activist and social economist Heather McGhee and others have demonstrated, racism and its impact on our policies and communities costs everyone. Addressing the upstream drivers of health disparities - including racism and related social and structural determinants of health - can improve health for everyone. The need to do so is even greater now given the impacts of the COVID-19 pandemic on Black women and birthing people, who have faced steeper declines in maternal mortality and unemployment than those of other races.

The actions and examples outlined in this document have been driven by the voices, experiences, and leadership of Black women and community members, and represent a significant and timely cross-systems and multi-sector effort to develop an action plan that includes innovative, data-driven policy and systems level strategies to address the social and structural determinants of health that impact infant mortality (IM) disparities. This action planning process is aligned with the national Healthy Start model to improve health outcomes before, during, and after pregnancy, and reduce racial/ethnic disparities in rates of infant death and adverse perinatal outcomes. The IHE Coalition believes that this action plan is essential to establishing a common strategy and collective action to reduce the disproportionate rates of death and poor health outcomes experienced by Black families in Allegheny County, while centering the lived experiences of those most impacted.

Prior to outlining these actions, it is important to outline the key stakeholders in Allegheny County referenced within specific action items, as well as share a few notes on the language used in this action plan.

A variety of stakeholder groups whose work focuses on maternal and child health (MCH) and/or social determinants of health (SDOH) are referenced within the action items in this plan. Appendix B provides a list of key Allegheny County stakeholders. Notably, this list is not comprehensive but rather highlights some key examples of stakeholders within the following categories:

- Elected offices
- Government agencies

- Community organizations and SDOH-addressing organizations
- Advocacy/policy groups
- Universities/research institutions
- Healthcare providers
- Managed care organizations
- Funders

NOTES ON LANGUAGE

An effort has been made to use equity-centered, community-driven, inclusive language through this action plan. Given the complex and evolving nature of these topics, this language is likely imperfect, but represents the best efforts of those involved in this action plan to use language that is both inclusive and resonates with community members.

Key language choices made in this report include the use of the following terms:

Black: This action plan uses the capitalized term ***"Black"*** to refer to this "specific group of people with a shared political identity, shaped by colonialism and slavery," and to confer "a sense of power and respect," as discussed in this New York Times Race/Related newsletter.

Black women and birthing people: To be inclusive of Black birthing people who do not identify as women, while also recognizing the particular experiences of those who do identify as Black women, the term ***"Black women and birthing people"*** is used throughout this action plan.

Black fathers and partners: To be inclusive of partners who do not identify as fathers, while also recognizing the particular experiences of those who do identify as Black fathers, the term ***"Black fathers and partners"*** is used throughout this action plan.

Black babies and families: Where discussion is not specific to birthing or partners but rather focused on the health or involvement of the entire family, the term ***"Black babies and families"*** is used.

Maternal and child health (MCH): This term is used throughout this action plan to refer to the range of health topics concerning women and birthing people, as well as infants and children - including but not limited to prenatal, childbirth, and postpartum care; prevention of death and illness before, during, and after childbirth for the birthing person and their child; newborn screening and care; and infant and child immunizations, healthcare, and nutrition and other services.

While the term ***"maternal and child health"*** is commonly used across the field, it is important to recognize that not all birthing people identify as mothers.

MCH workforce or MCH workers: This term is used throughout the action plan to refer to all those employed to support maternal and child health, including but not limited to: doulas, lactation support, childbirth educators, community health workers, midwives, mental health professionals, nurses, physician assistants, physicians, and healthcare administrators.

Other key terms included in this action plan are defined below:

Racism is defined by Camara Phyllis Jones as "a system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call "race"), that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources."

Health equity is defined in Healthy People 2030 as "the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities."

Health disparity is defined in Healthy People 2030 as "a particular type of health difference that is closely linked with economic, social, or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social or economic obstacles to health based on their racial or ethnic group, religion, socioeconomic status, gender, age, or mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."

Social determinants of health (SDOH) are defined by the World Health Organization as "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life."

Structural determinants of health are defined in Crear-Perry et al.'s recent review of maternal health inequities in the U.S. as "cultural norms, policies, institutions, and practices that define the distribution (and maldistribution) of SDOH. These structures and systems date back to the founding of this nation and its economy on principles of racial, class, and gender hierarchy. They shape the distribution of power and resources across the population, engendering health inequities along racial, class, and gender lines and intersections."



AN EQUITY-CENTERED, COMMUNITY-DRIVEN ACTION PLANNING PROCESS

ORIGINS OF THE ALLEGHENY COUNTY MATERNAL AND CHILD HEALTH STRATEGY TEAM

The core team behind this action plan – the Allegheny County Maternal and Child Health (MCH) Strategy Team – originally assembled in 2019, when the Pittsburgh Healthy Start program received funding from the Forbes Funds to explore how to improve infant and maternal mortality rates in the region for those experiencing the greatest health disparities. The objective of this strategy development process was as follows:

> *"By engaging local maternal and child health stakeholders in a series of learning, design thinking, and capacity building experiences to inform development of both an organizational and a collective county-wide strategy, including policy, practice, collaboration, data, advocacy and funding—to improve outcomes and achieve equity for populations experiencing the greatest disparities."*

This team's June 2020 report, the Allegheny County Comprehensive Maternal and Child Health Strategy, served as a starting point for long-term collaborative work and included:

- a summary of individual, organizational/institutional, and team level equity assessments among members of the Strategy Team;
- results from a social network analysis which identified 56 key MCH organizations in the region;
- mapping of local MCH philanthropic funding;
- a strategic plan focused on capacity and transformation, vision setting and collaboration, coordination and action, and evaluation.

MCH STRATEGY PROJECT TEAM



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ACTION PLANNING ACTIVITIES

The Pittsburgh Healthy Start program then had the opportunity to build upon this existing strategy process with this action plan, through supplemental funding from the US Department of Health and Human Services. This funding, awarded to 21 Healthy Start grantees across the nation, focused specifically on the creation of local action plans to reduce disparities in infant mortality in areas with high rates of Black or Indigenous infant deaths.

The existing Allegheny County MCH Strategy team served as the core team for this action planning process. The Pittsburgh Healthy Start program and this core team recruited a broader Infant Health Equity (IHE) Coalition (see Appendix A for a full list of members) to ensure the action planning process involved a wide range of community perspectives and experiences.

The IHE Coalition then engaged in a series of six facilitated sessions (from January to March of 2022) to:

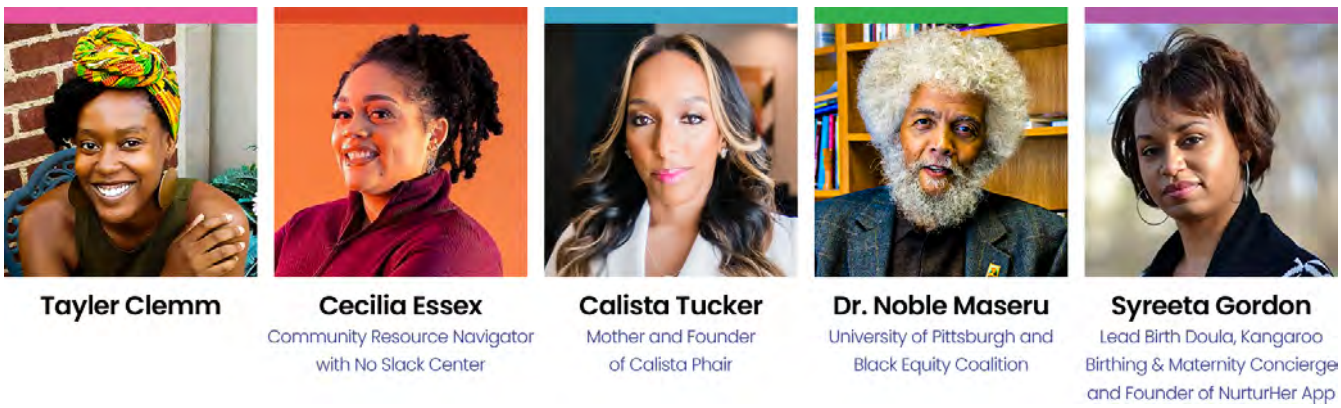
- determine guiding principles for the action planning process,
- brainstorm key challenges and potential solutions (building from the existing Allegheny County Comprehensive MCH Strategy as well as other ongoing efforts in the region),
- prioritize actions through assessment of feasibility and impact,
- provide input on how to operationalize prioritized actions (including identifying specific recommendations, resources, and examples for inclusion in the action plan),
- identify opportunities for broader public participation, and
- provide feedback on the draft action plan.

Coalition members also responded to surveys and contributed to shared documents in between sessions.

While the IHE Coalition was intentionally formulated to include a wide range of community perspectives, it is impossible for a limited number of individuals to fully reflect the community. Thus, broader community input was sought and incorporated at multiple stages of the action planning process. Early in the process, mini-grants were awarded to fund five community-led research projects to collect additional feedback on the first round of prioritized issues. Through this process, a total of 123 community members were surveyed and/or interviewed in individual or group settings over the course of three weeks. The information from these projects was directly integrated with the IHE Coalition's brainstorming around key challenges and potential solutions, as well as into the prioritization of actions for inclusion in the action plan.

Later in the process, a Town Hall was conducted to further engage community voices, provide a platform for information sharing on the social and structural contributors to maternal and child health inequities, and highlight innovative approaches to infant health equity led by Black women and community members in Allegheny County. Speakers and topics were as follows:

- Tayler Clemm; Mama Needs a Village
- Cecilia Essex; Help, Stigma and Underutilized Support Resources for Families
- Calista Tucker; NICU Care and Equitable Workplace Policies
- Dr. Noble Maseru; Public Interventions for Birth Equity
- Syreeta Gordon; Nurturing Mom to Mom



The experiences and solutions noted by these speakers were directly integrated into prioritized action planning, informing many of the specific recommendations as well as examples highlighted in this action plan.

To share information about this process with the community more broadly and provide additional opportunities for community input, social media and traditional and online media outlets such as the New Pittsburgh Courier and SoulPitt were used, and an informational web page was launched, with an online survey available for those interested in providing specific input and feedback. Finally, once the action plan was drafted, a public input session was held to enable community members to engage directly with the action plan, with their feedback then integrated into the plan. Through the Town Hall, public input session, and online survey, 166 community members were engaged (in addition to the 123 community members engaged via the community research projects).

ACTION PLANNING AIMS & GUIDING PRINCIPLES

This action planning process was collective and collaborative, centering the experiences and needs of community members and, specifically, Black women and birth workers. The process was guided by the following aim and guiding principles, collectively developed by the IHE Coalition.

Aim: The aim of this plan is to use innovative data-driven policy and systems level strategies that lead to concrete action steps to address the social and structural determinants of health and to improve infant and maternal mortality rates for Black babies, Black women and Black birthing people in Allegheny County.

Guiding Principles:



CALLS TO ACTION AND ACCOUNTABILITY

INTRODUCTION TO ACTION AREAS

This action plan includes four key action areas:

1. **Strengthen the MCH Workforce.**
2. **Strengthen Systems of Care.**
3. **Address Social Determinants of Health.**
4. **Coordinate and Streamline MCH Initiatives.**

The IHE coalition and community members involved in the action planning process identified the need to meaningfully address structural determinants and racism - at structural, institutional, and interpersonal levels - within each of these action areas. Many of the specific action steps and examples highlighted within these action areas were developed with the understanding that racism at all levels is a key contributing factor to health inequity and the disproportionate rate of preventable deaths for Black women and babies. The plan focuses on reshaping policies, systems, environments, workplaces, and workforces in ways that address the need to disrupt and dismantle racism. The plan also highlights Black owned and led organizations and initiatives, as well as explicitly equity-focused examples. The IHE Coalition recognizes the potential implementation of the recommendations and action items outlined in this plan could require substantial resources, such as time, money and advocacy, and may not be in the immediate control of individuals involved in the planning process. The goal of this action planning process has been to best represent community voice and needs. Healthy Start Pittsburgh will be seeking additional funding to support implementation of this action plan in the future.

Action steps within each area (e.g., 1.1, 1.2, and so on) are listed in order of priority, based on the input of the IHE coalition and community members involved in the action planning.

Within each action step, sub-items (e.g., 1.1.1, 1.1.2, and so on) are not listed in order of priority. Sub-items are described in further detail for only the two highest priority action steps within each area; sub-items in the third and fourth action steps within each area will be described in further detail during a future implementation phase. Where sub-items are described in further detail, these descriptions are not intended to be comprehensive, but rather offer a place to start, as identified by the IHE coalition and community members.

All identified stakeholders (e.g., policymakers, health systems, universities, community organizations, etc.) refer to those within Allegheny County or, for state-level entities, Pennsylvania. A sample of specific stakeholders are outlined in Appendix B of this report.

1. Strengthen the MCH workforce

This action area is focused on strengthening the Maternal and Child Health (MCH) Workforce, which includes doulas, lactation support, childbirth educators, community health workers, midwives, mental health professionals, nurses, physician assistants, physicians, and other workers that support the health and well-being of birthing families throughout the continuum of the perinatal period. Structural and institutional racism within the education system; within licensing, certification, and other such processes; and within healthcare and other organizations that employ MCH workers all contribute to the underrepresentation of Black MCH workers, lack of support for non-physician MCH workers, and lack of culturally competent and anti-racist MCH workers.

Key challenges and barriers with respect to the MCH workforce in Allegheny County identified by the IHE coalition include:

- Lack of diversity among the workforce, with community members not adequately represented by practitioners/providers;
- Inability to search for/connect with Black and Indigenous providers;
- Insufficient training for the workforce, especially with respect to bias, racism, and diversity;
- Barriers and limitations related to workforce pathways, including recruitment into academic programs, content of academic programs, and licensing and certification requirements and processes (e.g., academic programs and licensing/certification often being prohibitively expensive, long wait times for licensing);
- Lack of adequate functional integration and imbalance of power and resources between clinical and nonclinical MCH roles/workers.

Key themes from community input related to the MCH Workforce in Allegheny County include a desire for:

- MCH healthcare providers to interact with patients more directly (as opposed to relying solely on paper screenings and forms), listen to them, take their concerns seriously, and provide meaningful and feasible solutions;
- Greater compassion, more cultural sensitivity, and a warmer bedside manner from MCH workers;
- More MCH workers that are Black, that look like them, and are from their communities - especially more Black mental health professionals;
- Better insurance coverage for care from doulas and mental health professionals.



IN THE COMMUNITY'S WORDS

Their Experiences

- "Overall, providers don't listen. Some are biased, while others are so progressive that they still seem to miss our voices and concerns."
- "People becoming numbers and not individuals is dangerous in health care. I find medical providers to be extremely cold and void and that makes trust hard to establish."
- "A lot of Black women fear having a child wondering if they will make it through childbirth."
- There are "not enough Black people working in the medical field."
- "The most positive experience I've had is that of a provider who really takes the time to listen to my concerns and or issues."

Their Needs

- "Just listen. Respect our voices and genuinely care. We don't need you to have all the answers on the spot but at least refer me to someone else, run some tests, add notes to my file. Act like you hear me!"
- "At postpartum check ups, [having] a social worker there who can give you an actual mental health assessment, someone to touch base with rather than here's a paper with your insurance information…."
- "We need the support of doulas who are looking out for the mom and [have] the ability to successfully navigate the healthcare system using the proper verbiage and can also support the mom in navigating the millions of unplanned things that happen to women."

1.1 Provide supports to retain diverse MCH workforce.

1.1.1. Ensure equitable pay and benefits.

Gender and racial gaps in pay and benefits hinder the retention of a diverse MCH workforce. **Policymakers should close the loopholes in the Pennsylvania Equal Pay Act, and expand the ban on state agencies asking about a job applicant's current compensation or compensation history to all employers in the state.**

> **Key Resource:**
>
> The Women's Law Project is a "nonprofit public interest legal organization working to defend and advance the rights of women, girls, and LGBTQ+ people in Pennsylvania and beyond" – including a focus on equal pay.

1.1.2. Create standards for providing financial and professional support to Black and underrepresented MCH workers.

Members of the MCH workforce, particularly those who are Black or otherwise underrepresented in the MCH field, often do not receive sufficient financial or professional support. **State and local healthcare associations should establish standards and provide recommendations** regarding how higher education institutions and professional boards can best provide financial and professional support to these MCH professionals. These associations could also conduct cost-benefit analyses, which may help demonstrate to higher education institutions and professional boards the financial return on investment for investing in such supports for MCH professionals.

1.1.3. Establish regular support groups for Black professionals to connect professionally and socially.

Members of the MCH workforce who identify as Black frequently feel unsafe and unsupported in the workplace. **Professional boards should initiate and recruit group leaders to run support groups** for Black MCH professionals (employed by large healthcare systems, higher education institutions, the local health department, and others). These groups should focus on creating safe spaces for underrepresented professionals to receive and provide support; receive resources, education, and training; and develop skills in conflict management. It is vital that such groups be adequately resourced and granted autonomy to establish their own work areas of focus and control the use of contributed resources.

In addition, **employers can facilitate the establishment of Employee Resource Groups** (where employees develop connections among their peers of similar backgrounds or with those interested in similar topics) and allow time during the workday for these to occur. **Offices of Diversity within health organizations** can also help facilitate Black and other underrepresented MCH workers to connect socially through their own **social programming** as well as by connecting their employees with social networks and events in the community.

Example Organization:

The Urban League Young Professionals of Greater Pittsburgh aims to create a supportive social network of diverse young professionals through engagement in economic empowerment, civic engagement, and volunteerism.

1.1.4. Provide mentorship to MCH workers from other underrepresented mentors.

Mentorship from other MCH workers who look like them or have had similar life experiences is instrumental in supporting underrepresented members of the workforce. **State licensing and credential boards should establish opportunities for such mentorship** – for example, by enabling seasoned professionals to receive payment or other incentives for mentoring newer professionals, allowing time during the workday for such mentorship, and accounting for involvement in mentorship within performance metrics. Mentorship could be provided in topics such as scholarships, the licensure/credentialing process, business development, insurance and liability issues, continuing education, professional norms, and networking.

Example Program:

The I.M.P.A.C.T Program provides comprehensive financial assistance and educational and mentoring support for those seeking to become a doula with DONA International.

The Promoting Academic Talent in the Health Sciences (PATHS) program "pairs residents, fellows, and junior faculty members with senior faculty mentors in order to facilitate the retention and upward progression of mentees into senior faculty positions at the University of Pittsburgh and UPMC".

1.1.5. Provide accessible professional development opportunities.

Meaningful professional development can help retain Black and other underrepresented members of the MCH workforce. **State (as well as national and international) boards** should provide or support the creation of accessible professional development opportunities (e.g., trainings in new and changing topics and specialties). Such opportunities should include the offer of **scholarships, sliding fees, and other approaches** to make these opportunities more widely and equitably accessible. In addition, these boards, MCH employers, and others should offer **professional development focused specifically on the topic of equity**.

Example Program:

Founded in the fall of 2018 by Dr. Dara Mendez, the Maternal & Child Health Equity Scholars (MCHES) group has served as a platform for learners and early-career researchers to exchange ideas, network and collaborate on projects related to health equity, reproductive justice and maternal and child health rooted in anti-oppression scholarship and critical race theory. The group also works in collaboration with local community and governmental partners on practice and policy interventions addressing race-based health inequities, as well as with the University of Pittsburgh Medical School on reshaping its curriculum (e.g., to include anti-racism training, reading of Medical Apartheid, field placements).

1.1.6. Structure, strengthen and clarify career advancement pathways.

Career advancement opportunities are vital to retaining Black and other underrepresented MCH workers, and to closing wage gaps. **MCH employers** should create or strengthen advancement pathways, providing **clear and transparent pathways to help individuals transition positions** in ways that meet their career goals. It is important employers provide the necessary structure and supports for such transition pathways, and that there is transparency around these pathways so all those interested in pursuing them have the information they need to do so.

1.2 Implement efforts to recruit Black and other underrepresented MCH workers

1.2.1. Diversify the make-up of program boards at higher education institutions and among MCH employers.

Recruiting a more diverse MCH workforce requires more diverse leadership. **Universities and MCH employers should recruit more non-white, non-male, underrepresented individuals to advisory and functioning boards** and set **term limits** for board membership to encourage new and changing ideas. In addition, the boards of university schools of medicine, public health, and other MCH-relevant schools should ensure recruiting a diverse student body is a board priority.

1.2.2. Expand employment training and certification opportunities for community members.

A pathway for community members to receive training/certification and join the MCH workforce is a key step in establishing a workforce that looks like and understands the community it serves. **Healthcare systems and payers should establish free or low cost programs to train and help community members secure a wide range of positions within the MCH workforce as an investment in improved outcomes.**

Example Program:

The original Freedom House program in Pittsburgh in the 1960s (the city's first mobile emergency program) recruited young Black men as emergency medical technicians, addressing the need for more jobs as well as more ambulance care. The program began serving the mostly Black Hill District and went on to become a national model.

Freedom House 2.0, a program of UPMC and UPMC Health Plan, recruits, trains, and employs first responders from economically disadvantaged communities. A similar model could be used to equip individuals from these communities to join the MCH workforce supporting a more diverse pipeline for providing patient care across the span of clinical disciplines.

1.2.3. Offer paid shadowing, training, and fellowship opportunities.

In-person, hands-on experience – ideally paid – can be a key way to bring Black and other underrepresented individuals into the MCH workforce. **Healthcare systems and practices should provide more paid shadowing, training, and fellowship opportunities** to new and underrepresented professionals.

1.2.4. Conduct proactive outreach campaigns to diversify and fill gaps in the MCH workforce.

Diversifying and filling gaps in the MCH workforce requires proactive outreach in the community and authentic relationship building. **MCH employers** (healthcare systems and practices, universities, nonprofits, etc.) should **"take inventory" on who and what they need to provide comprehensive care that meets the community's needs and then take a creative, boots-on-the-ground approach to outreach and advertising around recruitment**. Such institutions should meaningfully partner with residents and community-based institutions to listen, ask questions, and recruit, including via community anchoring points like churches and barber shops. Also consider diversity of recruitment staff and vendors.

1.2.5. Make it easier for members of the MCH workforce to continue working in the community in new or contract positions.

MCH employers often have conflict of interest clauses that prevent members of the workforce from working in the same community if they leave their job. These institutions should **change their policies and contract language around separation from the institution**, minimizing restrictions (regarding distance, time, specific organizations) on where someone can work next. MCH employers should also increase opportunities for contract work with community members.

1.2.6. Provide clarity and transparency to the hiring process.

Recruiting Black and other underrepresented MCH workers requires clear and transparent hiring processes. **MCH employers should publish clear information regarding hiring, including steps in the process, anticipated timelines, and expected pay ranges**. State and local **policymakers should pass pay transparency laws** requiring the inclusion of salary ranges in job postings.

> **Example Policy:**
>
> New York City's recently passed pay transparency law requires employers to include salary ranges in job postings.

1.3 Support non-physician MCH workers*

*In particular, doulas (across the spectrum of pregnancy - preconception, birth, abortion, miscarriage, adoption, postpartum), lactation support, childbirth educators, community health workers, midwives, mental health professionals, nurses, physician assistants, physicians, and healthcare administrators.

1.3.1. Educate and advocate around the role of doulas, lactation support workers, community health workers, and other non-physician MCH workers and why they are important.

1.3.2. Support business development for doulas, lactation support workers, community health workers, and other non-physician MCH workers.

1.3.3. Directly and fully reimburse doulas, lactation support workers, community health workers, and other non-physician MCH workers equitably via insurance.

Example Program:

As a natural extension of their work to eliminate poor birth outcomes and reduce infant and maternal mortality, Healthy Start, Inc. Pittsburgh launched a virtual doula program in 2020 -- at the onset of the COVID-19 pandemic -- to both address the fears expressed by Black women of giving birth in local hospitals without support due to pandemic protocols, and to support and partner with Black community-based doulas. The program currently provides prenatal education, birth support, and postpartum support both virtually and in-person, and connects women to other perinatal supports and programs, with a focus on 4th trimester wellness.

1.3.4. Diversify the Advanced Practice Providers (PAs and NPs) and Midwifery workforces (e.g., by advancing the work of the National Society for Black Physician Assistants).

1.3.5. Enable community health workers and peer supporters to provide ongoing mental health screenings in the community.

1.3.6. Expand basic mental health training so more MCH workers can provide mental health screenings, certain aspects of mental health counseling, referrals, resources, and other supports (which is particularly important given the dearth of mental health professionals and therapists, especially Black ones).

1.4 Establish standards, practices, and training that enable the MCH workforce to provide more compassionate, culturally competent, anti-racist, equitable care.

1.4.1. Create workforce policy, standards of practice and care, regular training and accountability systems and measures for physicians, nurses, and other MCH providers around:

- creation of culturally relevant materials that are linguistically appropriate and rooted in an anti-racist framework;
- bedside manner, reflective practices, active listening (i.e., physicians hearing and taking patients' concerns seriously, including running tests, making referrals, putting notes in files, seeking second opinions, etc. as appropriate); and
- reducing discrimination and judgment (especially towards Black patients/clients and/or those who are overweight).

1.4.2. Craft universal conversation scripts which take a trauma-informed approach and can be utilized in clinic, home visiting, or other settings.

1.4.3. Equip Black women and birthing people with the information, skills, and resources they need to understand how racism might impact their pre- and postnatal care and how they can speak to their healthcare providers about it and advocate for themselves.

Key Resource:

Protecting Your Birth: A Guide For Black Mothers, published in the New York Times by Erica Chidi (CEO of LOOM) and Dr. Erica Cahill (assistant professor of Obstetrics and Gynecology at Stanford University), addresses how "racism can impact your pre- and postnatal care — and advice for speaking to your Ob-Gyn about it". The guide informs Black women of the unique risks they might face during pregnancy, birth, and the postpartum period, and what they might do to prepare for those risks. The guide is "meant to help Black women feel safer, and to provide a modern framework for medical providers to actively address their own racism"

1.4.4. Reduce patient load so physicians, midwives, and advanced practice providers have more time with each patient.

1.4.5. Administer a quality of care survey after each visit with a MCH provider.

1.4.6. Replace or supplement paper mental health screenings/forms with one-on-one conversations with trusted MCH workers.

1.4.7. Educate physicians, nurses, and other MCH providers about historical trauma and racism, healthcare providers' roles in it (including individual bias in their interactions with patients), and what needs to change.

Example Program:

To address medical racism and bias, the Allegheny Health Network's First Steps and Beyond program will provide training and education on the history of racism in medicine to physicians, nurses, and other health care professionals who interact directly with patients. The program's goal is to decrease infant mortality of Black babies by at least 28% over the next five years

1.4.8. Review the diversity and bias training offered by large health systems and propose improvements.

1.4.9. Review existing curriculum around topics of diversity, bias, and social determinants (e.g., OB-GYN and Pediatric resident curriculum, Neonatal Advanced Practice Providers curriculum) and revise as needed to strengthen and scale what works.



2. Strengthen Systems of Care

While the prior action area focused on action and accountability at the level of individuals providing care, this action area is focused on strengthening the systems of care themselves. MCH systems of care include the healthcare system, public health system, social services, family support services, and other community supports and services that aid birthing families and families with children. Racism (at structural, institutional, and interpersonal levels) contributes to the devaluing of community-based models of care and lack of investment in Black communities.

Key challenges and barriers with respect to systems of care in Allegheny County identified by the IHE coalition include:

- The healthcare system's dependence on larger health institutions as opposed to more community-based models of care;
- Black families often experience lack of proximity to high-quality hospitals and health centers.

Key themes from community input related to systems of care include a desire for:

- More affordable and flexible health insurance that covers more services and is accepted by more providers;
- Resources and opportunities to strengthen family support, including home visits (which community members noted help fathers/partners get more involved);
- More support for community organizations and resources that community members rely on, such as the Pittsburgh Black Breastfeeding Circle, Healthy Start, and family support centers;
- More accessible mental health support, including via telephone hotlines, paraprofessionals, and lay members of the community who receive training in aspects of mental health counseling;
- Care teams that include a diverse range of supports (mental health, social work, doulas, lactation support, etc.) and sustained care from prenatal through postpartum periods;
- Greater investment in healthcare facilities in Black neighborhoods.



IN THE COMMUNITY'S WORDS

Their Experiences

- "Hostility and lack of hospitality. Lack of validation or value-sharing. Lack of respect. All of these feelings actually caused me to be terrified of medical facilities, particularly as an expecting Black mother."
- "Telehealth is helping and works great."
- "I think the most positive experience that I have when it comes to maternal mental health is the fact that there [are] programs like Healthy Start, Family Support Centers, Community Voices, Allegheny Family Network, and that is just to name a few...now that I'm a grandmother, I still love to network and be a part of [these groups] and try to make it whenever I can."
- "I have a strong family support network and a large village. I am incredibly blessed because not everyone can say that."

Their Needs

- "Stop halfway serving us. Invest in Black women to do the work without oversight. Let Black women lead in all of these conversations. We know what we need...Trust black women to save ourselves."
- "Make Mental Health a part of the plan from the beginning."

2.1 Increase connection to and collaboration with community-based care.

2.1.1. Center and expand the work of trusted institutions and individuals with deep roots and ties to the communities they serve.

Care for families and children is often delivered by **large healthcare systems and government agencies** that are disconnected from and not trusted by the Black communities they serve, often due to historical injustices and discrimination. **These institutions should seek to partner with – and communities should seek to further invest in and expand – the work of trusted, community-rooted entities and people**, including community organizations, community-connected agencies, faith-based organizations, and community health workers. This includes **trusting, credentialing, and paying these community-connected organizations and individuals** to perform mental health screenings, home visiting, and other such services that do not necessarily require a medical provider. Notably, these organizations and individuals should not be seen as supplemental to the healthcare system, but rather as part of one unified system of care working to improve maternal and infant health.

Example Program:

Jamaa Birth Village in Missouri "provides culturally-congruent traditional Midwifery care for Saint Louis area families," aiming to transform birth for Black families by providing midwifery and doula care, perinatal mental health support, breastfeeding education, holistic therapies, childbirth education, and family and other support services. In the past year, Jamaa families have experienced 97% vaginal births, 99% full-term births, 100% breastfeeding at discharge, and 0% maternal-infant mortality. Jamaa Birth Village is currently raising funds to expand to a birthing and postpartum retreat center model.

Healthy Start, Inc. Pittsburgh is an intensive community-based effort to eliminate perinatal health disparities, addressing maternal and child health through direct service and systems-level coordination--providing health education, support, resource coordination, and advocacy. The organization has made significant investments in increasing the pipeline and diversity of community-based birth workers in Allegheny County, has supported increased engagement in community-based participatory research and partners with local managed care organizations to increase accessibility to home visiting, lactation and doula supports for women and birthing people with Medicaid insurance.

2.1.2. Bring care and health information into communities rather than making community members come to hospitals and clinics.

Time, transportation, childcare and other challenges can be significant barriers to accessing care and health information, especially for Black families. Instead of expecting community members to come to care, **healthcare and other social service providers should bring care into Black communities**, for example via a traveling van that provides prenatal and well-child visits. In addition, family centers or other community-based agencies in Black neighborhoods can be outfitted to provide these services, and hair salons, bars, churches, and other such popular and trusted locations in the community can be equipped to provide health information and resources.

Example Program:

Community Checkups, is a pilot program of the Children's Hospital of Pittsburgh of UPMC funded by The Beckwith Institute, aiming "to make health care more accessible by bringing doctors to the community to conduct pediatric checkups at a nearby Family Support Center where low-income families routinely receive non-medical services."

Royally Fit Community Wellness Program aims to help Pittsburgh residents be mentally, physically and emotionally healthy in order to live their most balanced lives. Royally Fit achieves this through education, access, coaching, and connections, specifically targeting historically and disproportionately disadvantaged communities. Tackling core issues of food insecurity, inequitable access to health screenings and fitness training, inadequate mental, emotional and financial wellness support, Royally Fit's 12-week community wellness program operates in a mobile manner, at no cost to the communities they serve.

The University of Pittsburgh School of Public Health's Health Advocates in Reach (HAIR) program trains owners and staff of African American barbershops as lay health advocates who provide health information and host onsite health promotion and disease prevention activities for their customers.

2.1.3. Employ a Trauma Informed Community Development framework.

Various forms of trauma (including hunger, homelessness, lack of health care, violence, and racism) shape the community's viewpoint and culture, but community development efforts are rarely informed by an understanding of that trauma. **Communities should adopt a Trauma Informed Community Development framework**, informed by community members' lived experience of personal and collective trauma, and focused on promoting resilient healing

and healthy communities. This framework includes community support (e.g., assistance with food, clothing, transportation), community-based health and well-being interventions (e.g., community health centers, trauma response teams, "micro-community interventions" focused on community-driven revitalization), leadership development (e.g., Behavioral Health Community Organizers, Volunteer Trauma Responders), and assessing and analyzing the impact of trauma to inform interventions.

Key Resource:

The Neighborhood Resilience Project, which began with Rev. Paul Abernathy's work in a predominantly Black and underserved community in Pittsburgh, has established the Trauma Informed Community Development framework through its work.

2.1.4. Establish practices and structures that enable more open, inclusive communication and data sharing between larger health systems/ organizations and community-level care/grassroots organizations.

Collaboration between **larger health systems/organizations and community-based care and organizations** is often inhibited by lack of commitment to shared power, poor communication, and lack of transparency in data sharing. **Leadership of these organizations, policymakers, and others can help establish practices and structures that enable stronger goal alignment, more regular communication, and data sharing between these entities**. Data sharing infrastructure (similar to Electronic Medical Records systems) that enables sharing of medical and other records with all who provide services to an individual is key. In addition, pairing Community Health Workers with traditional clinical staff during training as well as in practice can help further foster meaningful collaboration.

Example Practices:

Allegheny County's Fetal and Infant Mortality Review (FIMR) is a partnership between Allegheny County Health Department, Healthy Start, Inc. and UPMC Children's Hospital. FIMR is a "community based, action-oriented process aimed at improving services, systems, and resources for women, infants, and families. FIMR brings a multidisciplinary community team together to examine confidential, de-identified cases of fetal and infant deaths. Review of individual cases helps teams understand families' experiences, including racism, and how those experiences may have impacted maternal and child outcomes."

The Infant Vitality Surveillance Network in Cincinnati, Ohio is a partnership of the local health department and university hospital to address infant mortality in targeted zip codes with high infant mortality rates. The partnership, which includes data surveillance and sharing, home visitation, and patient-centered medical home care coordination, demonstrated lower rates of premature birth and infant mortality compared to Cincinnati as a whole.

2.1.5. Establish, expand, and transparently share with the community healthcare metrics (disaggregated by race/ethnicity and other key demographics) that capture aspects of the patient experience that go beyond patient satisfaction (e.g., trust, respect, medications prescribed, time to diagnosis).

What gets measured gets done, and to that end, it is important to both **measure and publish information** about trust, dignity, respect, being listened to, medications prescribed (e.g., aspirin for preeclampsia), time to diagnosis (e.g., endometriosis), and other such aspects of **the patient experience**. These metrics should be disaggregated by race (given the often stark disparities in these experiences between Black and white women). To ensure sustained collection of such data, **these metrics could be added to HEDIS measures, the CAHPS health plan survey, physician scorecards, and other such measurement tools.**

2.1.6. Conduct a statewide best practice analysis around collaboration between the state, Managed Care Organizations (MCOs), and Community Based Organizations (CBOs).

This analysis could inform best practices, benchmark collaborations that are impactful and cost-saving, and uplift and develop effective, health equity promoting strategies.

2.1.7. Make the case for community care directly to healthcare providers and trainees.

Healthcare providers may be unaware of the value of community care, and the role it can play in enhancing the health and well-being of community members. It is important that the **case for community care be made directly to healthcare providers and trainees**. This could be done by leveraging the voices of community care providers –and providing resources for–working in impacted communities, incorporating this topic into training curricula for healthcare providers, as well as offering talks on the topic to large healthcare systems.

2.2 Invest in and strengthen key sources of community support in Black communities.

2.2.1. Elevate the voices, stories, and leadership of community members – especially Black women and birthing people – in ways that enhance these individuals' agency, build community, catalyze advocacy, and directly connect to improving their health-related experiences and outcomes.

Efforts to support Black women and birthing people and their families need to be driven by their voices, stories, and leadership. There are many pathways to doing so, from healthcare organizations restructuring health forms in ways that give voice to these individuals (e.g., asking them about who constitutes their support system instead of making assumptions) to community organizations establishing targeted monologue shows or creating career pathways in maternal health (e.g., Brown Mama Monologues, Mamatoto Village) to local institutions collaborating with local social media influencers (e.g., on TikTok and Instagram, which many young mothers and birthing people use frequently). However, if not designed well, listening sessions, storytelling opportunities, and other such efforts can be retraumatizing, disempowering, and fruitless. It is vital that such efforts be designed in such a way that they enhance individuals' agency, build community, catalyze advocacy, and directly connect to improving their health-related experiences and outcomes.

Example Program:

Brown Mama Monologues "showcase[s] the stories of black mothers to sold-out audiences in Pittsburgh." With four months of rehearsal and relationship building, the initiative aims to uplift and empower these women and their communities.

Mamatoto Village serves Black women in Washington, DC by providing accessible perinatal support services and creating career pathways in maternal health through its Perinatal Health Worker Training program, which "prepares individuals to serve within their own communities" via structured training and practical job experience.

2.2.2. Increase caregiver programming in Allegheny County, especially for Black fathers and partners.

Government, philanthropic, and other funders should provide financial support for increased caregiver programming (including specifically for Black fathers and partners) as well as more **inclusive programming** (that includes caregivers of all types) to ensure that all caregivers receive the support they need.

Example Program:

Paula Powe, child and adolescent psychiatrist and medical director of the Matilda H. Theiss Child Development Center in Pittsburgh's Hill District, is conducting a qualitative research study with Black fathers in Allegheny County to help them understand how toxic stress affects a child's brain development and what they can do to help protect children from toxic stress.

The Fathers Collaborative Council of Western Pennsylvania (FCCWPA) "works to support the ongoing growth and stability of fatherhood programs in the region". The Collaborative is composed of agencies and organizations that operate fatherhood programs, and the FCC aims to strengthen the fatherhood movement by maximizing members' collective potential and resources, while also recognizing each program's unique strengths.

2.2.3. Increase investment in and support for community-based programs.

Community members point to a range of helpful community-based programs in Allegheny County, including but not limited to family support centers, Allegheny Support Network, Pittsburgh Black Breastfeeding Circle, Healthy Start, community-based providers of doula services (especially those that are black owned and/or led), and those who help facilitate access to basic needs, tangible goods, and other

enabling supports (such as those listed in Brown Mamas Big List of Resources for Pittsburgh Moms) . Government, philanthropic, and other funders should invest in supporting and scaling such efforts.

2.2.4. Utilize the expertise residing in the community to plan for change.

Community action planning should center and be driven by the expertise within the community at hand. This includes including investing in Black women and birthing people to lead and research such efforts (especially those who already have a trusted relationship with the community on these topics, such as doulas and childbirth educators); creating more spaces for community conversations that directly inform action planning; engaging social media influencers from the community to ensure they have accurate information and can disseminate it to their networks; determining what organizations can serve as neutral conveners to broker such conversations with local leaders and influencers to share key health-related messages they can help disseminate; and paying community members for their expertise and input.

Example Program:

The Black Women and Femmes Health Initiative aims to develop a Black Women's Health Agenda for Allegheny County. Their investigation will "assess if and how systems (health and social) may or may not address the health and well-being of Black women and femmes in Allegheny County and surrounding areas", and "develop a strategic plan and health agenda focused on centering the health and well-being of Black women and femmes in Allegheny County that includes actions related to research, practice, and policy".

2.2.5. Expand high-quality healthcare centers – with providers and staff that look like the families they serve – in Black communities.

Government, philanthropic, and other funders should increase investment, grants, and other funding to establish and expand high-quality healthcare centers in Black communities, instead of expecting community members to travel outside their communities to access such care. The focus on quality is essential given evidence that Black-serving hospitals provide lower quality maternity care. It is also important that this investment **prioritize the hiring and retention of Black providers and staff.**

2.3 Establish stronger care coordination and integration.

2.3.1. Establish a robust county-level referral network across all healthcare and social service organizations. Such a network should, where possible:

- connect directly to a comprehensive database of community resources;
- integrate information into electronic health records (e.g. UPMC birth plans start perinatally; the patient brings it to the hospital, and it is included in their electronic health record)
- use warm referrals and provide consistent follow-up;
- grant all relevant personnel (including case managers, social workers, and others who can help make connections to community resources) clearance and access to this information, while addressing any privacy and data security concerns;
- be based on community experience and minimize the need for families to repeatedly share their trauma to have basic needs met.

Example Program:

To address the disproportionate level of Black infant mortality in Cuyahoga County, among the highest in the nation, First Year Cleveland convened a diverse group of family, community, civic, faith-based, and healthcare stakeholders around three goals: "activating system-wide interventions, addressing structural racism, and coordinating, aligning and expanding evidence-based services." Their efforts have resulted in a 35% reduction in overall infant deaths since 2015.

2.3.2. Integrate existing mental health supports into primary healthcare in ways that improve access - including by enhancing coverage and affordability and reducing wait times.

2.3.3. Train all healthcare staff to identify the signs of mental health concerns (including via direct conversations as opposed to paper screening forms, as noted in action item 1.4.6) and connect individuals with relevant resources and referrals (through the robust network described in action item 2.3.1).

2.3.4. Craft care teams that include Community Health Workers, nutritionists, mental health professionals, social workers, and others to provide comprehensive and integrated care (spanning both physical and mental health and wrap-around services) and real-time conversations and consultations from prenatal through postpartum care.

2.3.5. Equip care teams to co-create (alongside their clients and patients) a comprehensive and feasible care plan that:

- spans from prenatal through postpartum care;
- is based on needs identified, described, and prioritized by the client (e.g., based on a social determinants of health assessment questionnaire);
- includes specific timelines and plans (e.g., for accompanying the client to certain meetings);
- is taken to doctor's appointments as well as integrated into patient portals so that conversations with medical providers are rooted in the patient's goals for themselves.

2.4 Improve MCH related policies and policy implementation in ways that reduce inequities.

2.4.1. Establish multisector communication committees to analyze policies/ procedures and provide clear communication to those implementing (e.g., state home visiting policy, which includes two prenatal visits, does not have enough guidance around it).

2.4.2. Expand health insurance coverage and strengthen Medicaid - including making it easier and more affordable for families to acquire insurance and use insurance to receive care from a wide range of providers; removing caps on mental health visits; and providing coverage for healthcare-related transportation.

2.4.3. Ensure consistency in the way Child Youth Family (CYF) regulations are applied to Black families compared to white families, as well as consistency in how any identified concerns are addressed.

2.4.4. Strengthen the Women, Infants, and Children (WIC) program, including via more effective outreach and promotion (e.g., having applications for WIC and other benefits available at doctor's offices and other community locations), more comprehensive and culturally appropriate nutrition education and resources (e.g., around learning how to grow your own food/ maintain a garden), providing a greater variety and quantity of fruits and vegetables to shop for, and increasing the availability of stores that accept WIC benefits in underserved communities.



3. Address Social Determinants of Health

This action area is focused on addressing social determinants of health, which are defined by the World Health Organization as ***"the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life"***. As noted in the background section of this action plan, social determinants that impact infant and maternal health include income, education, housing, safety, access to healthy food, and access to healthcare. Structural racism within housing, healthcare, and other systems shapes inequities in social determinants of health, which in turn influence the inequities in maternal and child health experienced by Black families in Allegheny County.

Moreover, the COVID-19 pandemic and its repercussions have "made workers and caregivers more vulnerable to mistreatment, discrimination, and health risks on the job." The impact of the pandemic on Black women in particular has been severe, with a greater increase in maternal mortality compared to white women, as well as significantly higher unemployment than that of Latinas, Asian women, or white women. The economic recovery following 2020's coronavirus recession has also left Black women behind, "with hiring discrimination, burnout, and a lack of substantial benefits in lower-paid industries" playing a key role.

Key challenges and barriers with respect to social determinants of health in Allegheny County identified by the IHE coalition include:

- Food insecurity;
- Transportation challenges;
- Lack of living wage;
- Lack of affordable/accessible childcare;
- Inadequate health insurance coverage.

Key themes from community input related to addressing social determinants of health include a desire for:

- Paid leave for all parents and more support from workplaces for taking time off as well as for addressing mental health;
- Better employment opportunities and programs to assist Black women and birthing people as they try to enter the workforce or start small businesses;
- More accessible and affordable transportation options, including bus lines and insurance coverage for healthcare related transportation needs;
- More accessible and affordable childcare options;
- Greater access to high-quality and affordable fruits, vegetables, and cooked meals, as well as more culturally relevant nutritional information.



IN THE COMMUNITY'S WORDS

Their Experiences

- "Mental health is not looked at as an issue within the workplace and it's biased. People of color are looked down upon when trying to deal with mental health challenges or it's not taken seriously."
- "At the job I had, you had to book pumping rooms. Prior to coming back to work I tried to contact HR to find out how to navigate the process when I returned. They told me to deal with it when I got there. When I got back to work, I saw a room was open so I set up my equipment and started pumping. Ten minutes later there was a knock on the door and someone said they had booked that room, so I couldn't pump that day."

Their Needs

- "A mother with no car should be provided transportation to postpartum doctor visits directly after birth for a certain time period."
- "The solution is having accessible help...so what we do is we provide mommy concierge, which is a lifestyle manager that you can select on the [NurturHer] app ...We provide pre-cooked family size meals that can feed up to five family members...that is so convenient for moms that are coming home postpartum that are tired, worn out from just having birth, and now they have to have the load of running their household when they get home, it doesn't stop. So having that pre-cooked meal ready for you and you can just nurse your baby and relax and connect with your family..."

3.1 Transform Workplace Policies and Environments to be Supportive of Current and Future Parents

3.1.1. Increase wages by establishing a living wage and offering universal basic income.

Many jobs in Allegheny County - particularly those typically held by Black individuals - do not pay a living wage. Establishing a living wage and offering universal basic income can provide a baseline of financial security, especially for birthing families and families with children.

Example Programs:

A guaranteed basic income pilot started in late 2021 to address poverty and inequality, the Assured Cash Experiment PGH (AcePGH) provides $500 a month in unrestricted cash to 200 people in the City of Pittsburgh, 100 of which are Black women. The focus on Black women is in direct response to the Gender Equity Commission's 2019 report that outlines the inequities they face in Pittsburgh.

3.1.2. Establish programs to help individuals as they try to enter the workforce or start a small business

Reentering the workforce after time away or starting a small business can be challenging on multiple fronts (especially for single mothers with multiple children). Employers should establish return-to-work programs and community organizations should establish programs and seminars to support and invest in those who wish to start a small business in the community.

Example Programs:

Catapult Greater Pittsburgh engages in emergency resource distribution, peer-to-peer support, wealth building, trauma-informed financial counseling, and policy advocacy to ensure systematically disenfranchised communities can meaningfully achieve economic justice and lead dignified and equitable lives.

AHN's RetuRN to Practice™ Program aims to re-integrate nurses (who have been away from nursing practice but wishing to return) into the workplace, with flexible scheduling, a paid 12 week refresher course, and a network of support.

The UPMC Pathways to Work program provides job training and support resources for people seeking careers at UPMC. The program is geared toward individuals who are unemployed or underemployed, and "people with barriers to finding and keeping a job, such as those with intellectual or physical challenges."

3.1.3. Provide paid leave for all parents

Paid leave for all parents is vital to supporting parental and child health as well as equity in the workplace. Policymakers and employers should guarantee paid leave for all parents, as well as extended leave (additional 6-12 weeks after release from hospital) for those who have a child with special care needs or in the NICU. Employers should transparently share their paid leave policies. Community organizations and advocates should engage in joint advocacy efforts and campaigns to fight for paid leave at the state level (e.g., the Family Care Act Campaign, which aims to make "paid family leave a reality for all Pennsylvanians").

3.1.4. Provide more workplace support for taking time off from work to care for children.

Even when paid leave is provided, taking time off from work to care for children – including for doctor's visits and medical procedures – is often frowned upon. It can be difficult to request and be granted time off or flexibility in completing work duties outside of traditional work hours. Employers should explicitly state in their sick time policies that caring for a sick child or an interruption in child care are acceptable forms of paid sick time. Employers who are able to should allow employees to shift their hours or work remotely when child care interruptions occur or when there is a need to care for a sick child.

> **Example Organization:**
>
> The Women & Girls Foundation (WGF) is a non-profit organization based in Pittsburgh, Pennsylvania engaged in statewide programming and policy work for women and girls in Pennsylvania to have equal access, opportunity, and influence in all aspects of their public and private lives.

3.1.5. Increase recognition from employers that mental health is a concern.

Employees need their employers to recognize that mental health is important and provide supports and flexibilities to help employees address mental health problems as well as pursue mental well-being. Employers should take a trauma-informed approach to employment and the workforce system and offer free and confidential mental health supports including Employee Assistance Programs (which provide mental health assessments, short-term counseling, referrals, and follow-up services for employees facing personal and/or work-related challenges).

Key Resource:

The National Fund for Workforce Solutions recently published an introductory guide for employers and workforce development organizations, A Trauma-Informed Approach to Workforce. The guide "was created to help employers and workforce development organizations understand toxic stress and the effects of trauma on individuals in the workplace" and puts forth "a selection of organizational strategies and practices to advance trauma-informed approaches in employee management."

3.1.6. Provide a certification/designation for employers who undergo training to better support pregnant women in the workforce.

There are many ways in which workplaces could be more supportive of pregnant women, from providing flexibility and paid leave to providing accessible and convenient breastfeeding accommodations to providing childcare supports. In order to build employers' understanding and capacity to provide such supports, it would be beneficial for community organizations to offer employers training to better support pregnant women in the workplace. Pairing this training with a publicly visible certification or designation could help further incentivize employers to undergo this training.

Key Resource:

Centering the Experiences of Black Mamas in the Workplace, a joint report of the Black Mamas Matter Alliance and A Better Balance, includes "analysis and stories from Black organizational leaders across the country highlighting the maternal health & economic benefits of pregnancy accommodations legislation."

3.1.7. Establish a stamp of approval for companies with good accommodations for moms and families that have recently given birth or had a child.

Establishing a stamp of approval for companies with good accommodations for moms and families that have recently given birth or had a child – similar to the Allegheny County Breastfeeding Friendly Place Awards – can help potential employees identify supportive workplaces as well as incentivize workplaces to be more supportive of moms and families.

3.1.8. Hold employers accountable for supporting moms and families.

Another way to hold employers accountable for supporting moms and families is by bringing families together in support groups, focus groups, or online forums to share their experiences navigating the workplace, including bringing forth any complaints. This should be paired with identifying mechanisms to hold employers accountable when complaints are brought forth.

Key Resource:

The Pittsburgh Commission on Human Relations, "an independent Commission that enforces and ensures civil rights protections within the City of Pittsburgh," investigates instances of discrimination and recommends protections in The City Code to ensure equal opportunities for all Pittsburghers.



3.2 Improve Accessibility and Affordability of Child Care

3.2.1. Expand employer-supported childcare.

Employers should directly support childcare for their employees – including on-site childcare for employees, providing employees a childcare benefit (e.g., flexible spending accounts, vouchers, subsidies, coverage for emergency childcare), and/or contracting spots from a local child care provider specifically for employees' childcare needs. Such measures can greatly enhance the accessibility and affordability of childcare for employees.

Key Resource:

The U.S. Chamber of Commerce Foundation recently published an executive briefing entitled Essential Care for Essential Workers, outlining key strategies senior leaders in workplaces can employ to support frontline working parents with their childcare needs, including working parent support, flexible scheduling, backup care, childcare vouchers, subsidies, onsite care, public advocacy around childcare quality/access/affordability, and expanding community capacity and supply for childcare.

3.2.2. Strengthen the respite care system.

Families in Allegheny County need more robust and accessible respite childcare, which provides caregivers temporary relief. Government, philanthropic, and other entities should fund respite childcare.

Example Program:

Jeremiah's Place in Pittsburgh aims to provide "a safe haven of respite, health, renewal, and support for children when their families are experiencing a critical need for childcare." 75% of the families they serve identify as African American or bi-racial, 20% of families use the program as they search for work or attend job training, 14% of families use the program to attend medical appointments, and 9% of families use the program during medical emergencies.

3.2.3. Support and expand home-based child care.

Many families seek home-based child care because they need care that is affordable, accessible, offered during nontraditional hours (e.g., evenings, nights, weekends), enables siblings to be cared for together, and/or offers the same language and cultural practices as at home. **Government, philanthropic, and other funders should invest in quality home-based child care providers; policymakers should support expanding the number of quality home-based child care providers; and community providers and organizations should build networks of support** for home-based child care providers to offer peer support and share resources.

> **Key Resource:**
>
> The Council for a Strong America's Ready Nation program released a report in October 2021 calling for Pennsylvania policymakers to develop and enhance supports for home-based child care. Recommendations included enhancing mentorship for home-based childcare providers and increasing compensation to cover the cost and reimbursement of high-quality home-based care.

3.3 Improve Access to Transportation

3.3.1. Strengthen public transportation options for getting to work, healthcare, and other key locations, including by reestablishing local bus lines that have been removed.

3.3.2. Provide insurance coverage for transportation to and from healthcare appointments and births.

3.4 Address Food Insecurity

3.4.1. Partner with Black grocers to sustain them in the community.

3.4.2. Revisit land use practices, particularly vacant lots that can be used for local farming and support.

3.4.3. Expand options like mobile stores with fresh produce that accept food bucks (e.g., as Giant Eagle is doing).

3.4.4. Explore additional options to make healthy foods accessible and affordable in Black communities (including by strengthening WIC as noted in Action 2.4.3).

Example Program:

Farmer Girl Eb is a community farmer and educator who grows and sells her herbs, plants, produce, and other goods locally. In collaboration with other farmers in the region, she provides fresh produce to the community, as well as education on agriculture and nutritional living.

The NurturHer App, a project in partnership with the Pittsburgh: A Safer Childbirth City project, provides women with a mommy concierge team and postpartum supports including delivery of "nutritionally high calorie healthy snacks and pre-cooked postpartum family sized meals that are convenient for recovering mothers during and after birth."

3.4.5. Equip the MCH workforce and healthcare providers to provide compassionate, culturally-sensitive nutritional information.

Example Program:

A CDC-funded initiative of the Allegheny County Health Department, the Racial and Ethnic Approaches to Community Health (REACH) program is a coalition of over 25 partners whose goal is to achieve health equity and prevent chronic diseases in the County's East End and Northside neighborhoods.The coalition aims to increase access to healthy foods and physical activities, and to provide support and encouragement for breastfeeding.

3.4.6. Make meal trains and postpartum doulas a standard of care to support healthy nutrition during and after pregnancy.

3.4.7. Limit television and online commercials for unhealthy foods.

4. Coordinate and Streamline MCH Activities

4.1 Reduce Overlap and Duplication of MCH Initiatives

The Allegheny County Comprehensive Maternal & Child Health Strategy, published in 2020, identified 56 key organizations in the county whose primary mission included serving mothers and children, spanning government agencies, advocacy/policy organizations, universities/research institutions, managed care, health providers, funders, and community-based or SDOH-addressing organizations.

Conducting a detailed inventory and assessment of the MCH ecosystem is a key first step. This would include a review of MCH organizations and initiatives in the County – based on a review of websites and a standard list of questions asked of each entity in survey and/or interview format. This could help identify where overlap and duplication is occurring, where gaps remain, and where partnerships may be beneficial to move forward a shared agenda.

In particular, there is a need to **better coordinate services** (e.g., connecting pregnancy and early childhood research cohorts in Allegheny County), as well as **timelines** (e.g., a joint focus on particular topics for public awareness at certain times of year; not offering programs for the same audience at the same time). An ecosystem approach to programming - in which similar or related programs are aware of each other's programming, season of offering, and capacity - can help organizations work together to best serve the needs of the community.

4.2 Increase Effectiveness and Efficiency of MCH Initiatives

In addition to coordination, there is a need **to assess the impact and effectiveness of equity-focused MCH initiatives** in Allegheny County, **streamlining duplicative or ineffective approaches (as described in Action 4.1) and further scaling and sustaining effective ones**. This requires a concerted effort to evaluate initiatives as well as assess the needs and experiences of the Black mothering community. This would require **building the necessary infrastructure for such evaluation and streamlining of initiatives**, gathering relevant data from organizations and the community in order to objectively assess relative effectiveness, set benchmarks and standards for maternal health in Allegheny County, and facilitate communication across initiatives and with the community.

4.3 Assess and Strengthen MCH Organizations' and Collaboratives' Equity Capacity

Collecting and assessing equity statements, plans, and other documents from MCH organizations, initiatives and collaborative efforts to **assess both individual initiative as well as collective capacity for equity and change** could help identify strengths, gaps, required skills and resources, and opportunities for partnership.

4.4 Increase equitable funding for MCH initiatives in the region

Increasing financial support and sustainability for MCH initiatives in the region -- with a focus on equity for community-based, Black woman-led initiatives -- requires **communicating directly with local and national foundations to understand their MCH-related funding priorities and encourage investment in the region**. In addition, there is a need to conduct an environmental scan of funders investing in **MCH initiatives** (e.g., by developing a running list of past, present, and potential funders of MCH efforts in the region and what/who/how much they are seeking to fund).

Allegheny County would benefit from a dedicated, local entity that would spearhead coordination and streamlining of equity-focused MCH initiatives across the aforementioned actions in this section. This may be achieved by building capacity of existing organizations like Healthy Start or by forming a collaborative membership-based entity to serve this role, spearheading or directly conducting the aforementioned actions, providing communication, data gathering, and other infrastructure to facilitate the necessary coordination. The existing Birth Equity Strategies Together (BEST) initiative in Allegheny County may provide the necessary infrastructure for such an entity, and local health plans could provide seed funding.

APPENDIX A:
Infant Health Equity (IHE) Coalition Members

First Name	Last Name	Affiliation
Nancy	Bell	Gateway Health
Kelsey	Brentley	Allegheny Health Network
Montia	Brock	Mental Health Therapist/Birthworker
Janet	Catov	Magee Women's Research Institute
Rick	Cobbs	Healthy Start Fatherhood Coordinator
Gerria	Coffee	Genesis Birth Services
Alysia	Davis*	March of Dimes
Elissa	Edmunds Hunt	Allegheny Health Network
Paris	Ekeke	UPMC Magee-Women's Hospital
Grace	Ferguson	Allegheny Health Network
Renee	Green	UPMC Lactation Center
Syria	Harrell	PA Department of Health
India	Hunter	Healthy Start
Vinu	Ilakkuvan**	PoP Health
Rochelle	Jackson	Black Women's Policy Center
Dawndra	Jones	Magee
Marcia	Klein Patel	AHN Women's Institute
Margaret	Larkins-Pettigrew	Allegheny Health Network
Amy	Malen*	Allegheny County DHS
Noble	Maseru*	University of Pittsburgh
Emily	McGahey	The Midwife Center
Dara	Mendez*	University of Pittsburgh

*Core Team Member
**Project Consultants

First Name	Last Name	Affiliation
Muffy	Mendoza	Brown Mamas
Becky	Mercatoris	Department of Children's Initiatives
Megan	Nestor	Allegheny County Department of Children Initiatives
Cara	Nikolajski	UPMC Center for High-Value Health Care
Onome	Oghifobibi	Children's Hospital
Allyce	Pinchback-Johnson**	Pinchback Consulting
Daniel	Shaw	University of Pittsburgh Center for Parents and Children/Pitt Parents and Children Laboratory
Jada	Shirriel*	Healthy Start
Danielle	Smith	Allegheny Health Network
Arthur	Terry	Allegheny County Health Department
Ngozi	Tibbs	Independent Birth Workers
Calista	Tucker	Community Voice
Demia	Tyler*	Healthy Start
Veronica	Villalobos	Allegheny Health Network
Dannai	Wilson*	Allegheny County Health Department

*Core Team Member
**Project Consultants

APPENDIX B:
Key Stakeholders in Allegheny County with a Focus on Maternal and Child Health (MCH) and/or Social Determinants of Health (SDOH)

Elected Offices

- Mayor Ed Gainey
- Pittsburgh City Council
- Allegheny County Council
- Pittsburgh Black Elected Officials Coalition
- PA State Senators and Representatives
- School Boards

Government Agencies

- Allegheny County Department of Children Initiatives
- Allegheny County Department of Human Services-Office of Children, Youth, and Families
- Allegheny County Health Department-Infant Mortality Collaborative
- Allegheny County Health Department-Maternal and Child Health Services
- Allegheny County Health Department-Women, Infant and Children Program
- Allegheny Intermediate Unit
- City of PIttsburgh Gender Equity Commission
- Urban Redevelopment Authority of Pittsburgh

Community Organizations or SDOH-Addressing Organizations

- Birth Doulas of PIttsburgh
- Birthing Hut
- Brown Mamas
- Center for Family Excellence
- Council of Three Rivers American Indian Center
- Cribs for Kids
- Elephant Song
- Family Foundations Early Head Start
- Genesis Pittsburgh

- Gwen's Girls
- Healthy Start Pittsburgh
- Jeremiah's Place
- Latino Community Center
- Maya Organization
- NuturePA
- Oli's Angels
- The Pittsburgh Black Breastfeeding Circle
- Pittsburgh Business Group on Health
- Single Mom Defined
- Three Rivers Milk Bank
- UPMC Department of Family Medicine's Birth Circle
- Urban League of Greater Pittsburgh
- Western PA Diaper Bank
- YWCA of Greater Pittsburgh
- Zita's Healthy Beginnings

Advocacy/Policy Groups

- Black Women's Policy Agenda
- Build Health Initiative
- March of Dimes
- MomsRising
- New Voices for Reproductive Justice
- Trying Together
- WHAMglobal
- Women for a Healthy Environment

University/Research Institutions

- Duquesne University School of Nursing
- Magee-Women's Research Institute (UPMC)
- Pitt Center for Women's Health Research and Innovation
- Pitt Graduate School of Public Health
- Pitt Maternal Child Health Adolescent and Young Adult Health Research Network
- Pitt Office of Child Development

- Pitt School of Medicine
- UPMC Shadyside Family Medicine Residency Program-Women's Health

Healthcare Providers

- Adagio Health
- Allegheny Reproductive Health Center
- Hilltop Community Healthcare Center
- KidsPlus Pediatrics
- The Midwife Center
- Planned Parenthood of Western PA
- Steel City Midwives
- UPMC Children's Hospital of Pittsburgh
- UPMC Magee Women's Hospital

Managed Care Organizations

- Allegheny Health Network
- Alliance for Infants and Toddlers
- Gateway Health
- PA Health Wellness
- UPMC Children's Hospital of Pittsburgh-Family Care Connection Centers
- UPMC Health Plan

Funders

- Buhl Foundation
- Eden Hall Foundation
- Forbes Funds
- Heinz Endowments
- Hillman Foundation
- Jewish Healthcare Foundation
- Opportunity Fund
- The Pittsburgh Foundation
- Richard King Mellon Foundation
- Women and Girls Foundation

