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The years 2017 and 2018 marked a turning point in the fight for Black maternal and infant health in California. While advocates have long been confronting and spotlighting the systemic injustices faced by Black families, the launch of the California Perinatal Equity Initiative in 2018, combined with a series of high-profile media stories and data reports helped to refocus legislative and advocacy efforts to address a decades-old issue, both across the state and nationally.

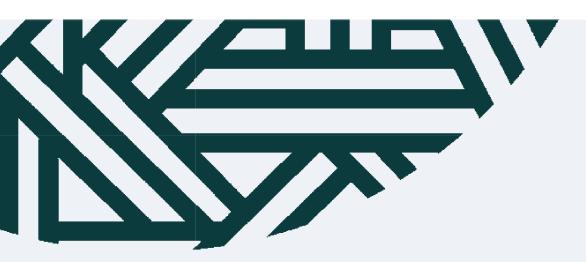
Reports and research released in the last several years have helped changemakers better understand the current state of birth equity, give shared language to root causes, and elevate strategic solutions. The fruit of these efforts have helped to pave the way for bold new standards and reforms. Landmark legislation like SB-464 (Dignity in Pregnancy and Childbirth Act), SB-65 (California Momnibus), and guaranteed basic income initiatives reflect meaningful progress in expanding healthcare access, reducing maternal stress, and holding institutions like healthcare organizations and state agencies accountable.

A CHALLENGING, SHIFTING LANDSCAPE

Despite these victories, Black mothers and babies continue to face disproportionate risks. Black women in California are still faced with a 3.6 times higher rate of pregnancy-related mortality compared to their white peers, have the highest rates of Severe Maternal Morbidity which continues to climb, and experience infant mortality rates that are two times higher than other racial and ethnic groups^{1,2}.

In addition to this challenging reality, the current federal landscape has presented new and significant threats to the progress of advancing birth equity and supporting families. Following the political shift after the January 2025 inauguration, a wave of harmful executive orders and federal actions—including threats to Medicaid (Medi-Cal in California, which covers 40% of all births), the deliberate

dismantling of public health infrastructure, cuts to essential safety-net programs, and a rollback of health equity research—have already begun to harm California families. These actions threaten to further destabilize an already underperforming perinatal system in California that is simultaneously facing provider shortages, hospital closures, and underinvestment in community solutions. These dynamics threaten to reverse progress and deepen inequities in California and across the nation.



MEETING THE MOMENT: ABOUT THE LANDSCAPE ANALYSIS

We believe that in order to face these immediate and ongoing threats, we must review and re-assess our collective strategies. We need clarity on current efforts, opportunities, threats, and call for a realignment of our shared goals across disciplines. The State of Black Birth Equity in California Report, developed by the California Coalition for Black Birth Justice (the Coalition or CCBBJ), a statewide, Black woman-led organization dedicated to unifying and strengthening the Black birth justice movement in California, in order to support this broader reassessment. It offers a thorough examination of the movement's current needs and opportunities within today's political and social climate. Through a structured analysis of existing research, new primary sources of data, Black birth equity initiatives and organizations across the state, this report investigates the policy and power dynamics needed to drive change, as well as the readiness and support for institutional efforts.

We hope this analysis fosters a shared understanding of California's current position, its unique challenges, and the potential pathways for progress. We extend our deepest gratitude to the authors of the pivotal reports, papers, articles, documentaries, and social content that continue to enrich the birth justice knowledgebase.

IMPORTANT CONSIDERATIONS

The data and information in The State of Black Birth Equity in California Report represents a snapshot in time. A majority of the research and analyses were conducted in 2024 and early 2025 and may not fully reflect the rapid changes in the state and federal landscape. The California Coalition for Black Birth Justice is committed to working alongside many partners to keep the birth justice movement abreast of large-scale shifts that impact our collective work.

HOW TO UTILIZE THIS REPORT

The content of this report has been organized into chapters. Chapters 1-3 contain a review of the research literature, a compilation of birth equity related organizations and policies, and a stakeholder power analysis. Chapters 4-5 contain primary research findings related to birth equity in California based healthcare settings.

We encourage scholars, advocates, and community members alike to embrace the findings most pertinent to your field and perspective, and to explore with curiosity that which falls outside of your approach. We hope you will utilize this information to inform your work and build upon the tools at your disposal to realize sustained systems level change.



WHEN READING THIS REPORT, PLEASE CONSIDER THE FOLLOWING QUESTIONS:



Considering your role in the system, what actions can you take in response to the findings shared in this report?

Who else could you share this report with?

How might you encourage others to commit to action based upon these findings?





EXAMINING THE
BLACK BIRTH
EQUITY RESEARCH
LANDSCAPE

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CHAPTER 1

Over the past few years, the increasing focus on birth outcomes and experiences have brought about new studies and solutions. Given this expansion of data and research, The California Coalition for Black Birth Justice (the Coalition or CCBBJ) conducted a literature review to assess the contemporary state of research regarding Black birthing health outcomes, care quality, and untapped areas of exploration.

RESEARCH APPROACH

For this review, the Coalition established the following inclusion criteria: articles and papers with a focus on a Black study population, published between 2019 and 2024, and primarily California-focused. In all, this literature review compiled (n=39) equity-related articles, drawing from peer-reviewed journals, policy reports, and institutional publications to capture both empirical findings and applied strategies (see Appendix A).

DEFINITIONS

In reviewing the literature, trends were categorized as "established", "emergent", or "rising" to reflect their prominence and evolution in the field of Black birth justice research.

ESTABLISHED TRENDS are those with a strong foundation in the literature, widely recognized by scholars and institutions, and central to shaping discourse and policy. The framing of racism—not race—as the root cause of maternal health disparities exemplifies this, having been solidified through years of scholarship and institutional acknowledgment.

EMERGENT TRENDS represent areas of growing focus that have gained momentum in recent years, expanding research methodologies and amplifying historically overlooked perspectives. The shift toward patient-reported experiences as a critical measure of care quality illustrates this, as researchers increasingly center Black birthing people's voices in qualitative assessments.

RISING TRENDS signal the early stages of inquiry into innovative approaches with limited but promising research. The exploration of non-dominant models of care, including community-based birthing support and guaranteed income initiatives, are in the early stages of analysis, marking a potential shift in maternal health policy and practice.

KEY TRENDS IN THE LITERATURE

I. AN ESTABLISHED TREND RACISM NOT RACE: STRUCTURAL RACISM AS A ROOT CAUSE

Prior to 2019, public health researchers introduced the connection between race and adverse maternal health outcomes to the broader scholarly literature. This introduction included illuminating the critical disparities experienced by Black women. Concepts like weathering—the physical toll of chronic stress from systemic racism³—began to proliferate throughout published research.

However, 2020 and its racial reckoning in response to the murder of George Floyd brought about a marked shift not only in research methods and topics but also in the language through which findings were communicated. Black scholars and advocates like Dr. Karen Scott⁴, Dr. Rhea Boyd⁵, Dr. Joia Crear-Perry⁶, Dr. Brittany Chambers⁷, Dr. Zea Malawa⁸, and Dr. Camara Jones⁹ further solidified racism and not race as a root cause of maternal and infant health disparities in the public health discourse. Over the course of 2020-2021, 268 entities (public health departments, city/town councils, county boards, educational entities, state legislatures, gubernatorial/mayoral offices) more broadly declared racism as a public health emergency or crisis. Leading institutions such as The American Public Health Association (APHA), The Centers for Disease Control (CDC), and The National Institutes of Health (NIH) followed suit in issuing declarations of their own, centering racism as a structural driver of inequities in health outcomes.

Research of Black scholars and clinicians that elevated racism not race as a root cause of maternal health inequities.

- ⁴The ethics of perinatal care for Black women: dismantling the structural racism in 'mother blame' narratives," 2019.
- ⁵ On Racism: A New Standard for Publishing on Racial Health Inequities," 2020.
- ⁶ Social and Structural Determinants of Health Inequities in Maternal Health," 2021.
- ⁷ Black Women's Perspectives on Structural Racism across the Reproductive Lifespan," 2021.
- ⁸ A Racism as a Root Cause," 2021.
- ⁹ Allegories on Race and Racism," 2022.

These foundational works have inspired other scholars to build upon this literature by referencing this theoretical framework and others alike (i.e Black feminist theory and critical race theory). The literature has numerous articles that explicitly mention racism as a root cause of the maternal mortality and morbidity crisis^{10,11,12}. These studies and many others underscore the systemic inequities embedded in healthcare systems, often citing examples of implicit bias, lack of culturally competent care, and discriminatory policies that disproportionately affect Black mothers and their families.

II. AN EMERGENT TREND PATIENT-REPORTED EXPERIENCES: IN THEIR OWN WORDS

Hospitals across the US by in large have adopted some form of a Patient Reported Experience Measurement (PREM) tool. One of the most commonly used of these tools is the Hospital Consumer Assessment of Healthcare Providers and Systems survey (HCAHPS) which was developed by Centers for Medicare and Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ) in 2002. While traditional PREM tools like HCAHPS are survey tools used to record patient perceptions about various elements of the healthcare they received, they are distinct from satisfaction surveys and can lack depth, variation, consistency, and effective interpretation¹³.

California sought to develop its own patient reported experience tools through the creation of the Maternal and Infant Health Assessment Tool in 2017 and the Listening to Mothers in California Survey¹⁴ in 2018. Despite the needed development of these tools, birth equity focused researchers and advocates have continued to push for a more comprehensive approach to understand marginalized patient's experiences of obstetric care. Specifically, researchers have championed for centering patient voices and have heavily emphasized the importance of qualitative data collection's role in improving care and ultimately outcomes^{15,16,17}.

Today, the emergence of this trend has continued to be set by scholars through their adoption of methodologies that center the voices of care recipients^{18,19,20}. Thanks to these pioneers, today, there are alternative tools to assess care experiences in healthcare settings including

Continued. Research of Black scholars and clinicians that elevated racism not race as a root cause of maternal health inequities.

^{10, 11, 12} Daalen et al, 2022.

¹⁵ Vedam et al, 2019.

¹⁸ Wang et al, 2021.

²² Community-Based Models, 2021.

¹³ Sundaram et al, 2022.

¹⁶McLemore et al, 2018.

¹⁹ Chambers et al, 2023.

²³ Oparah et al, 2018.

¹⁴ Sakala et al, 2018.

¹⁷ Altman et al, 2020

²¹ De Ornelas et al, 2025.

Dr. Karen Scott's PREM-OB Scale which relied on the lived experiences of Black birthing people to develop its three independent valid measures (Humanity, Kinship, and Racism) that characterize the impact of the quality of hospital-based services on patient experiences and Kimberly Seals Aller's Irth App. Finally, this trend has also led to the creation of various campaigns like The University of California San Francisco Preterm Birth Initiative's Voices for Birth Justice project and the Center for Disease Control's Hear Her Campaign.

III. A RISING TREND NON-DOMINANT MODELS OF CARE

From the mid 20th century on, the traditional medical model of obstetrics has focused on hospital-based care administered largely by physicians and nurses. As such, much of the literature is focused on the quality of this care and/or the outcomes derived from it. Some examples of institutional efforts to measure and improve quality have included the creation of the California Perinatal Quality Care Collaborative (CPQCC), the California Maternal Quality Care Collaborative (CMQCC), and The Joint Commission's levels of maternal care verification and advanced perinatal certification.

Although most pregnant people still receive care through the traditional obstetric model, recent years have seen a resurgence of non-dominant models of care. These services include group prenatal, midwifery-led care, doula support, and guaranteed basic income. These models/services focus on creating environments that prioritize the specific needs and experiences of Black mothers. They play a vital role in addressing systemic inequities within maternal health by offering culturally competent and community-centered approaches. By fostering trust, respect, and culturally relevant care practices, they aim to mitigate the adverse impacts of systemic racism and improve maternal and infant health outcomes. Birth equity researchers have begun to document their efficacy and powerful expectation defying outcomes. The literature is increasingly documenting how these approaches not only enhance care delivery but also contribute to the broader framework for equity in maternal health.

Scholars, writers, and advocates are drawing attention to these innovative and efficacious approaches to care. The following examples exemplify how scholarship is beginning to catch up: The BElovedBIRTH Black Centering program in Oakland, California, demonstrates how group prenatal care led by Black healthcare professionals fosters community support and culturally relevant care, leading to improved maternal outcomes²¹. The Commonwealth Fund highlights the success of community-based maternity care models, including midwifery and doula support, in advancing equity through respectful, patient-centered care²². The "Battling Over Birth" report by Black Women Birthing Justice documents the narratives of over 100 Black women, who emphasized the significance of culturally relevant and respectful care provided by community-based workers²³. Midwifery-based birth center care is finally being recognized as

a high-quality alternative to traditional hospital settings, particularly for low-risk births²⁴. And guaranteed basic income for pregnant people is being explored as yet another non-traditional way to support better outcomes²⁵. These models underscore the importance of culturally competent care that aligns with the unique needs of Black mothers and their families.

RESEARCH GAPS

In reviewing the literature, a number of gaps became clear. While the introduction and establishment of the aforementioned trends represent progress, although not exhaustive, the following populations and subjects remain largely missing from the maternal and infant health research landscape.

Examples of missing populations include:

- Those with substance use disorders (SUDs),
- Gender expansive and transgender individuals,
- Homeless individuals
- · Those with disabilities, and
- Incarcerated/justice involved individuals.

Examples of missing subjects include:

- Studies that explore the disaggregation of 'Black' identity,
- Studies that measure the efficacy of driving change within institutions,
- Studies that chronicle midwifery and doula integration into existing systems,
- Infertility, and
- Post-partum experience.

Continued. Research of Black scholars and clinicians that elevated racism not race as a root cause of maternal health inequities.

²⁴ Wallace et al. 2024.

²⁵ Karasek et al, 2025.

OUR PRESENT REALITY

Despite widespread acknowledgment in the literature that racism is a root cause of inequities, and the significance of patient-reported experiences and the effectiveness of alternative care models, the foundational theories supporting these ideas are increasingly under attack. With the shifting political climate, major institutions have softened—or in some cases, completely abandoned—the language they once strongly endorsed. Academic institutions are now questioning the <u>validity of terms like "obstetric violence</u>," and initiatives grounded in the recognition of racism as a root cause of inequity are increasingly facing legal challenges. Given the current climate, it is important that researchers, scholars, and advocates alike continue to:

- 1. Center racism as a root cause of maternal health outcome disparities in published work.
- 2. Take note of the advice of scholars and others and engage in disciplinary self-critique and counter-framing.
- 3. Continue to cite those that worked to establish these important trends. 4. Continue to push for institutional recognition of these frameworks despite pressure to shift language.



CALIFORNIA'S ORGANIZATIONAL INFRASTRUCTURE AND POLICY LANDSCAPE

CHAPTER 2





EXAMINING THE ORGANIZATIONAL AND POLICY LANDSCAPE FOR BIRTH JUSTICE

In the last several years, various national and California-based organizations, initiatives, and policies have emerged to address the Black maternal and infant health crisis. Growing awareness of disparities in care and outcomes has led to an increase of solution-focused strategies and approaches. In order to understand this ever-evolving landscape of organizations and polices, the Coalition compiled and analyzed over 77 organizations engaged in Black birth equity and justice work and over 45 legislative and administrative policies.

APPROACH

The Coalition sought to answer questions about the geographic spread of Black birth equity efforts, the range of approaches (e.g.- direct service provision, advocacy, education, research, community engagement, etc.), year of founding, and whether the organization or initiative is Black-led or founded. The team populated the organizational and policy tracker through existing knowledge of organizations, initiatives, and policies, comprehensive internet searches, fielding additions from the Coalition backbone team, and 2024 strategic advisor cohort. The collected data was verified through checking organizational websites and policy tracker web pages. The data was cleaned and checked for inconsistencies before analysis.

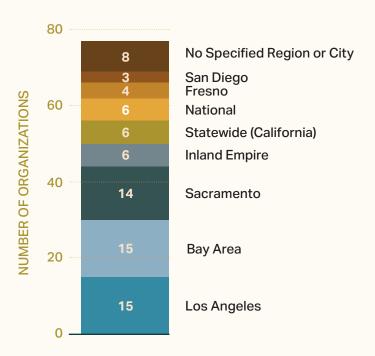
KEY FINDINGS

ORGANIZATIONAL LANDSCAPE

In addition to collecting information on region or city of operation, the organizational portion of this tracker compiles each organizations' approach to addressing the Black maternal and infant health crisis. This 'approach' is inclusive of methods, their organizational function, and the tools they utilize to reduce disparities in care and outcomes.

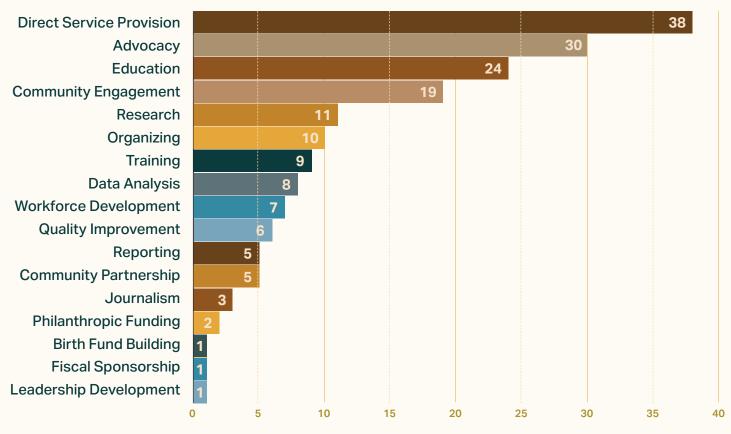
CHP2. FIGURE 01: ORGANIZATIONS ENGAGED IN BLACK BIRTH EQUITY AND JUSTICE WORK

At the time of initial analysis, the Coalition along with community partners identified 77 organizations engaged in Black birth equity and justice work (see Appendix B. for details). This list includes (n=6) national organizations and (n=71) California based organizations. The identified organizations represent a diverse set of regions and cities primarily within the state.



CHP2. FIGURE 02: CA ORGANIZATIONAL STRATEGIC APPROACH LANDSCAPE

Among all organizations (n=54) were Black founded and are Black led while (n=24) were not.



ANALYSIS

The organizational and policy tracker illuminated assets, gaps, and opportunities in the field for further development. The organizational portion of this tracker presented a number of patterns.

GEOGRAPHIC SPREAD

California benefits from having a large number of organizations, primarily Black led, that impact the birth justice and equity landscape. A significant proportion of organizations are concentrated in Los Angeles, the Bay area, and Sacramento. While these regions of the state represent higher concentrations of Black Californians, there are other parts of the state such as the Central Valley (i.e. Stockton, Fresno, etc.), the Central Coast (i.e. Ventura, Monterey, etc.), the Inland Empire region (Riverside, San Bernardino, etc.), and the southern region of California (i.e. San Diego, Imperial, etc.) that warrant more attention and resources (see Appendix B. for details).

ORGANIZATIONAL APPROACHES AND STRATEGIES

In addition to geographic spread, organizational approaches and functions provided valuable insights. Among the organizations compiled, a majority focused on direct service provision (i.e. healthcare delivery, doula care, midwifery care, etc.), policy and systems-change advocacy, education, awareness, and community engagement (i.e. patient navigation). We found fewer organizations engaged in activities such as researching, analyzing, and reporting on outcomes or care quality; training current healthcare providers on improved care models and addressing bias; partnering with healthcare systems on quality improvement; building funding pathways to help families access the care they choose; fiscally sponsoring emerging organizations; or coordinating entities around a shared vision for progress (see Appendix B. for details).

POLICY LANDSCAPE

The Coalition and our community partners conducted a policy scan and identified 45 proposed bills with the following statuses: proposed or in progress, enacted, failed, and vetoed. We included bills from the 2018-2019 through 2025-2026 legislative cycles. Bills that were included focused on maternal and child health, reproductive health, birth equity, hospital policy, economic equity, maternal mental health, and reparative justice and were categorized accordingly (see Appendix B. for details). Our analysis revealed a shifting policy landscape with progress and attention in some areas, and persistent gaps in others.

BIRTH EQUITY: AN EMERGING FOCUS

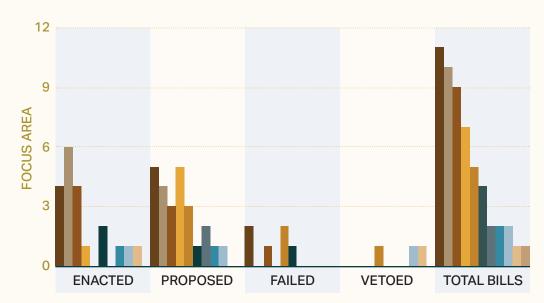
Birth equity has emerged as an area of focus in recent legislation. Bills such as the SB 65 (the California Momnibus), SB 464 (Dignity in Pregnancy and Childbirth Act), AB 904 (Medi-Cal coverage for doulas) seek to improve maternal health inequities and have established the foundation for implicit bias training, doula coverage, postpartum coverage and more. Community-based models of care are increasingly centered in proposed legislation, with efforts to remove licensing barriers for birth centers and studying the expansion of midwifery education. However, more ambitious efforts such as prohibiting drug and alcohol testing of pregnant people without consent have failed.

REPRODUCTIVE HEALTH REMAINS KEY PRIORITY

In 2019, Governor Newsom declared California a Reproductive Freedom State. In the following years, California has moved swiftly to protect abortion rights, contraception access, and education, especially following the overturning of *Roe*. In our analysis, bills categorized as having a reproductive health focus were the most enacted. Legislative wins such as Proposition 1, SB 345 (Abortion Shield Law), and SB 729 (Fertility Coverage), AB 2586 which established the California Reproductive Justice and Freedom Fund, have bolstered legal protections and financial commitments to protect reproductive rights.

CHP2. FIGURE 3. CALIFORNIA BILLS RELATED TO MATERNAL, CHILD HEALTH BY STATUS FROM 2019- 2025





HOSPITAL ACCOUNTABILITY AND HEALTHCARE ACCESS ON THE RISE

Policies focused on hospital accountability are gaining traction as legislators seek to confront the role medical institutions play in addressing maternal health inequities. Enacted bills such as AB 3161 on patient safety and AB 1204 on equity reporting—signal a growing push to hold hospitals accountable. There is also interest in ensuring Californians have access to maternal healthcare in the face of maternity unit closures and maternity deserts. Proposed bills such as SB 669, which would pilot perinatal services in rural hospitals, SB 32 which would develop standards around geographic accessibility of perinatal units to ensure timely access to care, and AB 1386 which would require perinatal services to be considered a basic service at general acute care hospitals, indicate a growing focus on timely accessible care.

BILLS SPECIFIC TO DESCENDANTS OF PERSONS ENSLAVED AND EMANCIPATED IN THE UNITED STATES (AMERICAN FREEDMEN), CONTINUE TO FACE POLITICAL RESISTANCE

One of the most politically fraught areas is *reparative justice*. Several bills rooted in California's Reparations Task Force recommendations, including SB 1331 and SB 1403 have failed. Even a bill to recognize and accept responsibility for the harms and atrocities committed by representatives of the State of California related to slavery (ACR 135) has failed. Despite growing public awareness and championing of reparations, these bills continue to face an uphill battle, which may signal a larger issue—failure to address anti-Blackness at a systemic level. Recent proposed legislation examines the importance of lineage instead of race, and the need to disaggregate data for specificity around the Black/African American demographic.

POLICY OPPORTUNITIES

COMMUNITY-BASED INFRASTRUCTURE AND FUNDING IS LARGELY MISSING

There are still *no major bills directly funding* community-based organizations (CBOs) or expanding capacity-building for community-rooted maternal health organizations, despite their central role in delivering culturally concordant care. Bills like the Birthing Justice for California Families Pilot Project (AB 583) failed, which would have established a three-year program to provide grants to community-based doula groups, local public health departments, and other organizations, to provide full-spectrum doula care to low-income pregnant and birthing people who do not qualify for Medi-Cal. Similar efforts such as the Health Equity and Racial Justice Fund (not included in analysis) which proposed \$100 million annual fund for CBOs failed despite the state's \$45 billion budget surplus at the time.

WORKFORCE NEEDS INVESTMENT

While some bills address midwifery education and healthcare worker wages, California needs a comprehensive workforce and pipeline strategy for recruiting, retaining, and resourcing a culturally-aligned, community-based perinatal workforce. This includes midwives, doulas, lactation consultants, mental health professionals, researchers, advocates and more.

MATERNAL MENTAL HEALTH INTEGRATION AND POSTPARTUM SUPPORT

While some progress has been made around maternal mental health—notably through AB 1936 (maternal mental health screenings) and AB 3032 (maternal mental health education) — a more systemic approach is needed to integrate mental health into perinatal care, expand services and providers, ensure insurance coverage, and embed trauma-informed support. The proposed SB 626 (perinatal mental health screening and treatment) shows promise but must be supported with financial commitments.

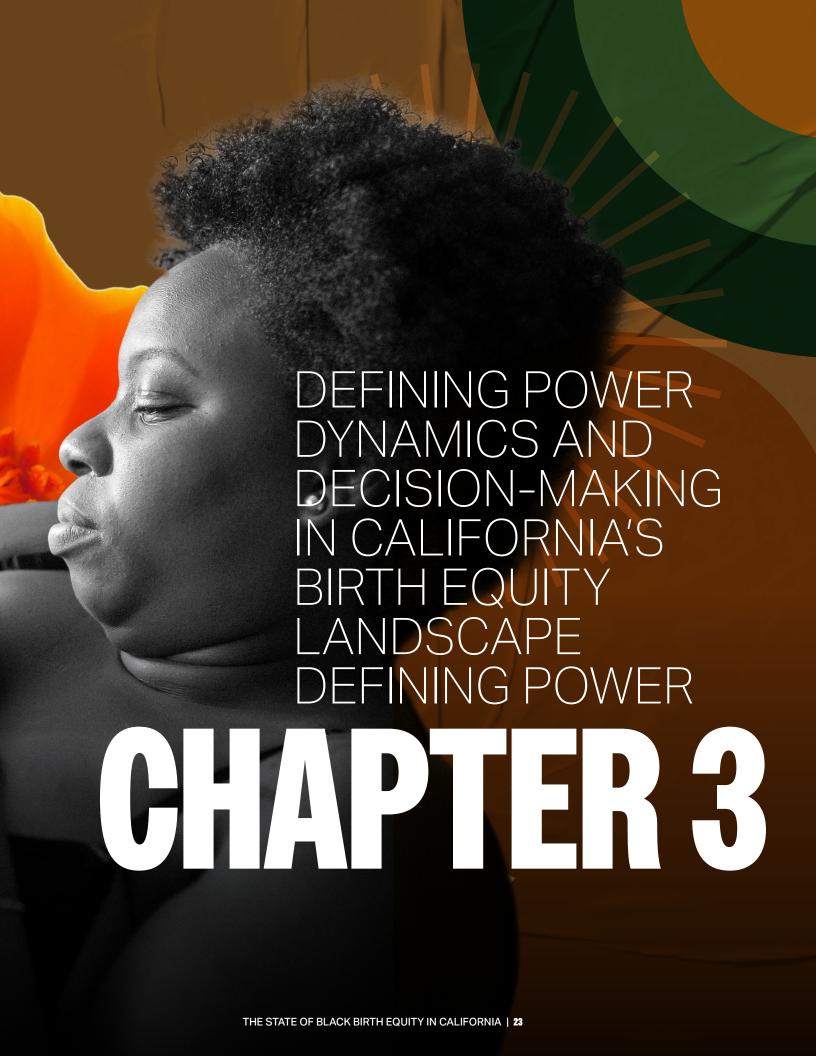
ELEVATE INTERSECTIONALITY

In our analysis, very few bills explicitly address the needs of youth, gender-expansive, disabled birthing people, and those with substance use disorder (SUD). Similar to our research findings, these populations seem to be largely overlooked in the legislation.

LIMITATIONS

While this dataset represents the collective efforts of a number of experts in this field, it is not an exhaustive listing of all organizations and polices that relate to birth equity and justice. This dataset represents an initial compilation of organizations and policies. Future iterations of this tracker are planned that will field and include input from additional stakeholders.







CHAPTER 3

The Grassroots Power Project <u>defines</u> **POWER** as the ability of marginalized communities to reshape their social and political landscape to reflect their needs and visions. Governing power extends beyond reactive actions or short-term efforts. It aims to build lasting influence over governance structures, driving transformative change that addresses racial, economic, and gender injustices. Governing power is about not only engaging with existing systems but fundamentally altering them to align with community values.

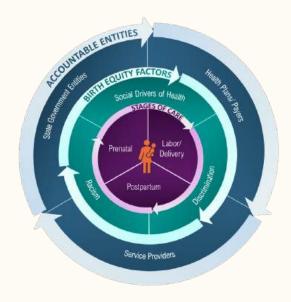
UNDERSTANDING POWER STRUCTURES THAT INFLUENCE BIRTH EQUITY IN CALIFORNIA USING THE BIRTH EQUITY MEASUREMENT FRAMEWORK

To help frame the power analysis, we utilized the <u>Birth Equity Measurement Framework</u> developed by a team at the Praxis Project and the National Committee for Quality Assurance (NCQA). This evidence-based, community-informed framework serves as a guide for conceptualizing a range of factors that influence birth equity and accountability structures. At the center of the framework is the birthing person, surrounded by three rotating layers—stages of care, birth equity factors, and accountable entities.

THE FACES OF POWER

While each entity identified in the Birth Equity Measurement Framework holds influence over advancing birth equity, it is crucial to note that entities hold varying types of power.

The Faces of Power framework, developed by Steven Lukes, describes three distinct ways power is exercised: visible power, hidden power, and invisible power. VISIBLE POWER is related to formal decision-making through laws, policies, budgets, regulations and institutional rules. HIDDEN POWER influences the visible power and shapes what is prioritized and decided. INVISIBLE POWER are the beliefs, ideology, social norms and culture that shape narratives and people's ideas of what is normal, fair, and right.



As it relates to birth equity and justice, those that hold the most visible, formal decision-making power are the entities that have legislative and economic authority, including the Governor of California, the California state legislature, various state government departments (e.g. CDPH, DHCS, etc.), philanthropy, hospitals and health systems, and insurance payers. Hidden power is driven by community-based organizations, advocates and birth workers, clinicians, research institutions, local health or public health jurisdictions, professional associations, and privately held businesses. Invisible power is advanced through media and can be influenced by all other entities.

THE IMPORTANCE OF UNDERSTANDING AND MAPPING POWER TO ADVANCE BIRTH EQUITY

Advancing birth equity requires a strategic understanding of who holds influence, how decisions are made, and what levers can be pulled to create lasting change. Mapping power across institutions, sectors, and communities reveals not only where influence resides, but also how different forms of power intersect to either advance or obstruct progress. By understanding where power is concentrated, we can better understand where the levers exist to create change, identify where gaps and opportunities exist in our collective strategies, anticipate challenges, activate unengaged decision-makers, and strengthen collaboration across power types.

Appendix C includes a table of the roles and responsibilities of various entities that influence birth equity in California. This table is intended to support the broader movement in understanding where various types of power are positioned and to support strategic programming, planning, and advocacy efforts.

RECOMMENDATIONS FOR POWER BUILDING AND SHARING

To make meaningful and sustained progress toward birth equity, it is essential that individuals and institutions with formal decision-making authority (visible power) intentionally share power with the communities most impacted by inequities. This begins with recognizing that technical expertise alone is not sufficient—transformational change requires redistributing power, elevating community leadership, and creating structures for accountability, transparency, and co-governance.

VISIBLE Power

Formal decision-making through policy and economic authority

HIDDEN Power

Influences what is prioritized and decided

INVISIBLE Power

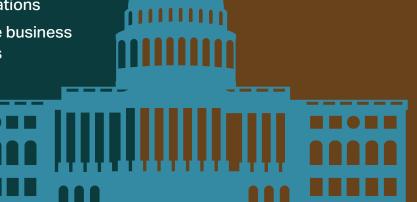
Beliefs and narratives that shape views of what is right and fair

WHO HOLDS THE POWER?

- CA Governor
- CA Legislature
- CA Health and **Human Services**
 - Dep. of Public Health
 - Dep. of Health Care Services
- Philanthropy
- Insurance payers
- Hospitals & Health
- Systems

- Community-based organizations
- Advocates and birthworkers
- Clinicians
- Research institutions
- Local public health **Jurisdictions**
- Professional associations
- Private business entities

- Media
- · Many sources of hidden power



WHO HAS THE POWER TO ADVANCE BIRTH EQUITY IN CALIFORNIA?



THOSE WHO HOLD VISIBLE POWER MUST:

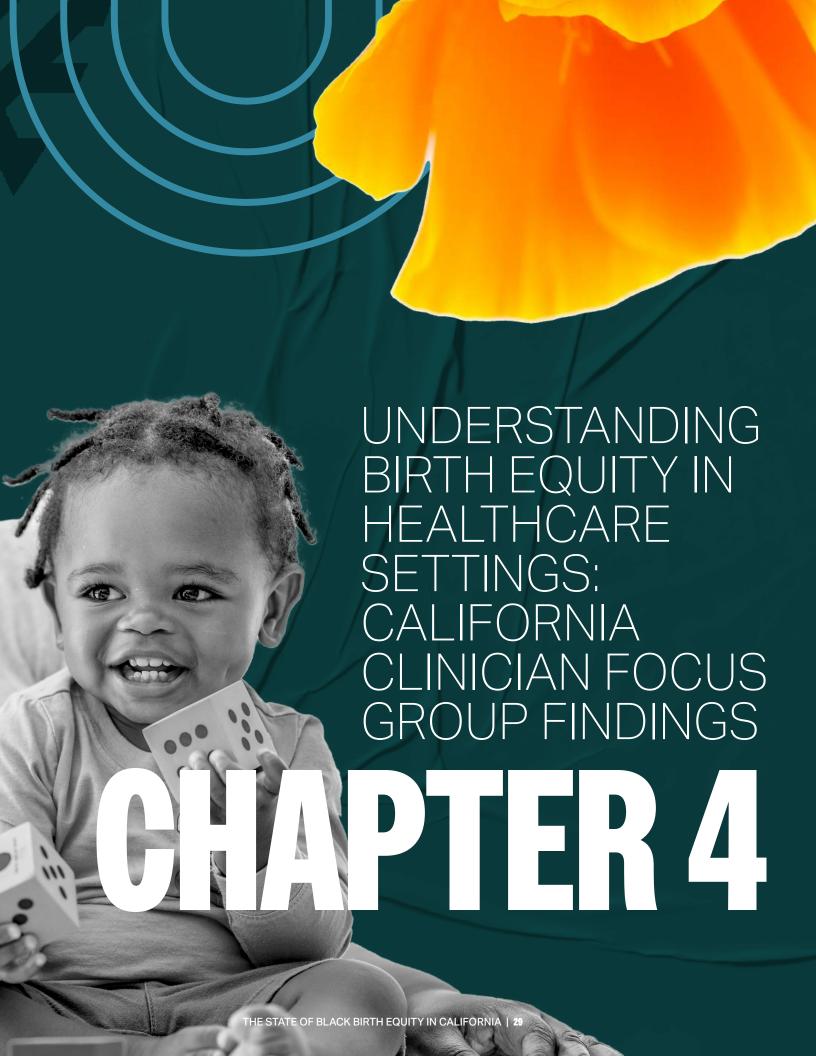
- Establish formal mechanisms for community accountability, such as advisory councils, oversight committees, or participatory governance structures that are led or co-led by Black birthing people, doulas, clinicians, scholars, and birth equity advocates.
- Embed equity-centered frameworks into policymaking, ensuring that racial and birth equity are not peripheral, but core to the design, implementation, and evaluation of policies and programs.
- Invest in birth equity infrastructure, including sustainable funding for Blackled community-based organizations, workforce pipelines, data systems that disaggregate by race and payer, and culturally centered models of care.
- Align resource allocation with community-identified priorities, using participatory budgeting, community-designed grant criteria, or shared decision-making in funding processes to ensure dollars follow community expertise and need.

THOSE WHO HOLD HIDDEN POWER MUST:

Those with HIDDEN POWER play a critical role in shaping agendas, elevating priorities, and shifting norms. While they may not always hold formal authority, they often influence what is seen as possible, important, or legitimate. Their power must be used to:

- Activate and align cross-sector supporters, including health professionals, researchers, faith leaders, media, and advocates, around a shared vision for birth equity.
- Establish common language, values, and goals, grounded in reproductive justice, anti-racism, and the lived experiences of Black birthing communities.
- Open space for community voices in agenda-setting, using their influence to prioritize issues historically excluded from institutional conversations (e.g., maternal mental health, community midwifery, or culturally grounded healing).
- Amplify community-defined solutions by uplifting stories, data, and success models that center Black maternal health and joy.









EXAMINING HEALTHCARE INSTITUTIONAL READINESS TO ENGAGE WITH BIRTH EQUITY

To address the need to more effectively achieve equity driven systems change in California's healthcare settings, The California Coalition for Black Birth Justice sought to assess the readiness of California clinics and hospitals to advance birth equity to inform priority setting. Through the facilitation of a series of focus groups, we identified the needs and capacities of these systems to engage in comprehensive quality improvement projects to advance Black birth equity. The goal of this research was to focus on identifying ways to support Black advocates, scholars, clinicians, public health officials, and policymakers in this work by filling existing knowledge gaps that limit collective birth equity efforts. By adding to the literature of how to successfully implement quality improvement projects and avoid potential pit falls, advocates in California can directly impact the disparities in care and outcomes for Black moms and birthing people that persist despite efforts to address them.

DEFINING 'INSTITUTIONAL READINESS'

The California Coalition for Black Birth Justice defines **INSTITUTIONAL READINESS** as the willingness, preparedness, and organizational capacity of a health care institutions (hospital, clinic, etc.) to meaningfully engage in, adopt, and sustain birth equity promoting quality improvement work. This baseline level of preparedness is a predictor of success in enacting and sustaining systems level change in service to improving racism-based disparities in care provision and outcomes.

*Primary Data Collection: The following sections of this report detail the findings from our primary data collection efforts in 2024, all of which sought to deepen our understanding of attitudes towards birth equity quality improvement work, challenges in implementing this work, and recent experiences of Black moms and birthing people receiving care.***

APPROACH

DESIGN

We used a focus group design that included both quantitative and qualitative research methodologies to investigate clinician held perspectives on institutional readiness to engage in birth equity promoting quality improvement work.

All focus groups were held virtually to ensure participation from clinicians across California. Separate virtual focus groups were held for the following professions: Physicians (MDs), Nurses (RNs), Certified Nurse Midwives (CNMs), and C-Suite/ Quality Improvement staff.

PROCEDURES

The focus group guide which employed a semi-structured interview approach was developed by staff at The California Coalition for Black Birth Justice and was used in all focus group sessions. Focus group questions covered participants' understandings of birth equity promoting practices, what is necessary for successful implementation in their facilities, potential facilitating factors and challenges, and past experiences with quality improvement projects, if applicable.

KEY FINDINGS

THEMES

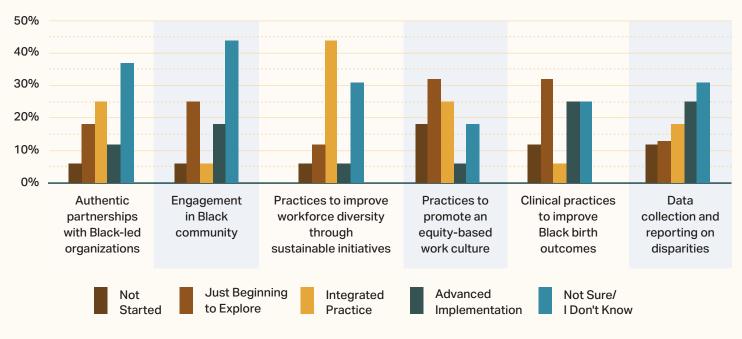
Across the 7 focus groups, a total of a 61-codes were generated from participants representing the following 4 distinct topic areas: institutional readiness, facilitators of success, challenges to implementation, and future quality improvement ideas.

INSTITUTIONAL READINESS

For the purposes of this research, 'Institutional Readiness' was operationalized into six domains:

- I. Data collection and reporting on disparities;
- II. Clinical practices to improve Black birth outcomes;
- III. Practices to promote an equity-based work culture;
- IV. Practices to improve workforce diversity through sustainable initiatives;
- V. Engagement in the Black community;
- VI. Authentic partnerships with Black-led organizations.





The levels of preparedness were defined by the following categories: Not started; Just beginning to explore; Integrated practice; Advanced Implementation; Not Sure/ I Don't Know.

The majority of focus group participants responded that their respective institutions had not started in the domains of data collection and reporting on disparities (31%), engagement in the Black community (44%), and authentic partnerships with the Black led organizations (37%). Focus groups participants indicated that their institutions were just beginning to explore clinical practices to improve Black birth outcomes (31%) and practices to promote an equity-based work culture (31%). Finally, a majority of participants specified that practices to improve workforce diversity through sustainable initiatives are an integrated practice (44%).

In addition to asking participants to rank their institution's familiarity with our defined domains of readiness, participants were also asked who at their institution needs to be involved for a quality improvement project to be best supported? In response the following key players were identified:

- I. Division Chair/ Directors of Practice for each department (i.e. OB, Peds, Nursing);
- II. Quality Improvement department representation;
- III. Hospital media teams;
- IV. C-suite/administrators;
- V. Community Members/Patients;
- VI. DEI Department representation;
- VII. Risk Management/Legal Department representation; and
- VIII. Clinical Staff

FACILITATORS OF SUCCESS

Focus group participants were asked to imagine the successful implementation of a perinatal quality improvement project within their institution. When asked what the facilitators of that successful implementation would be, the following repeated responses were shared across groups.

LEADERSHIP BUY-IN: Participants overwhelmingly expressed that C-Suite administrators play a major role in the adoption and sustainability of equity driven perinatal quality improvement work. Many participants felt that without top-down commitment (i.e. vocal support, active delegation/expectation setting for staff, active participation in efforts, etc.) the work of meaningfully addressing disparities in outcomes and care is not possible.

"At the highest and or mid-levels of leadership, every leader needs to have this [work] on their dashboard as a priority ...so they can help move forward the advancement of the project making sure that everybody has the appropriate action items aligned with their capabilities so that it doesn't fall through the cracks." —C-SUITE MEMBER

WORKFORCE DIVERSITY: Participants repeatedly highlighted the importance of having a diverse workforce at all levels within a healthcare system to champion and push for work that addresses racism-based disparities.

"So, number one, you have to have the people that look like those that you're promoting sitting at the table. If you don't have that, if people are either unwilling or it's difficult for them to make those moves to get there, you're not going to have the allyship and the intentionality that you need." —C-SUITE MEMBER

They also expressed the importance of having a diverse workforce as protective against instances of bias in the provision of care.

"Diversity in the workforce is incredibly important, and ideally, our healthcare workforce, nurses and doctors match the patients they're taking care of so that there's plenty of opportunity for patients to be exposed to providers that are similar to them." —PHYSICIAN

EXTERNAL HELP: Most focus groups talked about external help via community-based organization support and/or pressure as a facilitator for quality improvement work. Citing that healthcare systems alone are not equipped to start or maintain work of this nature without external partnership or incentivizing pressure.

"So, to roll [a QI project] out, you would need to be an outside organization approaching the hospital. I think you cannot come and truly expect that the hospital or the organization by themselves, independent of anyone incentivizing them to do it, to just say, "You know what? This is a real problem, and we need to do X." —PHYSICIAN

CARE TEAM COHESION: Participants underscored the utility of clinical staff members having the same goal/mission and working well together as a team. When engaging in quality improvement work team unity and synchronicity facilitates the ability to work through challenges and sustain efforts.

"The other thing that is most important as far as things moving forward is that everybody has a common mission. So, if you have too many missions, or too many visions that are involved with this, it's not going to get done. Everybody needs to be on the same page. And once you can get on the same page with something, you have the right stakeholders in place."—C-SUITE MEMBER

Participants also talked about how the desire for good outcomes among teams serves as an important facilitator of success as a well as a thread that supports overall cohesion.

"I really believe in the good in people and they desire to actually do right especially my colleagues, the people that I work with that I know really do want to do right and really do want to take care. We could work anywhere else, but we don't. And it's definitely not for the paycheck. We could work in a lot of other places that would be a lot less stressful and more functional. And people work here because they want to serve." —CERTIFIED NURSE MIDWIFE

ACCESS TO DATA: Access to reliable data disaggregated by race and ethnicity was called out consistently among participants as a major facilitator. Specificity was also underscored as a means of illuminating disparities but also serving as a way to monitor progress in eliminating those disparities over time.

"Access to site specific and maybe even provider specific data seems really important because everyone tends to think it's somewhere else... we can't really do the work unless we make that data very site specific and relevant so that those people that don't believe that it's us, are accountable to actually what's happening within our own institution." —CERTIFIED NURSE MIDWIFE

Participants also underscored the importance of consistent analysis and reporting.

"One of the big facilitators is data and actually having access to segmented data and in, one, engaging with it, and then, two, having the humility to share it with your teams." —PHYSICIAN

CHALLENGES TO IMPLEMENTATION

LACK OF PROTECTED TIME: All groups from their respective vantage points talked about the dearth of protected time to engage in birth equity promoting work. Because birth equity work is a collateral duty, it is naturally deprioritized.

"There's so little time that other things become more pressing. And then the anti-racism work gets checked as a box because an e-learning was completed." —CERTIFIED NURSE MIDWIFE

BURNOUT: Focus group participants talked about the negative impact that burnout has on perinatal quality improvement work, siting that clinical staff are already over-taxed and struggling to stay afloat.

"And I think what people are not ready for is the investment because everyone is worn, everyone is weary. Everybody is weary. And so, it's not that people don't want and they aren't ready for the work." —CERTIFIED NURSE MIDWIFE

DIVISIONS IN CARE TEAM: Lack of cohesion within clinical teams and between clinical teams and patient invited support teams (i.e. doulas and midwives) present a myriad barriers to providing optimal care and achieving desired outcomes. Quality improvement work is hindered by the mistrust and some cases adversarial relationship that persists.

"It's unfortunate too because I enjoy working with everyone on the team, but then I have colleagues who are other board certified OBGYNs who they do not want to work with the midwife. They do not want to work with the doula. They have nothing but bad things to say about them." —PHYSICIAN

LACK OF STAFF BUY-IN: Participants indicated that not all clinicians or administrators believe that racism-based disparities exist for Black birthing people.

"I think the barriers are there's still people who don't believe this is a problem. There are still people embedded that we work with at work that are in the physician group and in the nursing group and the administration group who think, "Really, is this really a problem?" So those barriers are how do you get those people to listen and turn around that? How do we get all of the caregivers to listen better to women?"—PHYSICIAN

Participants highlighted that even among some healthcare providers that acknowledge that disparities exist, birth equity work is not considered important.

"I think that change is hard and long and it's a whole process, and I think that a lot of people feel like, well, if it's not broke, don't fix it and they don't realize how important it is. So I guess a challenge would be, which shouldn't even be a challenge, but just showing how important this work is and getting people to see it and understand that."—NURSE

IMPLICIT BIAS: Participants noted that the prevalence of implicit bias remains a persistent challenge in healthcare systems.

"A challenge is defensiveness that some people feel when we talk about implicit bias and racism. For people who are uncomfortable in these conversations or have not done any work to learn about these things, often, I've observed and seen firsthand the immediate response is defensiveness and no, that's not me, I don't do those things, I don't think that way, that's not what I believe. And if people can't get past that and depersonalize it or take their own feelings away from the center of the conversation, then it's really hard to move the conversation forward and to have any actual meaningful exchange." —NURSE

FEAR: Most groups talked about the prevalence of fear in the healthcare setting. Participants underscored how fear of poor outcomes hinders clinical staff from effectively listening and respecting the wishes of a birthing person.

"You can't listen if you're feeling scared." The provider's feeling scared. And so then the provider stops listening because they're worried about pushing their agenda because they're worried and they're no longer fully behind autonomy." —CERTIFIED NURSE MIDWIFE

Groups also talked about fear among patients as barriers to improving care and outcomes. This fear is a consequence of the warranted increased awareness of disparities but presents a challenge of increased mistrust.

"People are entitled to dislike whatever hospital or caregiver they have, but it's heartbreaking to me, personally, to think someone walks into our hospital and they're not white and they think, "Oh my God, something bad's going to happen to me." —PHYSICIAN

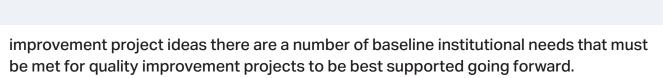
KEY TAKE-AWAYS

Focus group participants presented a myriad of facilitators and challenges to enacting and sustaining equity focused perinatal quality improvement work in their respective institutions. Based on this information and their shared future quality

FUTURE BIRTH EQUITY QUALITY IMPROVEMENT PROJECT IDEAS

Focus group participants were asked 'what other Black patient specific birth equity promoting practices they would like to see implemented as it relates to maternity care provision within their institution?' The following quality improvement project ideas were shared:

- I. Creating a structure for continual and consistent data analysis to pinpoint disparities as well as document progress.
- II. Support the creation of more robust complaint and feedback mechanisms to increase accountability within healthcare systems.
- III. Facilitate relationship strengthening through team building activities within clinical staff ranks and between clinical staff and Midwives/Doulas.
- IV. Facilitate community partnerships to introduce more wrap around holistic care services.
- V. Use external incentives like designations/certifications to encourage health systems to engage in perinatal quality improvement work.
- VI. Expand quality improvement technical assistance services to outpatient clinics that serve birthing people.
- VII. Center joy in quality improvement work to combat fear in clinical staff.
- VIII. Facilitate more robust provider education on implicit bias and racism in medicine by engaging in more role-play and simulations.

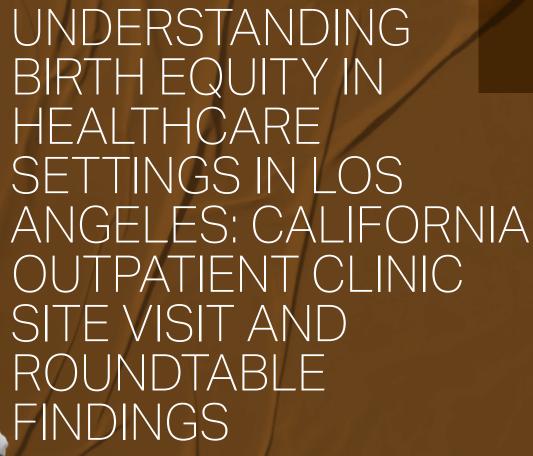


- Dedicated staff members at all levels need to be involved in moving equity driven quality improvement projects along;
- More rigorous and required trainings and education on bias and racism in medicine need to be made available and adopted;
- III. Innovative measures for patient experience need to be adopted across all health systems;
- IV. Protected and mandated time for staff to engage in this work;
- V. Authentic collaboration with community to create more pathways for accountability and collective problem solving.

While philosophical, psychological, and tangible barriers to this work remain, there is a persistent and powerful desire to engage despite these challenges. Healthcare administrators, legislators, community advocates, researchers, and quality improvement leaders collectively hold the power to lower these barriers and drive sustained progress in care and outcomes for Black birthing people and their families.







GIAPTER 5



CHAPTER 5

EXPLORING CLINIC READINESS TO ENGAGE IN SYSTEMS CHANGE WORK

Systems-level interventions in hospital care are effective in advancing Black perinatal equity, but these interventions are often limited to care that is provided during labor, birth, and the initial post-partum period only. Outpatient clinics provide long-term perinatal care, often from the first trimester of pregnancy through 6 weeks postpartum. Therefore, it is crucial to include pediatric ambulatory care services in intervention strategies, as this is where infants receive care from birth through age 18—including the critical first year of life, during which Black infants are 3-4 times more likely to experience mortality than white infants (March of Dimes). Birth equity efforts have historically centered on the hospital experience—understandably so, as most births in California take place in hospitals. However, the Coalition recognizes that hospitals account for only a small portion of the time patients and families spend during pregnancy and postpartum. To advance birth equity, outpatient clinics providing prenatal, postpartum, and pediatric care must also be included.

APPROACH

The Coalition conducted two observational clinic site visits in Los Angeles County and hosted a virtual clinic roundtable in the Fall of 2024 in order to explore approaches that increase clinic readiness to participate in systems change efforts to advance birth equity for Black families. During the site visits and roundtable discussion, the Coalition assessed current equity practices and opportunities for improvement by directly speaking with Black patients, Federally Qualified Health Centers (FQHC), Comprehensive Perinatal Services Program (CPSP), state-agency and other ambulatory care clinic staff. The following patient feedback and experiences were incredibly eye opening and aligned with what is well known about Black patient experiences in maternal healthcare.

KEY FINDINGS

Themes: Across the 2 clinic site visits and roundtable discussion, a total of 7 themes were identified from participants representing the following 2 distinct topic areas: Care Experiences and Desired Improvements.

CARE EXPERIENCES

The following themes are based upon the patient feedback we received during the clinic site visits.

I. FEAR AND COERCION:

Participants shared that their in-hospital providers used fear tactics without explanation to coerce the provision of Cesarean sections (C/S), experienced poor treatment from nursing staff during parts of their care including C/S recovery and postpartum, were labeled as "combative" when attempting to advocate for their needs, and related on needing to call clinic staff to advocate on behalf of them in the hospital setting.

II. TIMELY TREATMENT:

Participants discussed shared experiences of being referred for high-risk diagnoses without being given the proper priority with specialists. They also shared that staff at certain sites lost their paperwork and that excessive wait times at clinics contributed to their stress levels during pregnancy.

III. DESIRE FOR RACIALLY CONCORDANT CARE:

Participants expressed a desire to be seen and cared for by Black clinicians during their hospitalbased care but were unable to due to the overall shortage of Black providers in these settings.

IV. BEDSIDE MANNER AND STAFF COMPETENCY:

Participants stated they felt rushed to leave the hospital before they felt ready. Some patients stated that they were not given pain medication or food when requested and described substandard care from nurses who appeared unfamiliar with using medical equipment during their triage and labor and delivery stays.

V. LACK OF OPTIONS FOR CARE:

Participants voiced shared, negative experiences at the same hospital but were limited on where they could go for care based on insurance and clinic contracts. These limitations created barriers to accessing holistic care options like midwifery care and other culturally congruent supports.

DESIRED IMPROVEMENTS

The following recommended actions are based upon our roundtable participant contributions.

I. COMMUNITY-BASED MODELS OF CARE:

Clinics and hospitals need to develop more intentional relationships with community-based organizations that support families in their respective geographic locations. Care professionals like Licensed Midwives, community health workers, community doulas, lactation consultants are a short list of providers of care who are often better equipped to meet the needs of the community by enacting holistic community driven and defined solutions.

II. RECRUITMENT AND RETENTION:

There is an immediate need for more pipeline training programs and recruitment efforts for Black and POC providers of all disciplines that are representative of the communities they serve. Increasing recruitment and retention of culturally congruent providers from within the community will support the scale of midwifery and other models of care becoming accessible. For example, introducing trained interns into the outpatient clinic setting to build capacity for birth equity work.

III. UPSTREAM SOLUTIONS:

There is a need for improved collaboration between various stakeholders, including health plans, hospital-based, and community-based organizations to improve prenatal and postpartum care, and to support families from birth into early childhood and beyond. This could be in the form of regular stakeholder meetings, community forums or town halls that center Black birth equity. Decision makers like state agencies need to be responsive to the requests of the population of focus by removing barriers to accessing resources and support services.

IV. WRAP AROUND SERVICES:

There is a need to better support and expand holistic care options including financial and emotional support for families. Community based organizations and programs that have a direct impact on Black families need more financial support to hire staff and continue to provide quality services that are currently lacking in many healthcare institutions. Healthcare budget allocations at all levels should include wrap around services and sufficient care access needs to be regularly assessed.

KEY TAKE-AWAYS

From requiring clinics to participate in birth equity quality improvement efforts, to streamlining appointment and referral processes, removing insurance barriers to medical and community-based holistic care, and strengthening responses to patient grievances—there are numerous opportunities to advance birth equity for Black families within the outpatient clinic setting.

Continued birth equity work requires the addition of meaningful and direct engagement with outpatient clinics for assessment, education, training, and quality improvement opportunities designed to advance birth equity for Black families during all aspects of their clinic care, not isolated to the hospital experience. An additional key and often missing component of engagement in birth equity advancement includes insurance payers and managed care plans. Both entities play a pivotal role in birth equity but often are not included in conversations on how to improve access to care that families desire. The Coalition has identified the need for continued engagement with not only hospitals, but outpatient clinics and insurance payers to determine the most effective ways to collaborate with all entities providing care for Black families during prenatal, hospital, postpartum and pediatric care. Ultimately, the goal is to catalyze sustainable support structures to advance birth equity for Black families.



MAKING SENSE OF THE BIRTH EQUITY & JUSTICE LANDSCAPE

CONCLUSION

California holds the unique distinction of being the safest state to give birth, with the lowest maternal mortality and morbidity rates in the nation and is also among the safest states for infant health. It is home to numerous organizations focused on or aligned with birth equity and justice and has successfully enacted several significant related laws and policies. However, California continues to see disproportionately poorer outcomes and experiences of care for Black birthing people. With the recent untimely and preventable deaths of April Valentine and Bridgette Cromer in 2023, the work of addressing disparities in care and outcomes has never been more urgent.

Our examination of the literature suggests more work is necessary across multiple domains to achieve sustained progress. Published work in the field of birth equity and justice must broaden to include excluded communities, underexplored topics, and key areas for improvement. Although California is home to many community-based organizations deeply connected to the needs of families, these groups often lack the capacity and funding to conduct research, analyze data, and report on their own primary findings. Power imbalances between community-based organizations and state agencies remain a persistent challenge, highlighting the need for increased grassroots organizing—particularly to strengthen alternative sources of power within Black-led organizations. Our collection of primary data outlined within this landscape underscore specific needs for improvement in the clinical space across California. Our findings point to the need to secure protected time to engage in birth equity promoting work and more challenging and comprehensive trainings on implicit bias and racism in medicine. In addition to the statewide primary data collection, this landscape also includes Los Angeles-focused case study findings, but have far reaching implications for the policies and practices among perinatal clinics statewide.

In compiling the various data sources for this landscape analysis, we identified clear, persistent, and often hidden gaps. But where there are gaps, there are also opportunities. We encourage scholars, advocates, and community members to use these insights to inform their work and build upon existing tools to drive sustained, systems-level change.

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APPENDICES

APPENDIX A APPENDIX B





APPENDIX C



WEBSITE





