Birth Outcomes Exploratory Study



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FIRST 5 LA
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Executive Summary

Introduction

According to the California Department of Public Health, African-American babies are more than twice as likely as White babies to die before their first birthday.[1] The reasons for these poor outcomes and underlying health disparities are varied and complex, but organizations like First 5 LA are working to ensure that all "children are born healthy" by investing in targeted programs and promoting systems change. In November 2013, First 5 LA's Board of Commissioners approved the extension of the Los Angeles area Black Infant Health (BIH) program for an additional five years. The Commission also funded two, new components designed to address persistent health disparities in birth outcomes and engage young at-risk fathers in new and innovative ways. Specifically these targeted investments include:

- $500,000 for **policy and systems change efforts to address health disparities in birth outcomes** for African-American families; and
- $600,000 for a two-year effort that promotes the ability of young at-risk **fathers of children zero to five** to complete school, get a job, participate in their children's lives, and be strong and loving parents and partners.

Birth Outcomes & Health Disparities

- "Approximately one in seven African-American babies in California are born too early or too small."
- "African-American babies are more than twice as likely as White babies to die before their first birthday."
- "African-American women are much more likely than White women to die of pregnancy-related complications."

Quotation obtained from: http://www.cdph.ca.gov/programs/bih/Pages/default.aspx

The Commission approved these investments with the understanding that they will be integrated into the BIH program as well as the place-based work in the Best Start communities. To inform First 5 LA in these efforts, in January 2014 Harder+Company Community Research was contracted to identify models, best practices, and promising strategies that have the potential to 1) positively impact health disparities in birth outcomes or 2) promote father involvement with children zero to five. Harder+Company also sought to identify potential considerations for two geographic regions of Los Angeles County (Antelope Valley and South LA) that have historically experienced some of the highest rates of infant mortality and other poor birth outcomes.

To inform this study, Harder+Company conducted a **literature review**, **examined existing documents**, and **interviewed national and local experts**.[2] Throughout the process, the team worked closely with First 5 LA's Research and Evaluation Department as well as an **advisory workgroup** of representatives from various First 5 LA departments.[3] This collaborative approach helped ensure that the study provided relevant and useful

[1] For more information see: http://www.cdph.ca.gov/programs/bih/Pages/default.aspx

[2] Please see the full report introduction section and Appendices B and C for more information. The interviews and document review also included review of five programs across the country that focus on systems change related to health disparities in birth outcomes. Please see Appendix A for descriptions and lessons learned from each program reviewed.

[3] The advisory workgroup included representatives from the Grants Management, Policy, Program Development, and Research and Evaluation Departments. Please see Appendix D for advisory workgroup participants.

information to inform short-term programmatic decision-making as well as longer-term strategy considerations as part of First 5 LA's strategic planning process.[4]

Key Themes

Supported by multiple sources of data,[5] key themes were identified for each focus area of this study:[6]

- **To address health disparities in birth outcomes**: 1) Focus on women at risk for poor birth outcomes, 2) Engage women before and during pregnancy, 3) Target social determinants of health, 4) Increase access to and quality of culturally competent health care, 5) Facilitate multi-stakeholder collaboration that promotes sustainable change at the community and systems-level, and 6) Provide social support during pregnancy.
- **To promote father involvement with children zero to five**: 1) Recognize men as a valuable part of pregnancy and early childhood by incorporating fatherhood programs into maternal-child health programs, 2) Acknowledge that father involvement has a positive effect on child development and maternal behaviors during and after pregnancy, 3) Target the father's relationship with the child's mother, and 4) Reduce structural and policy barriers to father involvement.

Cross-Cutting Themes

There were a few themes that were common to these two focus areas:

- **Intervene before birth:** One of the strongest themes for improving birth outcomes was the need for early intervention. This theme also overlapped with the finding that to improve father involvement for young children, it is best to intervene during pregnancy. This suggests it may be important to consider how initiatives can be designed to be cross-purposed to both target birth outcomes as well as encourage father involvement.
- **Address social and community factors:** Literature and interviews indicate that to change health disparities in birth outcomes and support fatherhood, it is essential to address these issues through working at the institutional, social, and community level.
- **Partner with local community organizations:** Findings in each of these two areas also called for working with existing community partners and systems to prioritize strategies and plan programs. This is an important means to enact change, capitalize on current resources, and engage the local community and future participants.

These themes are relevant to First 5 LA investments overall as well as to **Antelope Valley and South LA**, communities with the highest rates of poor birth outcomes. Each of these geographic areas have specific social determinants of health and health care access issues that could be addressed, such as access to health care in Antelope Valley and poverty in South LA. Each geographic area also has existing community initiatives and advocacy efforts related to health care, fatherhood, and improving community conditions to promote community health.

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[4] Please see the full report for limitations of this study. The limitations included the following: 1) The study focused on peer-reviewed articles, local documents available at the time of the study, and a small number of local and national interviews. This approach may have unintentionally left out relevant information about study questions. 2) Some promising practices and lessons learned in this report are based upon early evidence about the implementation and initial outcomes of interventions, rather than based upon rigorous study of their impact.

[5] Data sources included peer-reviewed articles, other articles and reports, and local and national expert interviews.

[6] Please see the full report for more information and specific data sources for each theme.

Considerations for the Future

Based on the data sources reviewed, this study offered potential considerations for addressing health disparities in birth outcomes and fatherhood involvement. A "menu" of potential strategies was offered in categories such as integration into existing First 5 LA programs, policy and advocacy, public education, capacity building, and partnerships. Next steps for both the fatherhood and health disparities areas could be to engage key community stakeholders and potential partners in a focused planning process to determine priorities and identify short-term action steps based on existing community programs and the study's themes and considerations. Further planning, community input, and prioritization are needed.

First 5 LA's existing investments and relationships with the community, local providers, other funders, and government agencies can be leveraged toward both of these focus areas. First 5 LA has an opportunity to play an important leadership role in making system change locally while also adding to the national dialogue and evidence gap on how to address these vital community issues.

Introduction

"First 5 LA is committed to creating a future throughout Los Angeles' diverse communities where all young children are born healthy and raised in a loving and nurturing environment so that they grow up healthy, are eager to learn, and reach their full potential."
First 5 LA Strategic Plan (2009-2015)

Purpose and overview

First 5 LA strives to ensure that "children are born healthy" through investments in a variety of programs and by promoting systems change. With the exception of the Black Infant Health (BIH), a portion of the Welcome Baby program, and the now discontinued Healthy Births Initiative,[7] most of First 5 LA's investments focus on services after a child is born.[8] In November 2013, First 5 LA's Board of Commissioners approved the extension of BIH for an additional five years and also funded two new components designed to address persistent health disparities and engage young, at-risk fathers in new and innovative ways.[9] The Commission approved these investments with the understanding that they will be integrated into the BIH program as well as the place-based work in the Best Start communities. Specifically these targeted investments include:

- $500,000 for policy and systems change efforts to address health disparities in birth outcomes for African-American families; and
- $600,000 for a two-year pilot effort that promotes the ability of young at-risk fathers of children zero to five to complete school, get a job, participate in their children's lives, and be strong and loving parents and partners.

In an effort to inform First 5 LA's strategic focus on healthy births, in January 2014 Harder+Company Community Research was contracted to identify models, best practices, and promising strategies that have the potential to 1) positively impact health disparities in birth outcomes or 2) promote father involvement with children zero to five. First 5 LA was also keenly interested in understanding how some of these models and strategies could be applied to the local context. With that in mind, Harder+Company sought to shed light on potential considerations for two geographic regions of Los Angeles County (Antelope Valley and South LA) that have historically experienced some of the highest rates of infant mortality and other poor birth outcomes.

To inform this study, Harder+Company conducted a literature review, assessed existing documents, and interviewed national and local experts. Throughout the process, the team worked closely with First 5 LA's Research and Evaluation Department as well as an advisory workgroup of representatives from various First 5

[7] From 2005 to 2013, pregnant and postpartum women living in high-need areas of Los Angeles County received Healthy Births Initiative related services through the seven Best Babies Collaboratives (BBCs). Working toward improving high risk women's birth outcomes and their chances of having subsequent poor birth outcomes, BBCs provided intensive case management services – assessing their needs, setting goals, and providing referrals to community services. Each BBC was made up of a network of four to 16 service providers that worked in a specific geographic region.
[8] First 5 LA also supports post-partum women with the Welcome Baby and Select Home Visitation programs in various high-need communities throughout Los Angeles County.
[9] The funding is for 125% of previous funding with the extra funding intended to allow sites to continue using individualized case management and home visitation in addition to the standard BIH state model.

LA departments.[10] This collaborative approach helped ensure that the study provided relevant and useful information to guide program and strategy development. The advisory workgroup also had the opportunity to react to and reflect on the draft study before it was finalized in mid-March 2014. The study's guiding questions and methods are outlined in Exhibit 1.

Exhibit 1: Birth Outcomes Exploratory Study Framework

Guiding Questions	Data Collection Methods	Data Sources/Interviewees[11]
1. What are promising practices, community programs, and local/regional policies for addressing health disparities in birth outcomes? What are promising practices, community programs, and local/regional policies for improving birth outcomes broadly? 2. What are promising practices and initiatives related to fatherhood (particularly those serving at risk fathers of children zero to five)?	Literature Review	▪ Recent peer-reviewed literature on promising practices and programs for improving birth outcomes, reducing health disparities, local/regional systems change, and father's programs[12]
	Review of Existing Documents	▪ Select local and national program and funder websites and online publications
	National Expert Interviews	▪ Researchers and foundation leaders with expertise in promising practices and programs for improving birth outcomes, particularly those that target health disparities in birth outcomes and fathers
	National Program Interviews	▪ Representatives from promising programs such as fathers programs or local/regional change initiatives for improving birth outcomes.
3. What are existing resources, gaps, and opportunities in Antelope Valley and South LA for improving birth outcomes?	Secondary Data/ Document Review	Main sources of data: ▪ Best Start Capacity Assessment ▪ Healthy City ▪ Kaiser Permanente Community Health Needs Assessment ▪ LAMB 2010 Reports
	Local Expert Interviews	▪ Individuals with knowledge of existing resources, gaps, and opportunities in Los Angeles County, Antelope Valley, and/or South LA for fathers and/or health disparities in birth outcomes

[10] The advisory workgroup included representatives from the Grants Management, Policy, Program Development, and Research and Evaluation Departments. Please see Appendix D for advisory workgroup participants.

[11] Please see Appendix B for the bibliography and Appendix C for people interviewed. Throughout the study, interviewees are referred to as either national expert, local expert, or national program. Please see Appendix C for which people interviewed fell into each category.

[12] The literature review was conducted through an extensive search for published articles related to interventions addressing poor birth outcomes and health birth disparities as well as interventions aimed to improving parental involvement. Literature for this scan was identified through a search of databases such as CINAHL, PsycINFO, PubMed, ISI Web of Knowledge and Cochrane Key search terms were: "birth outcomes," "preterm birth," "low birthweight" "infant mortality," "infant health," "health birth disparities," "evidence-based programs," "best practices," "system-level interventions," "community-level interventions," "prenatal program," "father involvement," "paternal involvement," "male involvement," and "father programs." Searches were limited to articles published within the past 5 years that provide a comprehensive overview of relevant research such as meta-analyses and systematic reviews and other articles that synthesize recent literature on topics where systematic reviews are not available. Other articles were incorporated either if more recent studies were not available on a topic, or if the article had been identified during our initial literature scan before conducting the full Exploratory Study.

How to read this report

This report highlights the key themes and practices that emerged through this study as well as key considerations for First 5 LA to be aware of moving forward. The report is intended to inform short-term programmatic decision-making as well as longer-term strategy considerations as part of First 5 LA's strategic planning process.

The first section of the report focuses on health disparities in birth outcomes. The second section focuses on fatherhood. Both sections include key themes and considerations for the future. The third section includes case studies for two geographic regions in Los Angeles County with high rates of poor birth outcomes: Antelope Valley and South LA. Appendices also provide additional information from the study. Appendix A highlights five national programs focused on improving health disparities in birth outcomes at a systems level. Finally, Appendices B, C, and D provide specific sources and people who helped inform this study.

Limitations

When reviewing this report the following limitations should be noted:

- The literature review focused on identifying peer-reviewed articles that provided a broad and up-to-date look at the literature; this process may have excluded articles that did not meet search criteria, such as reports not published in academic journals. This means that there may be relevant information that was not represented in the report because of the process used to gather articles and resources.
- Documents and secondary data were reviewed based upon availability and relevance to the scan. This included either data and documents that were publically available or documents provided by First 5 LA. This approach may have excluded more up-to-date and relevant data and documents that were not yet publically available.
- This report shares promising practices and lessons learned from implementation of a selection of national programs. Best practices from these national programs are often based upon early evidence about their implementation and initial outcomes, rather than based upon rigorous study of the impact of their practices. Without evidence on their impact, it is unclear whether positive outcomes resulted from these programs, and therefore whether other communities can expect to see similar changes if they implement the similar programs or strategies.
- Given the small number of interviewees, interviewee reports should not be considered representative of the perspectives of the range of potential community stakeholders, especially those of local program clients and community members. Generally, interviewee reports were used to enhance the key themes from the literature and documents reviewed rather than to provide stand-alone findings.
- The time frame of the study was limited. The study was funded in January 2014 and completed in mid-March 2014. Additional time would have potentially allowed for recruitment of a broader range of interview participants and the inclusion of additional reports or research.

Health Disparities in Birth Outcomes

What are promising practices, community programs, and local/regional policies for addressing health disparities in birth outcomes?

Overview

Despite overall improvement in birth outcomes in the United States, there remains a distinct disparity in birth outcomes for African-Americans.[13] African-American babies are "two to three times more likely to die in infancy as any other race/ethnic group."[14] An April 2010 report from the Los Angeles County Department of Public Health noted that in Los Angeles County the African-American infant mortality rate is twice as high as the County rate.[15] Pre-term birth[16] and low birth weight[17] are risk factors for infant mortality. The same Los Angeles County study noted, "African-American moms in Los Angeles are about 40 percent more likely to have a preterm birth and about 70 percent more likely to have a low birth weight baby than other mothers."[18]

With a focus on disparities and the social determinants of health, this section of the report highlights key themes that emerged from the review of literature, program documents, and interviews with national and local experts. These findings may help First 5 LA shape, target, and promote practices, programs, and policies that benefit groups at highest risk of poor birth outcomes.

Key Theme #1: Focus on women at risk for poor birth outcomes

The top risk factors associated with poor birth outcomes[19] include: maternal age, late[20] or no prenatal care, poor nutrition, inadequate spacing of pregnancies,[21] substance abuse, smoking, socioeconomic status, and race/ethnicity.[22] [23] In addition, chronic health conditions, if not addressed, can adversely affect the health of

[13] Christopher, G. & Simpson, P. (2014). Improving birth outcomes requires closing the racial gap. *American Journal of Public Health, 104*(S1), S10-S12.

[14] County of Los Angeles Public Health (2010). *Health Disparities Among African-American Infants in Los Angeles County*. Retrieved from http://publichealth.lacounty.gov/mch/LACALC/ALC%20files/Health%20Care%20Disparities%20Brief.pdf

[15] Ibid.

[16] Preterm birth is defined as giving birth prior to the 37th week of pregnancy.

[17] Low birth weight is defined as babies born weighing less than 5.5 pounds.

[18] County of Los Angeles Public Health (2010). *Health Disparities Among African-American Infants in Los Angeles County*. Retrieved from http://publichealth.lacounty.gov/mch/LACALC/ALC%20files/Health%20Care%20Disparities%20Brief.pdf

[19] A poor birth outcome is considered having a pre-term birth; baby born with a low birth weight; perinatal, neonatal, or infant mortality.

[20] Late prenatal care refers to prenatal care that is initiated after the first trimester (12 weeks). US Department of Health and Human Services. (2012). Mother, infant, and child health. Retrieved from http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=26.

[21] Inadequate spacing of pregnancies (less than 18 months and longer than 59 month between pregnancies) has been associated with an increased risk of adverse birth outcomes. Conde-Agudelo, A,. Rosas-Bermúdez, A., Kafury-Goeta, A. (2006). Birth spacing and risk of adverse perinatal outcomes: a meta-analysis. *JAMA, 295*(15):1809-1823. doi:10.1001/jama.295.15.1809.

[22] In the United States, women from minority racial groups, primarily African American women, have a higher prevalence of a wide range of adverse pregnancy outcomes. US Department of Health and Human Services. (2012). Mother, infant, and child health. Retrieved from http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=26.

[23] NGA Center for Best Practices (2004). Healthy Babies: Efforts to Improve Birth Outcomes and Reduce High Risk Births. Retrieved November 30, 2012 from http://www.nursefamilypartnership.org/assets/PDF/Journals-and-Reports/NGAHealthyBabiesBrief.

the mother and baby- both prenatally and postpartum. For example, maternal depression[24] and gestational diabetes[25] during pregnancy have been associated with an increased risk of low birth weight, restricted fetal growth, and in more severe cases with spontaneous abortion or preterm labor. Another factor that has been linked to adverse birth outcomes is a previous history of negative birth outcomes. One poor birth outcome is a large predictor of a subsequent poor birth outcome. Providing interconception care is a means to target those women who are known to be at higher risk. Without focusing on those at risk, interventions might only further increase the gap in health disparities.[26] In communities such as Jacksonville, Florida and Milwaukee, Wisconsin, high-risk women are targeted before they plan on getting pregnant, such as through health screenings and education around stress.[27] [28] Some programs across the country also provide greater attention to community areas that are thought to be most at risk.[29] [30] [31]

Key Theme #2: Engage women before and during pregnancy

To improve the disparity in birth outcomes, researchers have called for the adoption of a "life course perspective" which considers the mother's health throughout her life span and through her pregnancy.[32] This approach was developed based upon years of research on the connection between maternal health before pregnancy and birth and maternal-child health outcomes.[33] It includes understanding how environmental stressors throughout a woman's life can predispose her child to poor birth outcomes. Recent literature discusses the importance of the life-course perspective which "conceptualizes birth outcomes as the end product of not only the nine months of pregnancy but the entire life course of the mother before pregnancy."[34] According to literature, healthcare alone cannot close the gap, but it is a good place to start. Closing the racial gap in birth outcomes requires a broader focus to include access to

> "Preconception focus is vital."
>
> ~ National Expert Interview Participant

[24] Grote, N. K., Bridge, J. A., Gavin, A. R., Melville, J. L., Iyengar, S., Katon, W. J. (2010). A meta-analysis of depression during pregnancy and the risk of preterm birth, low birth weight, and intrauterine growth restriction. *Archives of General Psychiatry,* 67(10):1012-1024. doi:10.1001/archgenpsychiatry.2010.111.

[25] Crowther, C. A., Hiller, J. E., Moss, J. R., McPhee, A. J., Jeffries, W. S., & Robinson, J. S. (2005). Effect of treatment of gestational diabetes mellitus on pregnancy outcomes. *New England Journal of Medicine*, *352*(24), 2477-2486.

[26] Florida Black Infant Health Practice Initiative (2008) A Review of the Literature on Black White Disparities in Birth Outcomes. Retrieved from http://www.hscmd.org/documents/BIHPI_Literature_Review_2008.pdf

[27] The Institute for Health, Policy and Evaluation Research Duval County Health Department (2007). The Magnolia Project: A Pilot Study of Impact of Pre and Interconceptional Care Case Management on Birth Outcomes of High-Risk Women. Retrieved from http://nefhealthystart.org/wordpress/wp-content/uploads/2011/03/Preliminary-report-14.pdf

[28] Rohan, A. M., Onheiber, P. M., Hale, L. J., Kruse, T. L., Jones, M. J., Gillespie, K. H, et al. (2014). Turning the ship: making the shift to a life-course framework. Maternal and Child Health Journal, 18(2), 423–30. doi:10.1007/s10995-013-1225-x

[29] Will, J. A., Hall, I., Cheney, T., & Driscoll, M. (2005). Flower Power : Assessing the impact of the Magnolia Project on reducing poor birth outcomes in an at-Risk neighborhood. *Journal of Applied Sociology/Sociological Practice*, *22, 2*(7, 2), 1–15.

[30] Association of Maternal & Child Health Programs. (2012). Forging a comprehensive initiative to improve birth outcomes and reduce infant mortality: policy and program options for state planning. Retrieved from http://www.amchp.org/PROGRAMSANDTOPICS/WOMENS-HEALTH/INFANT-MORTALITY/Pages/default.aspx.

[31] An evaluation of the program in Florida, The Magnolia Project, found small decreases in infant mortality, low birth weight, and very low birth weight after its first two years of implementation. Will, J. A., Hall, I., Cheney, T., & Driscoll, M. (2005). Flower Power : Assessing the impact of the Magnolia Project on reducing poor birth outcomes in an at-Risk neighborhood. *Journal of Applied Sociology/Sociological Practice*, *22, 2*(7, 2), 1–15.

[32] Lu, M. C., Kotelchuck, M., Hogan, V., Jones, L., Wright, K., & Halfon, N. (2010). Closing the black-white gap in birth outcomes: A life-course approach. *Ethnicity & Disease, 20*, 62-76.

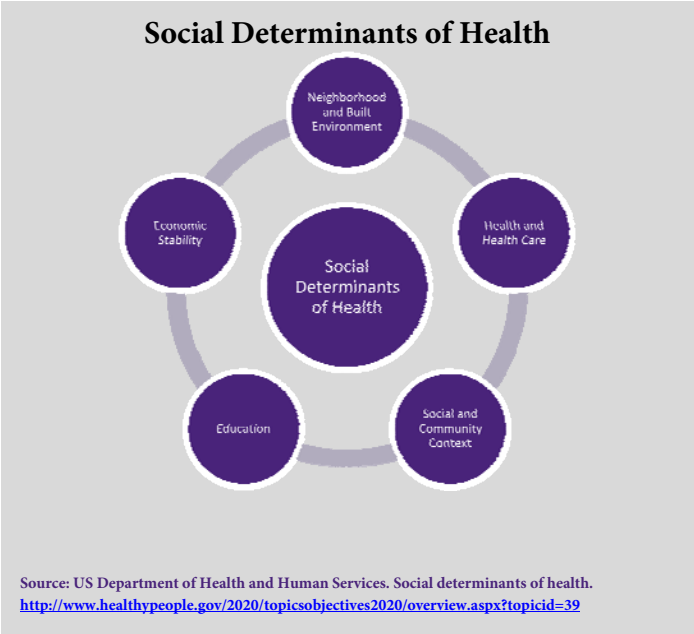
[33] Lu, M. C. (2014). Improving maternal and child health across the life course: where do we go from here? *Maternal and Child Health Journal*, *18*(2), 339–43. doi:10.1007/s10995-013-1400-0

[34] Ibid.

interconception and preconception care as well as quality prenatal care and health care over the life course.[35] [36] Several of the national experts, local experts, and national programs interviewed for this study echoed the need to focus on both the preconception and prenatal time periods. One national expert interviewed noted, "we have to identify the women before they are pregnant to make sure they are healthy…" Local experts interviewed also highlighted the importance of the life course perspective as it relates to high rates of unplanned pregnancies and the need to educate and support women who may be at higher risk throughout their lifespan.

Key Theme #3: Target social determinants of health

Literature stresses the importance of going beyond the biomedical model and individual interventions to address families and community systems that may influence the health of pregnant women, families, and communities.[37] [38] This departs from other approaches and creates a new paradigm by addressing the social and economic inequities that underlie health disparities.[39] The literature also emphasizes the need for a focus on policy and systemic issues, urging policymakers, healthcare providers, and leaders across multiple sectors to evaluate and formulate social and economic policies that improve the underlying living conditions that impact health.[40] Some of the most prominent themes that surfaced in the literature and interviews are outlined below.



Source: US Department of Health and Human Services. Social determinants of health. http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39

- **Racism:** Racism has been linked to poor birth outcomes, and it is thought to do so through increasing stress, increasing social isolation, and decreasing the quality of health care provided.[41] National and local experts interviewed noted the impact of racism on health disparities in birth outcomes which often manifests in the form of stress from racial profiling and discrimination. "We really need to address institutional racism as it exists," noted one national expert interviewee. "Nobody wants to do that. Nobody wants to hear that word. It exists. It is there and we need to address it. One of the things that we need to change is to train our doctors and our nurses so they know when they are treating people that have less resources that they don't call them underprivileged. The language that we use, it is really part of the system that holds

[35] Ibid.
[36] Ibid.
[37] Ibid.
[38] Christopher, G. C., & Simpson, P. (2014). Improving birth outcomes requires closing the racial gap. *American Journal of Public Health*, 104(S1), 10–13. doi:10.2105/AJPH.2013.301765
[39] Ibid. #
[40] Williams, D. R., Costa, M. V., Odunlami, A. O., & Mohammed, S. A. (2008). Moving upstream: How interventions that address the social determinants of health can improve health and reduce disparities. *Journal of Public Health Management and Practice, 14,* 8-17.
[41] Giurgescu, C., McFarlin, B. L., Lomax, J., Craddock, C., & Albrecht, A. (2011). Racial discrimination and the black-white gap in adverse birth outcomes: A review. *Journal of Midwifery & Women's Health, 56*(4), 362–70.

people down…language is a barrier that needs to be addressed and nobody is ready to address it yet." In an effort to address this issue, the National Healthy Start Association developed the "Toolkit for MCH Leaders Addressing Racism's Impact on Infant Mortality" as a resource and planning guide for organizations and providers.[42]

- **Intergenerational impact:** Consistent with the literature,[43] national and local experts interviewed noted the importance of considering generational issues including internalized stress and racism. They also shared that health and pregnancy information is often passed down from generation to generation; this may include misconceptions about health as well. Interviewees noted this pointed to the need to connect with the women before they are pregnant in order to impact generations of information, attitudes, and behaviors.
- **Healthy food access and nutrition:** Adequate nutrition is critical before and during pregnancy to facilitate healthy development of the child, particularly in regards to neurodevelopment.[44] [45] To improve birth outcomes, nutrition interventions are considered most impactful during critical periods early in pregnancy.[46] Adequate maternal nutrition during pregnancy can also help support the child's health long after birth.[47] Several national and local expert interviewees highlighted food insecurity, access to healthy food options, and information about nutrition as real and pressing issues that impact birth outcomes. One national expert noted, "A lot of them go hungry at night. Four out of seven pregnant women go to bed hungry….that should not happen." A common feature of prenatal programs is a nutrition education component. In Los Angeles, First 5 LA has leveraged funds to help address barriers to food access through its work with the California FreshWorks Fund as well as with WIC that provides food to women who are pregnant or new mothers.
- **Poverty and economic instability:** Poverty was noted by multiple national and local experts as a significant issue, reflecting a theme also found in the literature review. [48] [49] As one local expert interviewee shared, "Poverty is one of the biggest problems. We need to help women of poverty get equal access." Other national and local experts interviewed highlighted the need to provide support for employment and training, housing, education, childcare, and transportation as well as safety and violence issues.
- **Stress:** Stress is a common theme in some of the social determinants described above as well as its impact on birth outcome overall.[50] [51] Of particular concern is toxic stress.[52] This type of stress is strong

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[42] For more information see: http://www.nationalhealthystart.org/site/assets/docs/TakingFirstStepSupplementBooklet.pdf

[43] Christopher, G. C., & Simpson, P. (2014). Improving birth outcomes requires closing the racial gap. *American Journal of Public Health*, *104*(S1), 10–13. doi:10.2105/AJPH.2013.301765

[44] Herman, D. R., Taylor Baer, M., Adams, E., Cunningham-Sabo, L., Duran, N., Johnson, D. B., & Yakes, E. (2014). Life course perspective: evidence for the role of nutrition. *Maternal and Child Health Journal*, *18*(2), 450–61. doi:10.1007/s10995-013-1280-3

[45] Alio, A. P., Richman, A. R., Clayton, H. B., Jeffers, D. F., Wathington, D. J., & Salihu, H. M. (2010). An ecological approach to understanding black-white disparities in perinatal mortality. *Maternal and Child Health Journal*, *14*(4), 557–66. doi:10.1007/s10995-009-0495-9

[46] Alio, A. P., Richman, A. R., Clayton, H. B., Jeffers, D. F., Wathington, D. J., & Salihu, H. M. (2010). An ecological approach to understanding black-white disparities in perinatal mortality. *Maternal and Child Health Journal*, *14*(4), 557–66. doi:10.1007/s10995-009-0495-9

[47] Herman, D. R., Taylor Baer, M., Adams, E., Cunningham-Sabo, L., Duran, N., Johnson, D. B., & Yakes, E. (2014). Life course perspective: evidence for the role of nutrition. *Maternal and Child Health Journal*, *18*(2), 450–61. doi:10.1007/s10995-013-1280-3

[48] Lu, M. C., Kotelchuck, M., Hogan, V., Jones, L., Wright, K., & Halfon, N. (2010). Closing the black-white gap in birth outcomes: A life-course approach. *Ethnicity & Disease, 20*(2), 62-76.

[49] Alio, A. P., Richman, A. R., Clayton, H. B., Jeffers, D. F., Wathington, D. J., & Salihu, H. M. (2010). An ecological approach to understanding black-white disparities in perinatal mortality. *Maternal and Child Health Journal, 14*(4), 557–566.

[50] Ibid.

[51] Giurgescu, C., McFarlin, B. L., Lomax, J., Craddock, C., & Albrecht, A. (2011). Racial discrimination and the black-white gap in adverse birth outcomes: A review. *Journal of Midwifery & Women's Health, 56*(4), 362–70.

[52] Toxic stress is the stress response resulting from intense adverse experiences that may be sustained over a long period of time. This chronic exposure to stressful events leads to a prolonged activation of the stress response system which can lead to permanent changes in the development of the brain. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. (2008). *The Effects of Childhood Stress on Health Across the Lifespan.* Retrieved from: http://www.cdc.gov/ncipc/pub-res/pdf/childhood_stress.pdf

and persistent over the course of a lifetime and can wear on multiple biological systems.[53] [54] The impact of stress on emotional and physical health is well documented. In particular, stress due to social and environmental stressors is thought to act in different ways such as increasing susceptibility to infection[55] and increasing the likelihood of preterm birth.[56]

Key Theme #4: Increase access to and quality of culturally competent health care[57]

Quality and access to affordable and comprehensive health care continues to be at the forefront of national efforts to reform and improve the healthcare system. This is particularly important for high-risk women. One national expert interview participant suggested, "At the policy level, First 5 LA could have a policy role in making sure care coalitions connect with the social health model and not just traditional model…and connect to comprehensive insurance coverage." Longitudinal studies have associated Medi-Cal and Medicaid expansion with increased utilization of prenatal care in the 1990s and early 2000s.[58] [59] Researchers are now calling for insurance policies that encourage regular assessment and the specialized health care needed to improve birth outcomes for high-risk women.[60]

> "There are great disparities for African-Americans[…] particularly those that are uninsured or underinsured […] and there are a lot of people who have barriers to care. They have barriers getting to the clinic [and] getting to doctor's office..."
>
> ~ National Expert Interview Participant

National and local experts interviewed also noted concerns about quality of care and the extent to which health practitioners are implementing best practices. One local expert interviewed suggested that the high rates of C-sections in Los Angeles County may signal a need for retraining and education of doctors and hospital staff. "There is a lack of knowledge among staff that work in clinics and facilities that provide service to this population," one local expert interview participant noted. "We need to educate them about best practices." Multiple local experts interviewed also

[53] Shonkoff, J. P., & Garner, A. S. (2012). The lifelong effects of early childhood adversity and toxic stress. *Pediatrics*, *129*(1), e232–246. doi:10.1542/peds.2011-2663

[54] Pachter, L. M., & Coll, C. G. (2009). Racism and child health: A review of the literature and future directions. *Journal of Developmental and Behavioral Pediatrics*, *30*(3), 255–263. doi:10.1097/DBP.0b013e3181a7ed5a.Racism

[55] Ibid.

[56] Wadhwa, P. D., Entringer, S., Buss, C., & Lu, M. (2012). The contribution of maternal stress to preterm birth: Issues and considerations. *Clinical Perinatalogy*, *38*(3), 351–384.

[57] Health care utilization was not a focus of the literature reviewed and interviewees. This study focused on looking at systems and community-level factors for birth outcomes rather than the role of women's health behaviors. As a result many of the findings were about how the system could support women to have high quality care, rather than whether women would make use of care available.

[58] Annum, E. A., Retchen, S. M., & Strauss, J. (2010). Medicaid and preterm birth and low birth weight: *Journal of Women's Health*, *19*(3), 443–452.

[59] Rittenhouse, D. R., Braveman, P., & Marchi, K. (2003). Improvements in Prenatal Insurance Coverage and Utilization of Care in California: An Unsung Public Health Victory. *Maternal and Child Health Journal*, *7*(2), 75–86.

[60] Zhang, S., Cardarelli, K., Shim, R., Ye, J., Booker, K. L., & Rust, G. (2013). Racial disparities in economic and clinical outcomes of pregnancy among Medicaid recipients. *Maternal and Child Health Journal*, *17*(8), 1518–1525. doi:10.1007/s10995-012-1162-0

noted that doctors and hospitals should be held accountable for their C-section rates, which research has shown are higher among African-Americans than other race/ethnicities.[61] [62]

Both the literature and one national program interview participant underscored the importance of culturally competent health care as a critical component of quality. By promoting culturally competent communication with African-American women[63] primary care providers will be better equipped to screen for conditions and refer women to appropriate services. The Association of Maternal and Child Health Program's June 2012 report recommends incorporating the federal standards for the Culturally and Linguistically Appropriate Services as well as organizational assessment, training, and technical assistance focused on cultural competency.[64] The main principle of the federal standard is to "provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs."[65] Additional training and support may be needed to ensure culturally-responsive services.

The issue of access and quality extends to mental health services as well. Both the literature and local experts interviewed noted the importance of providing access and quality mental health services and screening for women before, during, and after pregnancy.[66] One issue is that African-American women may be less likely to utilize mental health services due to the stigma of doing so.[67] Two local experts further highlighted the need for training of mental health professionals on perinatal depression and mood disorders. They went on to note that Medi-Cal coverage is only available for six months postpartum and a mother may need mental health services beyond six months. The review of the literature revealed some additional insights about interventions that integrate behavioral counseling in primary care settings. A report on the DC-Hope program shows initial promise with the implementation of a theory-driven multilevel intervention[68] with low income African-American women in prenatal care settings. The study revealed that integrated interventions addressing multiple risks simultaneously can be successfully implemented in prenatal, primary care settings, assuming sufficient provider skill and flexibility in delivery of care. While the integrated intervention approach shows promise, the authors note the need to better understand ways to improve patient adherence and engage women who have complex and multiple risk factors.[69] With a focus on integration as part of the Affordable Care Act (ACA), this may be an area that warrants more exploration.

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[61] Getahun, D., Strickland, D., Lawrence, J. M., Fassett, M. J., Koebnick, C., & Jacobsen, S. J. (2009). Racial and ethnic disparities in the trends in primary cesarean delivery based on indications. *American Journal of Obstetrics and Gynecology*, *201*(4), 422.e1–7. doi:10.1016/j.ajog.2009.07.062

[62] Marie, L., Henley, M. M., & Roth, L. M. (2012). Unequal motherhood: racial-ethnic and socioeconomic disparities in cesarean sections in the United States. *Social Problems*,*59*(2), 207–227. doi:10.1525/sp.2012.59.2.207.

[63] Alio, A. P., Richman, A. R., Clayton, H. B., Jeffers, D. F., Wathington, D. J., & Salihu, H. M. (2010). An ecological approach to understanding black-white disparities in perinatal mortality. *Maternal and Child Health Journal, 14*(4), 557–66.

[64] For more information see: http://www.amchp.org/programsandtopics/womens-health/infant-mortality/Documents/AMCHP%20Birth%20Outcomes%20Compendium%202012.pdf

[65] For more information see: http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15

[66] Witt, W.P. , Wisk, L.E., Cheng, E.R., Hampton, J. M., & Hagen, E. W. (2012). Preconception mental health predicts pregnancy complications and adverse birth outcomes: A national population-based study. Maternal and Child Health Journal*, 16, 1525*-1541.

[67] Leis, J.A., Mendelson, T., Perry, D. F., & Tandon, D. (2011). Perceptions of mental health services among low-income, perinatal African-American women. *Women's Health Issues, 21,* 4, 314-319.

[68] The DC-HOPE intervention aimed to address multiple existing risks factors simultaneously. It included elements from social ecological, transtheoretical, and cognitive behavioral treatment models. Katz, K. S., Blake, S. M., Milligan, R. A., Sharps, P. W., White, D. B., Rodan, M. F., & Murray, K. B. (2008). The design, implementation and acceptability of an integrated intervention to address multiple behavioral and psychosocial risk factors among pregnant African-American women. *BMC Pregnancy and Childbirth, 8*(1), 1-22.

[69] Ibid.

Key Theme #5: Facilitate multi-stakeholder collaboration that promotes sustainable change at the community and systems-level

In recent years, there have been several promising examples of birth outcome initiatives that combine a collaborative multi-stakeholder approach with the life course perspective. Some of these models can be found in Alameda County (California), Northeast Florida, and Wisconsin where there is strong collaboration and a shared vision and approach for improving health across the life course.[70] When working with community partners, the initiative in Alameda County developed a broad vision of the life course perspective and health equity in general; they found that focusing on a more narrow set of health outcomes, such as infant mortality, did not align with the goals of each of their diverse community partners.[71]

In communities where people have experienced racial/ethnic inequality, successful interventions are responsive to community needs, reflect the community experience, and engage community members in meaningful ways. The literature and national programs reviewed provide strong examples of multi-agency community initiatives that focus on reducing health disparities through strong organizational collaboration and community engagement. All programs reviewed for this study included community engagement, leadership, and advocacy to create meaningful and lasting change. The literature suggests the potential benefit to empowering communities, both to begin to correct past inequalities and to work to improve the local community.[72] [73] One of the national experts interviewed also stressed the need to involve the community as part of program planning and implementation. Ultimately, the intention is to engage organizations and community members as partners in developing solutions to issues they care about. However, evidence of the impact of these interventions on birth outcomes is still lacking, as many of these initiatives are relatively newly implemented.[74] Please see Exhibit 2 for an example of one model program's goals and key partners needed to achieve the goals.[75]

> "The community voice is the most important voice to be heard.[…] we have to be able to take the community's voice and take it to places where community is not recognized. The voice of the community is always the voice to be heard first. Whatever we do, we listen to what community has to say and we follow the community."
>
> ~National Expert Interview Participant

[70] Rohan, A. M., Onheiber, P. M., Hale, L. J., Kruse, T. L., Jones, M. J., Gillespie, K. H., Lathen, L.S., & Katcher, M. L. (2014). Turning the ship: making the shift to a life-course framework. *Maternal and Child Health Journal, 18*(2), 423–30.

[71] Please see Appendix A for more information about the Alameda County Building Block Collaborative including a full description and lessons learned to date.

[72] Frey, C. A., Farrell, P. M., Cotton, Q. D., Lathen, L. S., & Marks, K. (2014). Wisconsin's lifecourse initiative for healthy families: Application of the maternal and child health life course perspective through a regional funding initiative. *Maternal and Child Health Journal.18*(2), 413-422.

[73] Lu, M. C., Kotelchuck, M., Hogan, V., Jones, L., Wright, K., & Halfon, N. (2010). Closing the black-white gap in birth outcomes: A life-course approach. *Ethnicity & Disease, 20*(2), 62-76.

[74] Northeast Florida noted a decline in infant and neonatal mortality in recent years since implementing the intervention, although this decline was for women overall, rather than African-American's in particular. Brady, C., & Johnson, F. (2014). Integrating the life course into MCH service delivery: From theory to practice. *Maternal and Child Health Journal*, *38*(2), 380-388.

[75] The Northeast Florida program is highlighted in the exhibit since there is public information about its partners and the goals partners are involved with. Please see the source document for more information about the program's strategies. Similar information was not publically available for other programs reviewed such as the Alameda County Building Block Collaborative.

Exhibit 2: Northeast Florida Healthy Start Coalition goals and critical partners by lifecourse phase

	Goals	Critical Partnerships
Preconception	1. Help simplify enrollment and use of Medicaid family planning waiver 2. Provide preconception health information and linkages to services to young women and men 3. Provide preconception education to mothers whose children are enrolled in the program 4. Preconception health, folic acid promotion 5. Smoking cessation 6. Provide consistent, accurate information on baby spacing 7. Outreach, linkage to medical homes for uninsured	1. State Agency for Health Care Administration 2. Universities and private colleges, community colleges, juvenile justice programs, outward bound, half-way houses, the Tiger SHOP, foster care group homes 3. WIC 4. March of Dimes 5. Area Health Education Centers, health departments, Florida Quit Line 6. OB/GYNs 7. Hospital Emergency Room Alternatives Program
Pregnancy & Childbirth	1. Address C-section rates, voluntary inductions, low prenatal screening rates 2. Smoking cessation 3. Family planning 4. Medicaid eligibility, coverage, and enrollment process 5. Healthy Start prenatal screening 6. Promotion of responsible fatherhood, male involvement 7. Postpartum breastfeeding, risks associated with postpartum obesity, chronic disease 8. Chronic disease and relationship to maternal mortality	1. Delivering hospitals and OBs 2. American Lung Association, etc. 3. Family planning providers in the community 4. Agency for Health Care Administration & Department for Children & Families 5. OBs, prenatal care providers 6. Jacksonville Urban League, Head Start, county health departments, other community-based initiatives 7. WIC 8. Healthy People, Healthy Communities

Excerpt from Northeast Florida Healthy Start Coalition, Inc.'s Healthy Start Service Delivery Plan 2009-2014

Key Theme #6: Provide social support during pregnancy

Researchers highlight social support as a promising mechanism for improving birth outcomes. Specifically, social support is thought to reduce stress, provide emotional support, as well as provide tangible resources such as someone to drive women to appointments and encourage healthy behaviors. While evidence on community interventions is limited, research on social support interventions have demonstrated how building social support during pregnancy may improve birth outcomes.[76] Some examples of effective interventions that increase social support among pregnant women are home visitation and group prenatal care.[77] [78] [79] Centering Pregnancy is a group prenatal care intervention that has been gaining attention from researchers and funders. There is growing research on the effectiveness of group prenatal care, including a few randomized control trials that demonstrate improved birth outcomes such as reduced rates of preterm birth, low birth weight, and caesarean delivery in comparison to traditional prenatal care.[80] [81] [82] Centering Pregnancy was also highlighted

[76] Manant, A., & Dodgson, J. E. (2011). Centering Pregnancy: an integrative literature review. *Journal of Midwifery & Women's Health*, *56*(2), 94–102. doi:10.1111/j.1542-2011.2010.00021.

[77] Novick, G., Reid, A. E., Lewis, J., Kershaw, T. S., Rising, S. S., & Ickovics, J. R. (2013). Group prenatal care: model fidelity and outcomes. *The American Journal of Obstetrics & Gynecology, 209*(2), 112.e1–112.e6.

[78] Picklesimer, A. H., Billings, D., Hale, N., Blackhurst, D., & Covington-Kolb, S. (2012). The effect of Centering Pregnancy group prenatal care on preterm birth in a low-income population. *American Journal of Obstetrics & Gynecology*, *206*(5), 415.e1–415.e7.

[79] Peacock, S., Konrad, S., Watson, E., Nickel, D., & Muhajarine, N. (2013). Effectiveness of home visiting programs on child outcomes: a systematic review. *BMC Public Health*, *13*(1), 1.

[80] Picklesimer, A. H., Billings, D., Hale, N., Blackhurst, D., & Covington-Kolb, S. (2012). The effect of Centering Pregnancy group prenatal care on preterm birth in a low-income population. *American Journal of Obstetrics & Gynecology*, *206*(5), 415.e1–415.e7.

[81] Tanner-Smith, E. E., Steinka-Fry, K. T., & Lipsey, M. W. (2013). The effects of Centering Pregnancy Group Prenatal Care on gestational age, birth weight, and fetal demise. *Maternal and Child Health Journal*. doi:10.1007/s10995-013-1304-z

by some of the national programs and local experts interviewed and is being implemented by two of the programs reviewed for this study. In addition, the group prenatal care model is one of three models part of the United States Department of Health and Human Services' Strong Start for Mothers and Infants implementation announced in February 2014.[83] Increasing social support is possible at the community level as well. One example is "One Hundred Intentional Acts of Kindness," a community participatory project implemented in Los Angeles to increase social support among pregnant women.[84]

Centering Pregnancy

Centering Pregnancy has three main components:

1. **Health assessment** with a licensed health care provider at group sessions.
2. **Education** consisting of facilitated sessions, with discussion guided by interests of group participants.
3. **Support** provided by other group members through the interactive group sessions.

Source: Centering Healthcare Institute, https://www.centeringhealthcare.org

Limitations

Each of the key themes were noted in interviews and also strongly grounded in research literature, primarily drawing from research on the relationship between key personal, social and community factors, and birth outcomes.[85] However, there are few rigorous evaluations that demonstrate that implementing these themes will reliably improve health disparities in birth outcomes in different community settings. Evaluations that have been done have focused on small-scale interventions, rather than interventions at the systems level. This means it is unclear what effect can be expected on health disparities in birth outcomes when implementing these themes in the community. Some key themes also draw on review of a few promising larger scale initiatives, most of which are grounded in the life course perspective. However, many of these interventions are relatively newly implemented and have not had time to demonstrate long-term impact on communities or identify which aspects of their strategies are necessary and sufficient to achieve intended impact.[86] The reports that do describe success at sites such as Northeast Florida Healthy Start Coalition, still leave the question of how to translate these efforts to a different scale, with perhaps fewer resources or organizational partnerships.[87] This means that it is unknown how to best adapt these model programs and initiatives to a different scale and/or geography, while still achieving the same successes. What the literature does provide are many possible options that, with further study, could potentially be successfully integrated into existing communities and systems.

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[82] Tilden, E. L. (2014). Group prenatal care review of outcomes and recommendations for model implementation. *Obstetrics and Gynecology*, *69*(1), 46–55.

[83] The LA County Department of Health Services is one of the grantees for a different program model (Maternity Care Home). For more information see: http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4537&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date

[84] Jones, L., Lu, M. C., Lucas-Wright, A., Dillon-Brown, N., Broussand, M., Wright, K. et al,. (2010). One hundred acts of intentional kindness toward a pregnant woman: Building reproductive social capital in Los Angeles. *Ethnicity and Disease*, *20*(1), 36–40.

[85] Much of the literature cited in this section draw from qualitative, correlational, or longitudinal research or literature reviews.

[86] Lu, M. C. (2014). Improving maternal and child health across the life course: where do we go from here? *Maternal and Child Health Journal*, *18*(2), 339–43. doi:10.1007/s10995-013-1400-0

[87] Policy and community level initiatives for improving birth outcomes are also often studied using quasi-experimental designs, such as those that observe changes in health indicators over time or compare participants in the initiative with those who do not participate; each of these approaches can lead to uncertain conclusion of the true nature of the initiative's impact. Taylor, Y. J., & Nies, M. A. (2013). Measuring the impact and outcomes of Maternal Child Health Federal Programs. *Maternal and Child Health Journal*, 886–896. doi:10.1007/s10995-012-1067-y

LESSONS LEARNED & PROMISING PRACTICES

This section highlights lessons learned from five model programs across the United States. These programs were chosen to be highlighted because they are focused on systems change to address health disparities in birth outcomes. These programs and their lessons learned are included in this report as models of how First 5 LA may consider learning from and incorporating elements of these programs in its systems change work moving forward. The programs were identified during the literature review and early interview process. The information highlighted below was either identified as part of an interview with the program and/or documented lessons learned in reports or articles about the program. Each program is at different stages of implementation providing different lessons based on their stage of development. The programs included are **Alameda County Building Block Collaborative**, **Best Baby Zone**, **Magnolia Project,** [1] **Missouri Foundation for Health Infant Mortality Initiative**, and **Wisconsin Lifecourse Initiative for Healthy Families**. Please see Appendix A for more information and lessons from each specific program.

> *"Shifting a paradigm is slow…investments in learning, creating space for inspiration and possibility, building new relationships and partnerships, and testing new apaches lays the groundwork for lasting change."*[2]

Partnership & Collaboration: Identify existing structures, resources, organizations, and people that share a common vision and interest in this work. Convene stakeholders to share information, identify priorities, and build strong collaborative relationships. Build trust, shared ownership, and collective vision among stakeholders by using strategies such as partners being actively involved in planning meetings, facilitating agendas, recruiting new members, and hosting meetings. Stakeholders or partners may include local and state public health departments, private philanthropy, community organizations, political leaders, and health care providers. Expect varying levels of capacity and existing infrastructure from community partners and consider the impact on the timeline. Anticipate the inherent tensions that exist between funders and potential grantees, while promoting a genuine spirit of partnership in addressing an important community issue. Create a flexible partnership structure such as a tiered engagement structure to allow for different levels of involvement. Support partners' capacity by offering trainings and scholarships.

Planning: Planning takes considerable resources, time, and deep commitment from leaders and partners. Build collective and broad goals by conducting an open process in order to understand and build on all partners and community strengths as well as existing community priorities. Transitions in leadership and staffing can create delays and challenges, particularly when a project is built around one person. It is important to institutionalize work and engage multiple stakeholders in providing leadership.

Time & Education: Allow sufficient time for planning to ensure full community-driven process and buy-in, particularly when introducing a new concept like the life course perspective. Even with presentations and education, some partners may need help incorporating this new concept into their daily work. Use a train-the-trainer model to help build capacity and knowledge. Gaining buy-in from collaborators can be a challenge at the beginning since the life course perspective can involve addressing a wide range of risk, protective factors, and critical periods.

Communication & Staffing: Communication is essential. During the planning phase, provide clear communication about goals and outcomes. Conduct ongoing communication and information sharing among partners. Multiple national programs created learning collaboratives so they could share what is working and what is not. Ensure that there is dedicated staff to plan, facilitate, and manage regular meetings with partners, trainings, collective funding opportunities, implementation projects, and ongoing communications.

Program Design: Focus on preconception and the lifecourse model. It is important to impact women before pregnancy and provide a system of care that spans reproductive health services, health education, and case management. Utilize culturally appropriate and evidence-based approaches whenever possible. Programs and services should in an accessible location. For example, the Magnolia Project has a storefront location with walk-in services during nontraditional hours that are located by a bus line. WIC and an immunization provider are next door and there are on-site case management and clinic services that are person-centered and strengths-based. It is also important to ensure staff reflect and understand the needs of the community.

Funder: Funders can play a critical role as a convener and can help ensure the project is community-driven. Funders need to be reflective and flexible, understanding that their roles may shift as they apply learning from one initiative to other initiatives. For example, the Wisconsin program is applying their healthy families planning model to a new obesity initiative also focused on community systems of change. Community-driven initiatives require some risk taking and funders may need to consider and shift their organizational culture.

Evaluation: Given the complex nature of this work, measuring progress and tracking systems change is challenging. Evaluation should focus on learning and continuous quality improvement.

[1] The Magnolia Project is affiliated with the Northeast Florida Healthy Start Coalition.

[2] Shrimali, B. P., Luginbuhl, J., Malin, C., Flournoy, R., & Siegel, A. (2014). The building blocks collaborative: advancing a life course approach to health equity through multi-sector collaboration. Maternal and Child Health Journal, 18(2), 373–379. doi:10.1007/s10995-013-1278-x

Considerations for Future

The previous themes provide solid evidence of the need and opportunity to target women during preconception and pregnancy as well as to examine the systemic issues that contribute to higher rates of preterm births and low birth weights among African-American women specifically. For First 5 LA, this may include taking a more comprehensive and systems-level focus, while targeting populations with the highest needs. Key considerations for future work are articulated in this section. Considerations are organized around five areas: programs, policy and advocacy, public education, capacity building, and partnerships. Unless otherwise noted all information in this section builds upon the themes discussed earlier in the report and are derived from the literature and interviews. A "menu" of potential strategies is also provided to help inform planning discussions and fodder for future work.[88] First 5 LA may wish to engage other stakeholders to explore opportunities and priorities for implementation in Los Angeles County.

Programmatic Considerations

Explore ways to leverage current program investments by incorporating focus on preconception and prenatal time periods

There is an array of current First 5 LA investments that directly or indirectly help ensure that children are born healthy. In particular, the Building Stronger Families framework seeks to enhance protective factors by connecting parents to supportive networks and resources in high need Best Start communities. Based on the Building Stronger Families framework, First 5 LA's community-building efforts appear to be focused on strengthening many of the issues outlined in this study, including addressing the health disparities and the social determinants of health. Best Start also offers an important linkage to women of all ages in order to provide information, education, and support. In addition to the Black Infant Health program, there is also a strong programmatic, content, and target participant connection to intensive home visitation services currently being implemented by First 5 LA. Potential programmatic strategies might include building upon existing programs as well as leveraging external relationships and institutional partners:

- ***Continue to support current programs focused on prenatal, high risk women*** (Black Infant Health). This may entail exploring enhancements to existing programs and sharing lessons learned with other First 5 LA programs (i.e., Welcome Baby, Select Home Visitation, and Baby Friendly Hospital).
- Assess the full portfolio of First 5 LA investments to determine opportunities to ***integrate a prenatal component and/or message into other current programs*** (i.e., peer support groups for parents, Welcome Baby, Select Home Visitation, Baby Friendly Hospital).
- Integrate pregnancy and birth outcomes education, awareness, and support into the ***Best Start*** place-based efforts. Example activities could include sharing the "100 Intentional Acts of Kindness for Pregnant Women"[89] and establishing peer mentoring programs in the model of the Birthing Project USA.[90]

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[88] The Association of Maternal and Child Health Programs has a June 2012 report outlining relevant policy and program options for the state level. Some of these efforts may also be appropriate for First 5 LA to consider. For information see: http://www.amchp.org/programsandtopics/womens-health/Focus%20Areas/improvingbirthoutcomes/infant-mortality/Documents/AMCHP%20Birth%20Outcomes%20Compendium%202012.pdf

[89] Jones, L., Lu, M. C., Lucas-Wright, A., Dillon-Brown, N., Broussard, M., & Wright, K. (2010). One hundred intentional acts of kindness toward a pregnant woman: Building reproductive social capital in Los Angeles. *Ethnicity & Disease*, *20*, 36-40. This activity was noted by a national expert as well as within literature reviewed. This activity was noted by a national expert as well as within literature reviewed.

[90] For more information see: http://www.birthingprojectusa.org/modelprograms.html This program model is being implemented as part of the Wisconsin Lifecourse Initiative for Healthy Families. Please see Appendix A for more information about that model program.

- Ensure that ***First 5 LA staff reflect the community*** they serve. Multiple local experts interviewed noted that First 5 LA events are not always inviting to the African-American community. In particular, they noted it was alienating to the African-American community to have some meetings primarily in Spanish.
- Explore ***funding partnerships*** with other existing preconception and prenatal programs for high risk women.

Policy and Institutional Practices

Explore opportunities to influence policy, advocacy, and institutional practices

The literature and interviews emphasize the importance of a more comprehensive approach that goes beyond health interventions to create policies and practices that address health disparities and improve access and quality of care.[91] This may include a focus on the practices of hospitals and clinical providers as well as advocacy efforts to improve health access among underserved populations. Policy and systems-level efforts might also include advocating for state and federal funding for maternal and child health programs. Potential policy strategies might include:[92]

- Continue current policy efforts focused on addressing health disparities and improving birth outcomes in the following focus areas that were identified in national and local expert interviews:
  - Partner with the Los Angeles County Department of Public Health to promote and encourage health providers to pursue ***comprehensive perinatal services center certification***[93]
  - Advocate for robust ***family leave***
  - Promote insurance coverage to pay for established ***best practices during pregnancy and delivery*** (e.g., urine culture versus dip stick for infection screening)
  - Advocate for ***non-traditional hours at community clinics*** (evening and weekend hours) to meet the needs of working women and men
  - Promote expansion of ***food stamps and WIC coverage***
  - Encourage ***hospitals and doctors to publically disclose*** birth outcomes and C-section rates
- Promote the ***rebranding of Maternal and Child Health*** to include fathers and create more welcoming environments and participation for ***fathers*** in prenatal and delivery activities to enhance social supportIdentify and prioritize which of the current health disparities and birth outcome policy efforts may need ***more focus and attention*** in order to encourage policy change.
- Identify how First 5 LA can act as a ***facilitator, catalyst, and leader*** in coordinating related policy efforts with other partners and funders.

[91] There is some literature available on related policies initiatives. This literature shows somewhat inconsistent impacts of policies on birth outcomes, potentially due to differences in policy implementation across different studies. Taylor, Y. J., & Nies, M. A. (2013). Measuring the impact and outcomes of Maternal Child Health Federal Programs. *Maternal and Child Health Journal*, 886–896. doi:10.1007/s10995-012-1067-y

[92] This study's advisory workgroup noted that these policy areas are already being pursued. The advisory workgroup also suggested a broader facilitative and leadership role that First 5 LA could play related to policy in this area.

[93] For more information see: http://www.cdph.ca.gov/healthinfo/healthyliving/childfamily/Pages/CPSP.aspx This specific certification program was suggested by a local expert interviewed.

Public Education

Educate women and the public about how to prevent poor birth outcomes and reduce risks

The literature and interviews noted that public awareness about birth outcomes and health disparities is limited. First 5 LA can play a key role in educating the public as part of existing campaigns and/or regular communications with First 5 LA's key stakeholders. A common theme among interview participants was the need for more information, public education, and resources. Potential public education strategies might include:

- Promote public awareness about ***infant mortality*** and the importance of ***preconception and prenatal focus*** to improve birth outcomes. The National Healthy Start Association has a resource document for community organizations about establishing an infant mortality awareness campaign.[94] Another resource is the National Organization for MCH Leaders' "MCH Lifecourse Toolbox."[95]
- Increase women's ***awareness and knowledge about important protective and risk factors*** such as birth spacing, contraception, breastfeeding, and health best practices before and during pregnancy. One local expert interviewed suggested developing a *reproductive life plan booklet* for distribution to male and female youth[96] and distributing free or low cost *pregnancy and delivery resource materials* for women through public health departments, clinics, doctors, and other partners.

Capacity Building

Build capacity and provide trainings to program and community partners

The literature and interviews noted opportunities to support and provide additional training to partners and others groups so that they can better address poor birth outcomes. First 5 LA can play a key role in building capacity and providing training to bolster the field. Potential strategies for building capacity include:

- Promote ***cultural competency*** training as well as ***continuing education*** to clinics and hospital in areas that impact birth outcomes (i.e., screening and monitoring for chronic disease and infection)
- Provide content knowledge and technical assistance about birth outcomes and health disparities to other entities that conduct ***advocacy training*** to community organizations.
- Provide training and capacity building to community organizations and clinics on addressing ***social determinants of health*** (i.e., racism and intergenerational impact of health). Multiple resources and ideas are available on the National Healthy Start Association's website and specifically "Toolkit for MCH Leaders Addressing Racism's Impact on Infant Mortality."[97]
- Identify opportunities to ***leverage*** already established capacity building efforts and add a health disparities and birth outcomes component (i.e., Welcome Baby partners and hospital trainings).[98]

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[94] The National Healthy Start Association. (n.d.) Celebrate Day 366: Every baby deserves a change. Retrieved from http://www.nationalhealthystart.org/site/assets/docs/IMAC_ToolKit Web.pdf

[95] For more information see: http://www.citymatch.org:8080/lifecoursetoolbox/index.php

[96] The local expert interviewed suggested distribution and partnership with schools, community center, and the foster system. The CDC has a reproductive life plan model for both individuals and health professionals. For more information see: http://www.cdc.gov/preconception/reproductiveplan.html

[97] For further information see: http://www.nationalhealthystart.org/what_we_do/partnership_to_eliminate_disparities_in_infant_mortality

[98] The study's advisory workgroup suggested this potential strategy.

Partnerships

Partner with other agencies, funders, and programs as a catalyst and convener on birth outcomes

As previously mentioned, the literature, experts interviewed, and national programs reviewed for this study make a strong case for building cross sector and interagency partnerships to ensure long-term and sustained impact on health outcomes. The literature and national programs reviewed emphasize the need for creativity in breaking down silos, changing mind-sets, influencing better policies, and leveraging resources.[99] For example, there are ample opportunities to catalyze shared funding agendas and goals with other public and private funders and community stakeholders. Multi-stakeholder partnerships are central to all programs reviewed and are a main vehicle for achieving systems change. Potential strategies might include:

- ***Convene key stakeholders and partners*** throughout Los Angeles County to determine the priorities and the potential for collective action. For example, the LA Best Babies Network was the product of a 2001 convening that brought together perinatal stakeholders to discuss the need to coordinate efforts and address poor birth outcomes across the region.
- ***Develop collective plans.*** Build on previous and current collaboratives and partnerships on this topic in Los Angeles County.[100] Potential partners might include public health departments, Head Start, WIC, the foster care system, and food banks, among others. Reflect on the lessons learned highlighted in this report and as part of the five national programs reviewed.
- Serve as a ***leading resource and information*** provider related to addressing health disparities in birth outcomes. As one local expert interviewed noted, First 5 LA is already connecting with women and communities; First 5 LA can then provide to women the menu of services and resources whether through First 5 LA or through a strategic partner.

[99] Lu, M. C., Kotelchuck, M., Hogan, V., Jones, L., Wright, K., & Halfon, N. (2010). Closing the black-white gap in birth outcomes: A life-course approach. *Ethnicity & Disease, 20*(2), 62-76.

[100] In 2008, the Los Angeles County Partnership to Eliminate Disparities in Infant Mortality formed. It is not clear if the partnerships is still in existence. Core partners included LA County Department of Public Health, Black Infant Health program, March of Dimes, University of Southern California among others. Sources: http://www.publichealth.lacounty.gov/mch/reproductivehealth/pedim%20alc%20website.pdf and http://publichealth.lacounty.gov/mch/LACALC/ALC%20files/Health%20Care%20Disparities%20Brief.pdf

Fatherhood

What are promising practices and initiatives related to fatherhood (particularly those serving at risk fathers of children zero to five)?

"…children from fatherless homes are more likely to be poor, become involved in drug and alcohol abuse, drop out of school, and suffer from health and emotional problems. Boys are more likely to become involved in crime, and girls are more likely to become pregnant as teens."
National Center for Fathering[101]

Overview

In the United States fatherhood programs began in the 1970s with the growing recognition of the important role fathers play in child health and well-being.[102] Early programs focused on employment and parenting services for low-income fathers and later expanded to include a wider range of topics such as "healthy marriage and co-parenting skills training, general fatherhood competency for all income levels, support for fathers involved with the child welfare and criminal justice systems, a focus on children's education and literacy, awareness of the needs of fathers who have children with special needs, and attention to issues of domestic violence."[103] In 2006, the United States Department of Health and Human Services, Administration for Children and Families, Office of Family Assistance began releasing federal funding opportunities for fatherhood programs [104] and the White House later initiated an interagency Responsible Fatherhood Working Group. Led by the White House Office of Faith-based and Neighborhood Partnerships, the Office of Public Engagement, and the Domestic Policy Council, the goal of the work group is "to advance responsible fatherhood and stable families through enhanced coordination and collaboration across federal agencies…and to encourage fathers to take responsibility for the intellectual, emotional and financial well-being of their children."[105] Locally and nationally, there has also been an increased focus on initiatives to benefit young men of color such as the White House's My Brother's Keeper Initiative launched in February 2014[106] and The California Endowment's Sons and Brothers initiative.[107]

[101] U.S. Department of Health and Human Services. (n.d.). The consequences of fatherlessness. Retrieved from http://www.fathers.com/content/index.php?option=com_content&task=view&id=391

[102] Fatherhood Incorporated (n.d.) *Responsible Fatherhood Toolkit: Resources from the Field*. Retrieved from http://ojp.gov/fbnp/pdfs/fatherhood.pdf

[103] Ibid.

[104] Ibid.

[105] Responsible Fatherhood Working Group. (2012). Promoting responsible fatherhood. Retrieved from http://www.whitehouse.gov/sites/default/files/docs/fatherhood_report_6.13.12_final.pdf

[106] For more information see: http://www.whitehouse.gov/the-press-office/2014/02/27/fact-sheet-opportunity-all-president-obama-launches-my-brother-s-keeper-

[107] For more information see: https://www.calendow.org/sonsandbrothers.aspx

Given First 5 LA's interest in supporting the important role of fathers in early childhood development, this section of the report focuses on key themes and considerations that emerged from the review of literature, program documents, and interviews with national and local experts. These findings can help inform the development of a two-year investment for at risk fathers of children zero to five as well as other policies and practices that support the active role of fathers in child health and well-being. [108]

Key Theme #1: Recognize men as a valuable part of pregnancy and early childhood by incorporating fatherhood programs into maternal-child health programs

Maternal and Child Health (MCH) programs funded under the United States Department of Health and Human Services are designed to meet the needs of mothers and children; however, fathers play a very small role.[109] National and local experts interviewed agreed that there has been a historic emphasis on providing funding for programs targeting mothers and children with very little funding focused on fatherhood programs. In addition, these experts went on to note most MCH programs are not inclusive of fathers and a cultural shift is needed to engage fathers and make programs more father-friendly. One local expert interviewed pointed to the increase in the percentage of single-father households and suggested MCH programs offer support to this unique group. Multiple national and local experts interviewed noted the need for government agencies and services (i.e., WIC, SNAP, Section 8, welfare) as well as health care providers to provide more opportunities for fathers to participate. One area where fathers could be greater engaged are initiatives aimed at improving parenting practices or preventing child maltreatment.[110]

The literature supports the need to also expand our thinking and definition of father and father involvement.[111] Societal norms and customs sometimes create false assumptions about the extent to which fathers wish to be or should be involved. For example, the use of marital status and father's name on the birth certificates is a legal construct that presumes a certain level of involvement. Conversely, as one national expert participant noted, "We cannot assume that just because the mother is unwed, she doesn't want the father involved." Together these findings point to the need for redefining our notions of father involvement and inclusion in MCH programs.

Key Theme #2: Acknowledge that father involvement has a positive effect on child development and maternal behaviors during and after pregnancy

While more research is needed, there is evidence to suggest that father involvement has been associated with positive child development and wellbeing as well as birth outcomes.[112] [113] [114] [115] [116] Father involvement has also

[108] Further literature may be available to explore advantages of different approaches for certain sub-groups of fathers.

[109] Alio, A. P., Bond, M. J., Padilla, Y. C., Heidelbaugh, J. J., Lu, M., & Parker, W. J. (2011). Addressing policy barriers to paternal involvement during pregnancy. *Maternal and Child Health Journal, 15*(4), 425–30. doi:10.1007/s10995-011-0781-1

[110] Lee, Shawna J., Yelick, A., Brisebois, K., & Banks, K. L. (2011). Low-income fathers' barriers to participation in family and parenting programs. *Journal of Family Strengths, 11*(1), 1-16.

[111] Lu, M. C., Jones, L., Bond, M. J., Wright, K., Pumpuang, M., Maidenberg, M., Jones, D., Garfield, C., & Rowley, D. L. (2010). Where is the F in MCH? Father involvement in African-American families. *Ethnicity & Disease, 20*[Supl 2], S2-49-S2-61.

[112] Lundahl, B. W., Tollefson, D., Risser, H., & Lovejoy, M. C. (2007). A meta-analysis of father involvement in parent training. *Research on Social Work Practice, 18*(2), 97–106. doi:10.1177/1049731507309828

[113] Alio, A. P., Mbah, A. K., Kornosky, J. L., Wathington, D., Marty, P. J., & Salihu, H. M. (2011). Assessing the impact of paternal involvement on racial/ethnic disparities in infant mortality rates. *Journal of Community Health, 36*(1), 63–8. doi:10.1007/s10900-010-9280-3

[114] Magill-Evans, J., Harrison, M. J., Rempel, G., & Slater, L. (2006). Interventions with fathers of young children: systematic literature review. *Journal of Advanced Nursing, 55*(2), 248–64. doi:10.1111/j.1365-2648.2006.03896.x

been associated with healthier maternal prenatal behaviors, such as early prenatal care, decreased smoking, and drug use.[117] [118] Research further supports that father involvement mediates stress which is an important risk factor for poor birth outcomes. Father involvement during pregnancy may improve birth outcomes through providing social support, reducing stress for the mother, and providing financial resources.[119]

The timing of efforts to engage fathers is an important programmatic consideration. For example, fathers may be more actively involved during pregnancy, providing a more opportune time for intervention.[120] Research has shown that most prenatal classes help fathers prepare for childbirth; however, they do not prepare them for the transition to parenthood.[121] The transition to parenthood may affect mother-father relationships and research suggests that interventions with both prenatal and postnatal components have a stronger effect on couple communication than either prenatal or postnatal interventions alone.[122] National and local experts interviewed noted that healthcare providers should encourage fathers to be involved in the prenatal care, delivery, and the well-baby visits.

Key Theme #3: Target the father's relationship with the child's mother to promote father involvement

Father involvement with the child is associated with the quality of the relationship with the child's mother.[123] [124] [125] Before and immediately following birth, the quality of the relationship has also been associated with maternal emotional health, maternal health behaviors, and infant birth weight.[126] After birth, many unwed couples do not stay together[127] and not surprisingly, fathers who do not live with the child report less involvement with their child.[128] Whether the parents are a couple or not, improving the relationship between

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[115] The Commission on Paternal Involvement in Pregnancy Outcomes. (2010). Commission Outlook: Best and promising practices for improving research, policy and practice on paternal involvement in pregnancy outcomes. Washington, DC: Joint Center for Political and Economic Studies. Retrieved from http://www.jointcenter.org/hpi/sites/all/files/CPIPO%20Report%20051910%20Final.pdf

[116] Jones, J., & Mosher, W. D. (2013). Fathers' involvement with their children: United States, 2006-2010. *National Health Statistics Reports*, *71*, 1–22.

[117] Lu, M. C., Jones, L., Bond, M. J., Wright, K., Pumpuang, M., Maidenberg, M., Jones, D., Garfield, C., & Rowley, D. L. (2010). Where is the F in MCH? Father involvement in African-American families. *Ethnicity & Disease, 20*[Supl 2], S2-49-S2-61.

[118] Alio, A. P., Salihu, H. M., Kornosky, J. L., Richman, A. M., & Marty, P. J. (2010). Feto-infant health and survival: does paternal involvement matter? *Maternal and Child Health Journal, 14*, 931-937.

[119]Stapleton, L. R. T., Schetter, C. D., Westling, E., Rini, C., Glynn, L. M., Hobel, C. J., & Sandman, C. A. (2012). Perceived partner support in pregnancy predicts lower maternal and infant distress. *Journal of Family Psychology*, *26*(3), 453–63. doi:10.1037/a0028332

[120] Lu, M. C., Jones, L., Bond, M. J., Wright, K., Pumpuang, M., Maidenberg, M., Jones, D., Garfield, C., & Rowley, D. L. (2010). Where is the F in MCH? Father involvement in African-American families. Ethnicity & Disease, 20[Supl 2], S2-49-S2-61.

[121] Bond, M. J. (2010). The missing link in the MCH: Paternal involvement in pregnancy outcomes. *American Journal of Men's Health, 4*(4), 285-286.

[122] Pinquart, M. & Teubert, D. (2010). A Meta-analytic study of couple interventions during the transition to parenthood. *Family Relations, 59*. 221-231

[123] Lu, M. C., Jones, L., Bond, M. J., Wright, K., Pumpuang, M., Maidenberg, M., Jones, D., Garfield, C., & Rowley, D. L. (2010). Where is the F in MCH? Father involvement in African-American families. *Ethnicity & Disease, 20*[Supl 2], S2-49-S2-61.

[124] Alio, A. P., Salihu, H. M., Kornosky, J. L., Richman, A. M., & Marty, P. J. (2010). Feto-infant health and survival: does paternal involvement matter? *Maternal and Child Health Journal,* 14, 931-937.

[125] Martinson, K. & Demetra Nightingale, D. (2008). *Ten Key Findings from Responsible Fatherhood Initiatives.* Retrieved from http://www.urban.org/UploadedPDF/411623_fatherhood_initiatives.pdf

[126] Bloch, J. R., Webb, D. A., Mathws, L., Dennis, E. F., Bennett, I. M., & Culhane, J. F. (2010). Beyond marital status: The quality of mother-father relationship and its influence on reproductive health behaviors and outcomes among unmarried low income pregnant women. *Maternal and Child Health Journal, 14*, 726-734.

[127] Lu, M. C., Jones, L., Bond, M. J., Wright, K., Pumpuang, M., Maidenberg, M et al,. (2010). Where is the F in MCH? Father involvement in African-American families. *Ethnicity and Disease*, *20*, S2–S49.

[128] Jones, J., & Mosher, W. D. (2013). Fathers' involvement with their children: United States, 2006-2010. *National Health Statistics Reports*, *71*, 1–22.

the father and mother can increase father involvement.[129] [130] Increased parental alliance, or ability to work together to care for their child, has been linked with greater father involvement.[131] There are several evidence-based programs that focus on improving the relationship between the mother and father while providing instruction on parenting skills. One example is a program called Family Expectations, which is focused on the relationship between the mother and father during pregnancy and after birth. The program has been shown to improve maternal well-being, father parenting behavior, and increase father involvement (e.g., by increasing the likelihood that the father would live with their child or provide financial support for raising their child).[132] Findings from these interventions suggest that community-wide strategies focused on improving the relationship between the mother and father may be effective as well.

Key Theme #4: Reduce structural and policy barriers to father involvement

Researchers have reviewed literature on barriers to father involvement and have highlighted policy issues related to these factors.[133] [134] [135] Specifically, researchers have called for the need to address structural barriers such as father unemployment, incarceration, and financial disincentives[136] for involvement.[137] [138] [139] National and local experts interviewed also noted policies and elements of federally funded entitlement programs that may limit father involvement. For example, the Family and Medical Leave Act (1993) allows parents to take up to 12 weeks of unpaid leave for childbirth, adoption, foster care or to care for a child. To increase involvement of fathers, it has been suggested that employers provide extended paid leave for both parents. In California, parents are allowed 6 weeks of paid leave, suggesting some progress in this area.[140] There is also a marriage penalty for public assistance programs like the Temporary Assistance for Needy Families payment which is based on family size and income. Similarly, the national and local experts interviewed discussed barriers to fathers related to the current child support policies, which in some cases result in financial penalties to be a father for their children. In addition, according to local and national experts interviewed, single fathers who

[129] Rienks, S. L., Wadsworth, M. E., Markman, H. J., Einhorn, L., & Moran Etter, E. (2011). Father involvement in urban low-income fathers: baseline associations and changes resulting from preventive intervention. *Family Relations, 60*(2), 191–204. doi:10.1111/j.1741-3729.2010.00642.x

[130] While this section focuses on how to increase father involvement, it should be recognized that there are situations, such as where there is domestic violence, where increasing father involvement would not be an desirable outcome.

[131] Rienks, S. L., Wadsworth, M. E., Markman, H. J., Einhorn, L. & Etter, E. M. (2011). Father involvement in urban low-income fathers: Baseline associations and changes resulting from preventive intervention. *Family Relations, 60*, 191-204.

[132] Devaney, B. & Dion, R. (2010). *15-Month Impacts of Oklahoma's Family Expectations Program.* Retrieved from http://www.mathematica-mpr.com/publications/PDFs/Family_support/BSF_15month_impacts.pdf

[133] Alio, A. P., Bond, M. J., Padilla, Y. C., Heidelbaugh, J. J., Lu, M., & Parker, W. J. (2011). Addressing policy barriers to paternal involvement during pregnancy. *Maternal and Child Health Journal*, *15*(4), 425–30. doi:10.1007/s10995-011-0781-1

[134] Lu, M. C., Jones, L., Bond, M. J., Wright, K., Pumpuang, M., Maidenberg, M., Jones, D., Garfield, C., & Rowley, D. L. (2010). Where is the F in MCH? Father involvement in African-American families. *Ethnicity and Disease*, *20*, S2–S49.

[135] Bond, M. J., Heidelbaugh, J. J., Robertson, A., Alio, P. a, & Parker, W. J. (2010). Improving research, policy and practice to promote paternal involvement in pregnancy outcomes: the roles of obstetricians-gynecologists. *Current Opinion in Obstetrics & Gynecology*, *22*(6), 525–529. doi:10.1097/GCO.0b013e3283404e1e

[136] For example, married couples tend to be eligible for less support under TANF than single families. Alio, A. P., Bond, M. J., Padilla, Y. C., Heidelbaugh, J. J., Lu, M., & Parker, W. J. (2011). Addressing policy barriers to paternal involvement during pregnancy. *Maternal and Child Health Journal*, *15*(4), 425–30. doi:10.1007/s10995-011-0781-1

[137] Alio, A. P., Bond, M. J., Padilla, Y. C., Heidelbaugh, J. J., Lu, M., & Parker, W. J. (2011). Addressing policy barriers to paternal involvement during pregnancy. *Maternal and Child Health Journal*, *15*(4), 425–30. doi:10.1007/s10995-011-0781-1

[138] Lu, M. C., Jones, L., Bond, M. J., Wright, K., Pumpuang, M., Maidenberg, M., Jones, D., Garfield, C., & Rowley, D. L. (2010). Where is the F in MCH? Father involvement in African-American families. *Ethnicity and Disease*, *20*, S2–S49.

[139] Bond, M. J., Heidelbaugh, J. J., Robertson, A., Alio, P. a, & Parker, W. J. (2010). Improving research, policy and practice to promote paternal involvement in pregnancy outcomes: the roles of obstetricians-gynecologists. *Current Opinion in Obstetrics & Gynecology*, *22*(6), 525–529. doi:10.1097/GCO.0b013e3283404e1e

[140] For more information see: http://www.edd.ca.gov/disability/paid_family_leave.htm

have full custody have less access to resources as many social services are targeted toward mothers, such as housing and WIC.

Limitations

While the literature provides some promising practices and strategies for father involvement, there are key gaps in what is currently known. For example, it is unclear how these strategies are effective long-term or whether they work with different subgroups of fathers or community contexts.[141] In addition, while some research demonstrates an increase in the level father involvement, it does not assess the change in quality of the involvement or ultimate effects on the child. [142] [143] This suggests that the likely outcomes of implementing these themes are still unknown. The literature and experts interviewed provided a few potential explanations for the lack of available research evidence on these topics.[144] First, the field of fatherhood is considered to be relatively underdeveloped; there are few accepted frameworks and models of interventions to be followed. There are also challenges that may inhibit research on fatherhood, such as inadequate methods of measuring father involvement,[145] difficulty in recruiting fathers to research and conduct long-term follow-up on intervention outcomes,[146] and the traditional focus of MCH research in general on mothers rather than fathers.[147]

This report provides a broad overview of promising practices and strategies for father involvement. Depending on the focus area selected within fatherhood, there are opportunities to explore specific areas in much greater depth. There may also be opportunities to explore literature in other topic areas that could be used to inform fatherhood programming, even if they were not focused on fatherhood issues specifically. For example, if one of the goals of a fatherhood program is to improve employment, it may be worth exploring evidence on employment programs in general, rather than employment programs specific to fatherhood. Regardless of the focus of the fatherhood program, the study's themes provide a set of principles that could be integrated into a variety of potential efforts to improve father involvement.

[141] Knox, V., Cowan, P. A., Pape Cowan, C., & Bildner, E. (2011). Policies that strengthen fatherhood and family relationships: What do we know and what do we need to know? *The ANNALS of the American Academy of Political and Social Science*, *635*(1), 216–239. doi:10.1177/0002716210394769

[142] Mitchell, S. J., See, H. M., Tarkow, A. K. H., Cabrera, N., McFadden, K. E., & Shannon, J. D. (2007). Conducting studies with fathers: Challenges and opportunities. *Applied Developmental Science*, *11*(4), 239–244. doi:10.1080/10888690701762159

[143] Knox, V., Cowan, P. A., Pape Cowan, C., & Bildner, E. (2011). Policies that strengthen fatherhood and family relationships: What do we know and what do we need to know? *The ANNALS of the American Academy of Political and Social Science*, *635*(1), 216–239. doi:10.1177/0002716210394769

[144] Mitchell, S. J., See, H. M., Tarkow, A. K. H., Cabrera, N., McFadden, K. E., & Shannon, J. D. (2007). Conducting studies with fathers: Challenges and opportunities. *Applied Developmental Science*, *11*(4), 239–244. doi:10.1080/10888690701762159

[145] For example, one metric of father involvement frequently used is whether or not the father is listed on the birth certificate.

[146] Mitchell, S. J., See, H. M., Tarkow, A. K. H., Cabrera, N., McFadden, K. E., & Shannon, J. D. (2007). Conducting studies with fathers: Challenges and opportunities. *Applied Developmental Science*, *11*(4), 239–244. doi:10.1080/10888690701762159

[147] Alio, A. P., Bond, M. J., Padilla, Y. C., Heidelbaugh, J. J., Lu, M., & Parker, W. J. (2011). Addressing policy barriers to paternal involvement during pregnancy. *Maternal and Child Health Journal*, *15*(4), 425–30. doi:10.1007/s10995-011-0781-1

EMERGING & PROMISING PRACTICES

Despite the growing number of fatherhood interventions there remains a striking lack of evidence on what works.[1] [2] Even for programs that have documented increased father involvement, there is very little information that shed light on what elements of these programs work and why. One interview participant noted there are a variety of reasons why effective practices for increasing father involvement are not well documented in the research. For example, fathers are seldom included in birth-related data collection or longitudinal studies. According to numerous interview participants, there is a general dearth of models for effective father involvement.

However, there are some emerging and promising practices that surfaced in interviews as well as the review of literature and program documents. Unless otherwise noted, the below information is from the United States Administration for Children and Families Office of Family Assistance's "How to implement promising practices: Peer guidance from the Responsible Fatherhood Program."[3] National and local expert interviews and additional literature also highlighted many of these same promising practices.

Planning & Partnerships: Conduct a needs assessment to inform fatherhood program design.[4] Use community partners to strengthen program capacity.

Staffing: Hire qualified staff that have compassion and respect for the targeted population, often based in a personal connection to the issue. Highlight the need for empathy while encouraging staff to personally and professionally model the skills they are teaching to participants. Provide support to staff to enhance their performance and capabilities.

Recruitment & Retention: Utilize community leaders and community settings to connect with potential participants. Use participants and partners in the recruitment process. Incorporate word of mouth recruitment and coordinate recruitment with the courts and programming valued by fathers such as employment assistance.[5] Help participants and their families develop bonds with each other and with the staff. Provide incentives to encourage participants to remain in the program.

Program Design: Offer one-stop centers so participants can access a variety of services. Offer culturally relevant curriculum customized to the needs of a particular target population. Allow for sufficient intensity since parenting interventions can increase involvement; fathers benefit from having multiple sessions and practical experience with children as part of the training.[6] [7] Target multiple risk factors since fathers may experience different social stressors that reduce their likelihood of positively engaging with the mother and child. Interventions should go beyond education on parenting practices to address other common challenges such as unemployment, stress, or previous incarcerations.[8] Provide transition assistance to help participants adjust to new challenges or employment.

[1] Lamb, M. (2010). Meta-analysis of the Effectiveness of Resident Fathering Programs : Are Family Life Educators Interested in Fathers ?, *Family Relations*, 59, 240–252. doi:10.1111/j.1741-3729.2010.00599.x

[2] Lu, M. C., Jones, L., Bond, M. J., Wright, K., Pumpuang, M., Maidenberg, M., Jones, D., Garfield, C., & Rowley, D. L. (2010). Where is the F in MCH? Father Involvement in African-American Families. Ethnicity & Disease, 20[Supl 2], S2-49-S2-61.

[3] Administration for Children and Families Office of Family Assistance. (n.d.) How to implement promising practices: Peer guidance from the Responsible Fatherhood Program. Retrieved from: https://fatherhood.gov/sites/default/files/files-for pages/How%20to%20Implement%20Promising%20Practices_09_29_09.pdf

[4] For further information see: https://www.fatherhood.gov/sites/default/files/FatherhoodToolkit.pdf

[5] Stahlschmidt, M. J., Threlfall, J., Seay, K. D., Lewis, E. M., & Kohl, P. L. (2013). Recruiting fathers to parenting programs: Advice from dads and fatherhood program providers. Children and Youth Services Review, 35(10), 1734–1741. doi:10.1016/j.childyouth.2013.07.004

[6] Magill-Evans, J., Harrison, M. J., Rempel, G., & Slater, L. (2006). Interventions with fathers of young children: systematic literature review. Journal of Advanced Nursing, 55(2), 248–64. doi:10.1111/j.1365-2648.2006.03896.x

[7] Maxwell, N., Scourfield, J., Featherstone, B., Holland, S., & Tolman, R. (2012). Engaging fathers in child welfare services: a narrative review of recent research evidence. *Child & Family Social Work*, 17(2), 160–169. doi:10.1111/j.1365-2206.2012.00827.x

[8] Sandler, I., Schoenfelder, E., Wolchik, S., & Mackinnon, D. (2012). Parenting : Lasting Effects but Uncertain Processes, Annual Review of Psychology, 62, 1–30. doi:10.1146/annurev.psych.121208.131619.

Considerations for Future

As previously noted, there is strong evidence for the need to invest in a fatherhood program and examine the policy issues that impact fathers' participation in the lives of their children. For First 5 LA, this may include incorporating a fatherhood component into current programs, funding already established community program(s), providing capacity building and training, and/or addressing policy priorities. Key considerations for future work are articulated below and are organized around programs and public education, policy and advocacy, and capacity building. Within each of those categories there are potential strategies. Unless otherwise noted all information in this section is based on the themes in the previous section of this report. All themes are based on multiple literature and interview sources. The below strategies provide a "menu" of potential options for First5 LA to consider. Further discussion and engagement with stakeholders, development of additional opportunities, and prioritization of all potential strategies would need to occur before implementation.

Programmatic and Public Education Considerations

Explore ways to incorporate a focus on father engagement

There is an array of current First 5 LA investments that directly or indirectly connect with fatherhood issues. The community-building efforts currently taking place in the 14 Best Start communities are focusing on parents and family strengthening. Best Start also offers an important opportunity for fathers and male caregivers to connect with information, resources, and social supports. In addition to the Black Infant Health (BIH) program, there is also a programmatic connection to home visitation services currently being implemented by First 5 LA.

Determine priorities and focus of fatherhood investment. In an effort to focus resources and priorities for the two-year fatherhood investment, First 5 LA should more fully articulate the desired short and long-term outcomes of this investment. As this study reveals, there is a wide range of fatherhood programs, some of which focus on specific race/ethnic groups or expectant fathers while others focus on economic stability, domestic violence, or relationship education.[148] [149] A focused planning process could be informed by the engagement of various partners and stakeholder groups (i.e., potential community partners, institutional partners, other funders, advocacy groups, and/or fathers) to help shape, prioritize, and focus First 5 LA's fatherhood investment. More specifically, this multi-stakeholder planning group could help identify who and how to leverage other partners and efforts in the region, articulate outcomes (in the short, medium, and long term), and identify indicators of progress and key implementation considerations. As part of this process, the advisory workgroup for this study also suggested generating a Request for Information (RFI) to ask community groups and organizations to share what types of programming they are providing for fathers. An RFI process could be one method to better understand the landscape of Los Angeles County fatherhood activities, potential partners, and gaps in programming.

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[148] In addition to highlighting potential curriculums to use, the following resource document also illustrates the great range in programs. US Department of Health and Human Services. (2011). Compendium of Curricula Used by Fatherhood Programs. Retrieved from http://library.fatherhood.gov/cwig/ws/library/docs/FATHERHD/Blob/78805.pdf;jsessionid=B2072AA148A47CACA8632328518CDD93?w=NATIVE(%27TI+ph+is+%27%27Compendium+of+Curricula+Used+by+Fatherhood+Programs%27%27%27)&upp=0&rpp=25&order=native(%27year/Descend%27)&r=1&m=1

[149] For further information see: http://www.aecf.org/~/media/Pubs/Topics/Special%20Interest%20Areas/Responsible%20Fatherhood%20and%20Marriage/40TopResources/40TopResourcesFINAL5%2011%2011.pdf

After determination of the goals of the fatherhood investment, potential strategies might include:

- Assess the full portfolio of First 5 LA investments to determine where to ***integrate father component and/or message*** (i.e., Black Infant Health, peer support groups for parents, Welcome Baby, Select Home Visitation). Integration into existing programs could include encouraging father participation and/or providing resources to mothers and fathers about father involvement.
- More intentionally integrate fatherhood education, awareness, and support into ***Best Start***. One example suggested by a national expert interviewed for this study is supporting Best Start communities to create and distribute the "100 Intentional Acts of Kindness for New Fathers."[150] The expert noted, "This allows men to take control because men of color feel very disenfranchised by the system." Another example activity identified during review of program documents is promoting Best Start community participation in local and national fatherhood activities such as the United States Department of Health and Human Services' Fatherhood Buzz that reaches out to dads with positive information through their barbers and barbershops.[151]
- Explore ***funding partnerships*** with established fatherhood program(s) in the region that share First 5 LA's commitment to father involvement and have the interest and capacity to work together to assess impact and progress over time. Some established fatherhood programs in Los Angeles County include the Children's Hospital Los Angeles's LA Fathers Program; Children's Institute International's Project Fatherhood; MENFOLK; and The California Endowment's Sons and Brothers.
- Explore partnership and support of ***existing conferences*** and trainings that connect to fatherhood (i.e., Children's Institute International's Project Fatherhood annual conference).[152] The events may already connect to fatherhood and/or First 5 LA could be an advocate to encourage inclusion of fatherhood topics and issues.
- Ensure that ***fathers' voices and representations*** are included in First 5 LA program and public education information. One national expert interviewed noted that men are not adequately represented in First 5 LA guides and materials, making the men feel less valued.

Policy and Institutional Practices

Explore opportunities to influence policy, advocacy, and institutional practices

The literature and interviews emphasize the importance of addressing the policy barriers to fatherhood involvement. While there are few studies about policy efforts focused on this topic, the literature review revealed a number of factors associated with father involvement that could be the target of policy and advocacy efforts. First 5 LA may wish to explore its role as a ***facilitator and leader*** in coordinating fatherhood policy efforts with other partners and funders. They could also focus on the practices of hospitals and clinical providers as well as advocacy efforts on fatherhood in general. As identified in national and local expert interviews, potential strategies might include:

- Promote the importance of ***fathers to maternal and child health*** and the rebranding of it to include fathers

[150] Jones, L., Lu, M. C., Lucas-Wright, A., Dillon-Brown, N., Broussard, M., & Wright, K. (2010). One hundred intentional acts of kindness toward a pregnant woman: Building reproductive social capital in Los Angeles. *Ethnicity & Disease*, *20*, 36-40. This is version for women could be used as a model to create one for men.

[151] For further information see: https://fatherhood.gov/fatherhood-buzz

[152] The study's advisory workgroup suggested this potential strategy.

- Promote fathers to be welcomed and encouraged to participate fully at ***prenatal and delivery activities.***
- Advocate for robust ***family leave for fathers*** and the use of the leave. The Family and Medical Leave Act (1993) allows parents to take up to 12 weeks of unpaid leave for childbirth, adoption, foster care or to care for a child. In California, parents are allowed 6 weeks of paid leave. Advocate for extended paid family leave.
- Advocate for removing the ***marriage penalty for public assistance***. Currently, the amount of the Temporary Assistance for Needy Families payment depends on family size and income.
- Promote ***alternatives to penalties for custody payment***. Fathering Court is a program that provides alternatives to penalties for non-payment of child support, such as mandated parenting classes and employment skill training.[153]
- Advocate for government and private agencies to conduct a ***self-assessment about their father friendliness***. The National Fatherhood Initiative created a model that could be adapted.[154]

Capacity Building

Build capacity and provide trainings to program and community partners

The literature and interviews noted that knowledge about the importance of fatherhood involvement and promising practices is limited. Therefore, First 5 LA could potentially play a key role in building organizational and programmatic capacity to incorporate a fatherhood focus in existing programs and services. Potential strategies might include:

- Provide ***fatherhood inclusion*** training to clinics, hospitals, and educational institutions (i.e., universities and colleges educating health professionals) in partnership with community partners.
- Promote capacity building opportunities for programs currently conducting or interested in conducting fatherhood programs. Helpful resources include the National Responsible Fatherhood Clearinghouse's archived ***webinars***[155] on topics such as "Effective strategies for working with fathers returning from prison" and "Getting and keeping fathers involved in program services" as well as the "Responsible Fatherhood Toolkit Resources from the Field."[156]
- Identify opportunities to ***leverage*** already established capacity building efforts and add a fatherhood component (i.e., Welcome Baby partners and hospital trainings).[157]

[153] For further information see: http://www.fathers.com/content/index.php?option=com_content&task=view&id=84&Itemid=117. While the advocacy area was identified from interviews, this recommendation was identified from document review.

[154] For further information see: : http://www.fatherhood.org/free-resources. http://fatherhood.ohio.gov/Portals/0/FatherFriendlyCheck_ChildWelfare.pdf While the advocacy area was identified from interviews, this recommendation was identified from document review.

[155] For further information see: http://www.fatherhood.gov/webinars

[156] For further information see: https://www.fatherhood.gov/sites/default/files/FatherhoodToolkit.pdf

[157] The study's advisory workgroup suggested this potential strategy.

Community Case Studies

This section describes two communities in Los Angeles County: Antelope Valley and South LA. These case studies are based on review of existing data and documents and a small number of local expert interviews.[158] The case studies focus on highlighting the main gaps, resources and opportunities for birth outcomes and fatherhood that emerged from this review.

Antelope Valley

The Antelope Valley is a fast growing community of approximately 2,200 square miles and a population estimating 417,787, consisting of mostly Latino (44 percent), and Caucasian (35 percent) residents.[159] Poverty, homelessness, access to healthcare (mental health care in particular), high rates of child abuse and neglect, and unemployment have served as barriers in promoting stable and healthy lifestyles for young families. Given the rapid nature of this community's growth, many of the families moving to Antelope Valley have had to seek new health providers, including prenatal care providers, breaking the continuity of care.[160] Additionally, most of the social services in Antelope Valley are centralized rather than dispersed throughout the community for residents to easily access. There are also environmental factors that prevent children zero to five from having quality healthy lifestyles. For example, the green space in the Antelope Valley is sparse compared to the other seven Service Planning Areas (SPAs)[161] in Los Angeles County. For example, 40 percent of children ages one to five do not have a park or play yard within walking distance, compared to only 5 percent in the South Bay area. In addition, 30 percent of children have not visited the park in the last month.[162]

Birth Outcomes and Risk factors among Antelope Valley residents:

- Antelope Valley has the highest infant mortality rate compared to the other seven geographic SPAs in Los Angeles County since 2000.[163]
- Approximately 8 percent of babies born in Antelope Valley in 2011 were born with low birth weight (5lb 8 oz. and below).[164]

[158] Please see Appendix C for the list of people interviewed. Some documents and interviewees may have only provided information on one of these two geographic areas, resulting in differences in what information was available to be reported upon.
[159] U.S. Census Bureau Decennial Census (2010)
[160] Chao, S. M., Donatoni, G., Bemis, C., Donovan, K., Harding, C., Davenport, et al. (2010). Integrated approaches to improve birth outcomes: perinatal periods of risk, infant mortality review, and the Los Angeles Mommy and Baby Project. *Maternal and Child Health Journal*, *14*(6), 827–837. doi:10.1007/s10995-010-0627-2
[161] Service planning areas (SPAs) are regions within Los Angeles County that guide regional planning of health and social services.
[162] CHIS data 2009
[163] LACPDH (2010). Health Disparities Among African-American Infants in Los Angeles County. Retrieved from http://publichealth.lacounty.gov/mch/LACALC/ALC%20files/Health%20Care%20Disparities%20Brief.pdf
[164] LACPDH (2010).

- The infant mortality rate among African-Americans in Antelope Valley was higher than other racial/ethnic groups. The infant death rate for African-Americans increased from 11.0 per 1,000 (7 cases) in 1999 to 32.7 per 1,000 (27 cases) in 2002.[165]
- Antelope Valley has the highest rate of gestational diabetes compared to the other seven SPAs[166]
- 76 percent of new mothers did not seek prenatal health counseling during the six months prior to giving birth, which is higher than the other SPAs.[167]
- Compared to other SPAs, pregnant women in Antelope Valley more commonly reported not having enough money for food (9 percent).[168]
- Antelope Valley has 15 percent of families living below the federal poverty threshold, 15 percent of residents without insurance, and the second highest rates of unemployment compared to other SPAs (7 percent).[169]
- 30 percent of women were uninsured right before their last pregnancies.[170]
- 26 percent of pregnant mothers had to travel 15 miles or more for prenatal care; this was higher than all other SPAs.[171]
- 25 percent mothers did not get prenatal care as early as they wanted; this was also higher than the other SPAs.[172]

Emerging resources and advocacy efforts

While the Antelope Valley has significant barriers that impact birth outcomes, their isolation from the rest of Los Angeles County has created a strong conservative, faith-based community that actively collaborates to help address community needs. In the early 2000's the Los Angeles County Department of Public Health, Maternal, Child, and Adolescent Health (MCAH) Programs partnered with local community task forces in the Antelope Valley to begin addressing the high rates of infant mortality. One particular effort was the population-based study Los Angeles Mommy and Baby Project (LAMB), which was piloted in Antelope Valley to examine the risk factors associated with adverse birth outcomes. Since then numerous efforts have emerged, including new resources in the community to support pregnant mothers, such as a Black Infant Health program site in Antelope Valley and the Antelope Valley Best Babies Collaborative.[173] The Antelope Valley Partners for Health (AVPH), a grassroots organization began in 1999 to address health disparities, with a particular focus in birth outcomes. This organization has provided numerous supports for pregnant women and mothers of children zero to five. AVPH is implementing First 5 LA's Welcome Baby program in Antelope Valley. Healthy Homes is another home-visitation program that incorporates evidence based practices to prevent child abuse and neglect, educates parents about positive parenting, child discipline, and relationship skills. Finally, AVPH has been working with local clinicians to advocate for the need of mental health care for maternal depression, an issue that seems to be on the rise in this region.

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[165] Chao, S. M., Donatoni, G., Bemis, C., Donovan, K., Harding, C., Davenport, et al. (2010). Integrated approaches to improve birth outcomes: perinatal periods of risk, infant mortality review, and the Los Angeles Mommy and Baby Project. *Maternal and Child Health Journal*, *14*(6), 827–837. doi:10.1007/s10995-010-0627-2

[166] LACPDH (2010).

[167] [167] LACPDH (2010). Health Disparities Among African-American Infants in Los Angeles County. Retrieved from http://publichealth.lacounty.gov/mch/LACALC/ALC%20files/Health%20Care%20Disparities%20Brief.pdf

[168] Los Angeles Mommy and Baby (LAMB) (2010)

[169] CHIS data 2009; U.S Census Bureau Decennial Census (2010), American Community Survey 5-year estimates (2006-2010)

[170] LACPDH (2010).

[171] Ibid.

[172] Ibid.

[173] Both programs are funded by First 5 LA. The Antelope Valley Best Babies Collaborative was discontinued in 2013.

The Family Focused Resource Center located in Lancaster is a well-known resource in the community and provides a variety of services including referral and support services to families of children zero to 22, with a focus on connecting families who have children with special needs to the appropriate services (i.e., California Early Start Program).

Enhancing the Role of the Father

There are few resources and support services available to fathers of children zero to five in the Antelope Valley, and many fathers of children zero to five struggle from a variety of barriers that prevent them from being stable partners and positive role models in their families. For example, eight percent of mothers in Antelope Valley reported that they or their partners went to jail during their pregnancy- higher than any other Los Angeles County SPA.[174] However, there has been a recent movement to promote a more positive, active involvement of fathers in their children's lives. Whereas traditional parenting support services have focused on the role of the mother as the main caretaker, community members are now identifying the need for the community to be more "father-friendly" in the private and public sector. MENFOLK (Males Encouraging Nurturing For the Ongoing Link to Kinship), founded over ten years ago in Palmdale, is a local program that implements parent support groups, for men with children, single fathers, and stay at home fathers. While some Antelope Valley organizations have received technical support and training from Project Fatherhood, a South LA program funded by Children's Institute Inc., there is still a great need for fatherhood programs that focus specifically on the role of the father during the prenatal period through early childhood. This need is further highlighted by the 2010 LAMB survey which found that 13 percent of mothers in Antelope Valley (highest rate compared to mothers in the other Los Angeles County regions) were dissatisfied with the support given by their baby's father during pregnancy.

Opportunities & Considerations for the Future

Antelope Valley has made some movement in targeting local community practices and policies to improve birth outcomes and address health disparities, as well as enhance the role of fathers in the community. Drawing on local expert interviewee comments about gaps and opportunities in Antelope Valley, potential considerations for the future may include:

- Address local policy to improve transportation (access to health care) to increase the amount of bus routes per day.
- Increase access to health care (decrease levels of uninsured, increase access to care).[175]
- Increase access to mental health care to address maternal depression and its impact on child bonding and forming social support connections.
- Improve access to prenatal care and perinatalogists for high risk pregnancies as well as linkages to pediatricians that serve babies and children with high-needs.
- Enhance smoking, alcohol, and drug prevention services before, during, and after pregnancy.
- Encourage community programs to be more "father-friendly"- more inclusive support groups and organizational practices that support fathers' connection with their children (e.g., skin to skin bonding between fathers and newborns as hospital practice).

[174] LACPDH (2012). Los Angeles Mommy and Baby (LAMB) Project 2010 Surveillance Report. Retrieved fromhttp://publichealth.lacounty.gov/mch/lamb/Results/2010Results/For_posting/Final_LAMB2010_databook_01.03.13.pdf

[175] The issues of health care utilization was not discussed as part of the interviews, but it is possible that health care utilization is a concern as well in this community. Reviewing or gathering additional community data would be needed to assess whether or not utilization is an issue.

- Increase engagement of fathers in the local Neighborhood Action Councils (NAC) to discuss the need for fatherhood programming in the area.

South LA

With a population of approximately 966,922,[176] South LA has the largest unemployment rate (7 percent) compared to the other seven SPAs in Los Angeles County, and 26 percent of families have an income below the Census poverty threshold.[177] South LA residents also struggle with hunger, housing, access to health care, and safety.[178] These external risk factors limit a family's ability to provide the essential needs for their children to live a healthy life. There has also been a significant shift in the ethnic diversity in this region in the last ten years, with an increasing immigrant Latino population (67 percent), and a decreasing African-American population (27 percent).

Birth Outcomes and Risk factors among South LA residents:

- Nine percent of babies born in 2011 had a low birth weight.[179]
- In 2007, South LA reported the highest rate of pre-term births, which is reported to be primarily among African-Americans.[180]
- 80 percent of mothers' breastfed after giving birth; this was the lowest among other mothers in Los Angeles County.
- South LA had the highest rate of high blood pressure during pregnancy in Los Angeles County.[181]
- South LA had the highest self-reported rates depression among pregnant mothers (34 percent) compared to other SPA.[182]
- In 2010, 7 percent of mothers were homeless during their pregnancy; this was higher than any other region in Los Angeles County.
- Compared to other SPAs, pregnant women in South LA more commonly reported not having enough money for food (9 percent).[183]
- Poor drinking water is a concern in South LA due to lack of regulated water dispensaries.[184]
- In 2010, 10 percent of pregnant mothers were divorced or separated during pregnancy- which have been associated with pre-term births and low birth weight babies.[185]
- 46 percent of women in 2010 were uninsured right before their most recent pregnancies.[186]
- In 2008 there were approximately 11 pediatricians for every 100,000 children[187] in South LA compared to 193 pediatricians per 100,000 children in West LA.[188]

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[176] U.S. Census Bureau Decennial Census

[177] American Community Survey 5-Year Estimates (2006-2010)

[178] Ratner, B. & Robison, C. C. (2013). Forging structures, systems and policies that work in communities stories and lessons from building healthy communities. Retrieved from http://www.calendow.org/uploadedFiles/Health_Happends_Here/SLA_BH_BHC_CaseStudy_final.pdf

[179] Ibid.

[180] LACDPH (2007). Los Angeles County infant mortality, preterm births, and low birthweight factsheet. Retrieved from https://admin.publichealth.lacounty.gov/mch/LACALC/ALC%20files/PretermLowBirthWeightFactSheet.pdf

[181] LACPDH (2012). Los Angeles Mommy and Baby (LAMB) Project 2010 Surveillance Report. Retrieved fromhttp://publichealth.lacounty.gov/mch/lamb/Results/2010Results/For_posting/Final_LAMB2010_databook_01.03.13.pdf

[182] Ibid.

[183] Ibid.

[184] Community Health Councils (2008) South Los Angeles Health Equity Scorecard

[185] Hobel, C., Goldstein, A.,Barrett, E. (2008). Psychosocial stress and pregnancy outcome. *Obstetrics and Gynecology. 51*(2): 333-348.

[186] LACPDH (2012). Los Angeles Mommy and Baby (LAMB) Project 2010 Surveillance Report. Retrieved fromhttp://publichealth.lacounty.gov/mch/lamb/Results/2010Results/For_posting/Final_LAMB2010_databook_01.03.13.pdf

[187] The report did not specify the age of children referred to.

Emerging resources and advocacy efforts

Despite its challenges, South LA is a resilient, tight knit community with a history of grassroots community-level initiatives.[189] Shields for Families, Great Beginnings for Black Babies, and St. John's Well Child and Family Center are some of the organizations focused on addressing health disparities in birth outcomes in South LA. In addition, funded by First 5 LA from 2005 to 2013, the South LA Best Babies Collaborative (SLABBC) provided case management to hundreds of women to reduce disparities and improve pregnancy and birth outcomes. SLABBC also coordinated "Healthy Births" training workshops to local child health specialists in the community to improve local capacity. Community Health Councils, a nonprofit health education and policy organization has also been working to overcome health disparities in low-income communities of color in South LA since 1992. In order to address the high rate of infant mortality, they have advocated for neonatal intensive care units by partnering with hospitals in the Watts community, and for better access to nutritious foods and quality water. Aside from several community-based organizations advocating for local policy change, women and children are utilizing community resources such as WIC, with approximately 99,454 individuals participating in 2013, most of whom are Latino and African-American.[190]

Enhancing the Role of the Father

There are few resources and support services available to fathers of children zero to five in South LA and many fathers of children zero to five struggle from a variety of barriers that prevent them from being stable partners and positive role models in their families, including unemployment and incarceration. For example, 23 percent of mothers in South LA reported that their partners had lost their jobs during pregnancy-higher than any other region in Los Angeles County.[191] However, there has been a recent movement to shift the social norms surrounding father's role during pregnancy and in the early child development. For example, whereas traditional parenting support services have focused on the role of the mother as the main caretaker, community members are now identifying the need for the community to be more "father-friendly" in the private and public sector. Project Fatherhood, a program funded by Children's Institute Inc. in 1996, has been a driving force behind this movement in helping fathers take a more active role in their children's lives. The curriculum implemented by Project Fatherhood addresses the barriers that prevent fathers from being involved (e.g., substance abuse, intergenerational community violence, domestic violence) and provides education to fathers of children (specifically those in the child welfare system), including focusing on prenatal issues and zero to five child development. Furthermore, Project Fatherhood has also received federal funding to provide technical support and training to over 70 agencies, many of which are in the South LA area.

Opportunities & Considerations for the Future

South LA has made some movement in targeting local community practices and policies to improve birth outcomes and address health disparities, as well as enhance the role of fathers in the community. Drawing on local expert interviewee comments about gaps and opportunities in South LA, potential considerations for the future may include:

- Use a multi-causal approach to prevent pre-term births and infant mortality. Provide better clinical care (e.g., screen for urinary tract infections during pregnancy), address psycho-social issues (e.g., maternal depression, substance abuse), and community factors (e.g., unemployment, poverty).

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[188] Community Health Councils (2008) South Los Angeles Health Equity Scorecard

[189] First 5 LA Community Assessment Report, Compton (2012).

[190] PHFE WIC Data Mining Project, LA County WIC Data (2013).

[191] LACPDH (2012). Los Angeles Mommy and Baby (LAMB) Project 2010 Surveillance Report. Retrieved fromhttp://publichealth.lacounty.gov/mch/lamb/Results/2010Results/For_posting/Final_LAMB2010_databook_01.03.13.pdf

- Address systems-level barriers for fathers. Focus on the development of more jobs, access to higher education, job training, and decreasing recidivism among young males (many of which are fathers of children zero to five). Assess how involvement in the criminal justice system impacts a father's ability to be a caretaker upon release (e.g., a felony charge limits future opportunities).
- Make community programs "father-friendly"-more inclusive support groups, organizational practices that support fathers' connection with their children (e.g., skin to skin bonding between fathers and newborns as hospital practice).

Summary

In an effort to inform First 5 LA's strategic investments, this study identified models, best practices, and promising strategies that have the potential to 1) positively impact health disparities in birth outcomes or 2) promote father involvement with children zero to five. The study also assessed related resources and gaps in South LA and Antelope Valley. This study was informed by recent peer-reviewed literature, interviews with national and local experts, and review of secondary data and documents. Supported by multiple sources of data,[192] key themes were identified for each focus area of this study:[193]

Key Themes

- **To address health disparities in birth outcomes**: 1) Focus on women at risk for poor birth outcomes, 2) Engage women before and during pregnancy, 3) Target social determinants of health, 4) Increase access to and quality of culturally competent health care, 5) Facilitate multi-stakeholder collaboration that promotes sustainable change at the community and systems-level, and 6) Provide social support during pregnancy.
- **To promote father involvement with children zero to five**: 1) Recognize men as a valuable part of pregnancy and early childhood by incorporating fatherhood programs into maternal-child health programs, 2) Acknowledge that father involvement has a positive effect on child development and maternal behaviors during and after pregnancy, 3) Target the father's relationship with the child's mother, and 4) Reduce structural and policy barriers to father involvement.

Cross-Cutting Themes

There were several themes that were common to these two focus areas:

- **Intervene before birth:** One of the strongest themes for improving birth outcomes was the need for early intervention. This theme also overlapped with the finding that to improve father involvement for young children, it is best to intervene during pregnancy. This suggests it may be important to consider how initiatives can be designed to be cross-purposed to both target birth outcomes as well as encourage father involvement.
- **Address social and community factors:** Literature and interviews indicate that to change health disparities in birth outcomes and support fatherhood, it is essential to address these issues through working at the institutional, social, and community level.
- **Partner with local community organizations:** Findings in each of these two areas also called for working with existing community partners and systems to plan programs and activities, to enact

[192] Peer-reviewed literature, documents, and local and national expert interviews

[193] Please see the introduction section for limitations of the study overall and the health disparities and fatherhood sections for specific topic area limitations.

change, to capitalize on current resources as well as to engage the local community and future participants.

These themes are relevant to First 5 LA investments overall as well as to **Antelope Valley and South LA.** With particularly high rates of poor birth outcomes, these geographic areas have specific social determinants of health and health care access issues that could be addressed, such as access to health care in Antelope Valley and poverty in South LA. Each geographic area also has existing community initiatives and advocacy efforts to build on related to health care, fatherhood, and improving community conditions to promote community health. For example, the Black Infant Health program has sites in both Antelope Valley and South LA.

Based on the data sources reviewed, this study offered potential considerations for addressing health disparities in birth outcomes and fatherhood involvement. A "menu" of potential strategies was offered in categories such as integration into existing First 5 LA programs, policy and advocacy, public education, capacity building, and partnerships.

Key next steps for both the health disparities and fatherhood areas would be to **engage key community stakeholders and potential partners in a focused planning process** to:

- Define goals, intended outcomes, and target groups;
- Collect additional data on the needs and community priorities;
- Prioritize potential strategies and assess the feasibility and sustainability of implementing them given available resources and potential for community partnership and integration with current systems;
- Conduct further study to learn more about promising or effective interventions related to approaches that are chosen to be implemented; and
- Plan evaluation and continuous quality improvement for chosen strategies to help assess progress toward desired goals.

First 5 LA's existing investments and relationships with the community, local providers, other funders, and government agencies can be leveraged toward both of these focus areas. First 5 LA has an opportunity to play an important leadership role in making system change locally while also adding to the national dialogue and evidence gap on how to address these vital community issues.

Health Disparities Themes Application Process

The table below begins to connect the health disparities in birth outcomes themes identified in this study to the national programs reviewed, potential First 5 LA opportunities and assets, potential First 5 LA challenges, and the Antelope Valley and South LA case studies. The table is intended to provide an initial example of how information from this report could be applied. A next step could be for First 5 LA to assess its programs, the targeted geographic regions, and other aspects of the local context in greater depth using these themes and this structure. A further developed version of this table could provide greater shared understanding of First 5 LA's opportunities, assets, gaps, and challenges to reduce health disparities in birth outcome.

Key Theme	National Program Incorporation of Themes[194]	First 5 LA Potential Opportunities and Assets[195]	First 5 LA Potential Challenges
1. Focus on women at risk for poor birth outcomes	All programs reviewed focus on specific geographic areas with the highest rates of poor birth outcomes. For example, Best Baby Zone is focused in specific neighborhoods within three cities. The Alameda County Building Block Collaborative is a countywide effort that has discrete projects within high risk communities. The Magnolia Project is exclusively focused in a specific neighborhood. The Magnolia Project also requires participants to meet selection criteria such as a previous poor birth outcome and repeated sexually transmitted diseases as part of referral into the program.	▪ The Black Infant Health (BIH) Program targets specific communities by working closely with local community organizations and public health departments. BIH's new model also requires 100 percent of clients to be African-American. ▪ Best Start is focused in 14 high need communities by partnering with community members and community organizations. ▪ LAMB and Healthy City data provides information about specific risk factors for each Best Start community. ▪ Antelope Valley (AV) and South LA (SLA) are both BIH program sites and former Health Birth Initiative (HBI) sites. Both programs target(ed) women at risk for poor birth outcomes.	▪ BIH's new model requires that 95 percent of clients be 18 or over. While the new model's program standards note that the program traditionally serves primarily low income women, BIH also does not have program criteria that target other risk factors such as age or previous poor birth outcome. ▪ Welcome Baby and Select Home Visitation are provided to all women regardless of risk for poor birth outcomes. ▪ It is unclear if AV's high rate of gestational diabetes prior to pregnancy and SLA's high rate of depression and high blood pressure have been targeted by any programs.

[194] Please see Appendix A for more information about each individual program. This footnote is relevant to all sections of the table. It is not repeated in interest of formatting.

[195] Antelope Valley and South LA information is based on the case studies in this report. Since the case studies were developed concurrently with the key themes, the case study descriptions were not developed with the themes in mind. This footnote is relevant to all sections of the table. It is not repeated in interest of formatting.

Key Theme	National Program Incorporation of Themes	First 5 LA Potential Opportunities and Assets	First 5 LA Potential Challenges
2. Engage women before and during pregnancy	All programs reviewed focus on the preconception time period. Most of the programs also focus on the prenatal time period.[196] All programs are utilizing the lifecourse perspective. The Magnolia Project's parent organization, the Northeast Florida Healthy Start Coalition, has specific goals and partners for each lifecourse phase. For example, their preconception goals include education about birth spacing and enrolling people with insurance.	▪ BIH targets women when they are pregnant. The new BIH model requires programs to have at least 90 percent of clients enroll during pregnancy. 75 percent must to enroll before their third trimester. ▪ Best Start partners with community members and community organizations involving women both before and during pregnancy. ▪ First 5 LA has an established peer support group program. ▪ AV and SLA are both Best Start communities as well as BIH sites.	▪ BIH does not target women during preconception. Some BIH clients enter during their third trimester and post-partum. ▪ Welcome Baby and Select Home Visitation are for post-partum women.
3. Target social determinants of health	All programs reviewed focus on or plan to focus on social determinants of health. For example, in the Alameda County Building Block Collaborative food access and housing are key areas of focus. While also focusing on food access and nutrition, the Magnolia Project's case management focuses on development of a life plan, which includes economic and social equity goals, and provides groups on specific health and social determinants (e.g., group topics on financial planning and GED preparation).	▪ BIH case management and groups target social determinants of health through the development of an individualized client plan and a life plan. BIH programs also involve an advisory council to help elevate community awareness about African-American birth outcomes and the impact on society. ▪ Best Start encompasses elements of social determinants of health. ▪ Some Select Home Visitation programs may address social determinants of health with post-partum women. ▪ AV and SLA are both Best Start communities as well as BIH sites.	▪ Based on Harder+Company's BIH evaluation focus groups in fall 2013, advisory councils and community awareness activities are not currently occurring. This may be due to staff time needed for implementing the direct service aspects of the program. ▪ In AV people have insufficient money for food and high unemployment. In SLA people have insufficient money for food and there is high rate of homelessness.

[196] The Magnolia Project focuses exclusively on the preconception time period.

Key Theme	National Program Incorporation of Themes	First 5 LA Potential Opportunities and Assets	First 5 LA Potential Challenges
4. Increase access to and quality of culturally competent health care	It is unclear how this theme is implemented by most programs reviewed. This lack of clarity may be since most programs reviewed are in the planning or early implementation phases. The Magnolia project provides a "one-stop shop" with quality health care, case management, WIC, and immunizations. The Magnolia Project also emphasizes cultural competency and the importance of having staff who understand the needs of the community.	▪ The BIH program is focused on providing culturally competent services. This is a central consideration to the contractors involved with the program, the contractors' staffing and training, and discussion topics with clients. ▪ Within First 5 LA's physical and mental health cluster there are activities focused on insurance enrollment. ▪ AV and SLA are both Best Start communities as well as BIH sites. There are also existing advocacy efforts for policies that support maternal and child health as well as mental health.	▪ First 5 LA insurance enrollment activities are focused on children and not women who are or may become pregnant. ▪ AV has low access and utilization of prenatal care, high rate of uninsured at onset of pregnancy, access to mental health care issues. SLA has high rate of uninsured before pregnancy and access to health care issues.

Key Theme	National Program Incorporation of Themes	First 5 LA Potential Opportunities and Assets	First 5 LA Potential Challenges
5. Facilitate multi-stakeholder collaboration that promotes sustainable change at the community and systems-level	All programs reviewed utilize a collaborative approach involving both cross-sector partners and the community. For example, the Wisconsin Lifecourse Initiative for Healthy Families (Wisconsin) collaborated with community members and organizations for three years before implementation began. The community member planning groups for each geographic community also continue to be involved as policy and advocacy groups. The Magnolia Project has a community council of current and former clients that receives leadership training and acts as an advocacy group for community issues.	▪ The Los Angeles Department of Public Health is a key partner on multiple programs including BIH. Other BIH partners include the Pasadena and Long Beach Departments of Public Health as well as numerous experienced community based contractors. ▪ Best Start is focused on collaboration and building community capacity. ▪ HBI was led by groups of community organizations from 2005 to 2013. These community organizations and relationships may be community assets. ▪ The Countywide Systems Improvement resource mobilization strategy is focused on partnerships as well as leveraging resources and relationships. ▪ AV has committed community organizations such as Antelope Valley Partners for Health, Family Resource Center, Partners in Care Foundation, and collaborative faith-based organizations. SLA has organizations such as Community Health Councils, Shields for Families, Great Beginnings for Black Babies, St. John's Well Child and Family Center, and LA Biomed Research Institute at UCLA Medical Center. Both AV and SLA were part of HBI and each had active collaboratives through fall 2013. These collaboratives may be continuing their work together outside of HBI.	

Key Theme	National Program Incorporation of Themes	First 5 LA Potential Opportunities and Assets	First 5 LA Potential Challenges
6. Provide social support during pregnancy	Among the programs already being implemented, both (The Magnolia Project and Wisconsin) incorporate social support during pregnancy. Both programs are implementing Centering Pregnancy. Wisconsin is also implementing the Birth Project USA sister friend model. Both programs also incorporate fatherhood aspects into their programs.	▪ BIH provides intensive case management and groups that provide social support. Some BIH sites involve male partners in some of their programs. ▪ First 5 LA has an established peer support group program. ▪ AV and SLA are both Best Start communities as well as BIH sites.	▪ Welcome Baby and Select Home Visitation are for post-partum women.

Appendix A: National Programs Reviewed

This appendix highlights five model programs across the United States. These programs and their lessons learned are included in this report as models of how First 5 LA may consider learning from and incorporating elements of these programs in its systems change work moving forward. The programs were identified during the literature review and early interview process. The intent was to review programs with a focus on health disparities and efforts to improve systems that impact birth outcomes. The information highlighted below was either identified as part of an interview with the program and/or documented lessons learned in reports or articles about the program. Each program is at different stages of implementation and provides somewhat different lessons based on their stage of development. Two programs are in their "planning phase," two in "early implementation phase," and the fourth "full implementation phase" (since 1999). The programs included are the **Alameda County Building Block Collaborative**, **Best Baby Zone**, **Magnolia Project**,[197] **Missouri Foundation for Health Infant Mortality Initiative**, and **Wisconsin Lifecourse Initiative for Healthy Families**. The information presented below was summarized from interviews with program leadership, websites, and documents.[198]

[197] The Magnolia Project is affiliated with the Northeast Florida Healthy Start Coalition.

[198] Information presented for each program is based on an interview with a lead staff member, review of the program's website(s) and other publically assessable reports, and available literature as cited. Budget and timeline details were not available for all programs. The interview protocol did not include questions about budgets and timelines. The Alameda County Building Block Collaborative was not interviewed.

PHASE	Planning: **Best Baby Zone**
PROGRAM DESCRIPTION	PURPOSE: To reduce infant mortality and racial disparities in birth outcomes and improve birth and health outcomes by mobilizing communities to address the social determinants that affect health. The program is focused in specific neighborhoods in Oakland, CA; Cincinnati, OH; and New Orleans, LA. STRATEGIES: The approach is zonal (for a specific community) and comprehensive – addressing four critical sectors – economics, education, health and community – in order to strengthen environments that support better and healthier outcomes. ▪ A small zone is selected where change is greatly needed and resources are aligned to produce and measure impact. ▪ A broad collaborative is formed to work across four sectors (health, economics, education and community) to achieve collective impact. ▪ A social movement is cultivated within the city to do whatever it takes to improve birth outcomes in the zone. ▪ There is a "backbone" organization for each zone. The type of backbone organization varies by site (New Orleans Healthy Start, Alameda Public Health Department, Cincinnati Children's hospital Medical Center). The program also has a national team of experts and consultants working with each site. FUNDING & TIMELINE: The program is funded for three years for $2.75 million by the Kellogg Foundation. It is not known if additional local site funding is also being utilized to support the program. Year one is planning, year two is development and relationship building to do the work, and year three is implementation. However, the focus is on 10 year outcomes. The intent is for each zone to become self-sustaining. The program was originally for 12 communities. They received funding for four communities but selected to implement the program in only three since one community did not have enough existing infrastructure in place.
PARTNE	National Partners: Association of Maternal & Child Health Programs, National Healthy Start Association, School of Public Health UC Berkeley Zone leads: New Orleans Health Department, Alameda County Public Health Department, Cincinnati Children's Hospital Medical Center Other Partners: Local community and economic development organizations, WIC, hospitals, and social service agencies
LESSONS LEARNED	Early lessons and key principles include: ▪ Program leaders should act as a convener to help make sure the program is community driven. ▪ Program leaders should allow the sites flexibility to be community driven. The program has a lot of control at the national level but they are learning the importance of giving more local community control. ▪ Building authentic relationships, trust, and the infrastructure to support the program takes time and dedication ▪ Building sustainability and long-term commitment is a challenge. They have 10 year outcomes but the program is for 3 years. They need to help people see the program as something that will stick around. The idea is that each zone will become self-sustaining. ▪ Introducing innovation into a system is challenging. Great ideas are generated but then they are told they cannot do it because the system cannot work that way. It is about changing the system at a community level but also often at city, county, state, and federal levels to make community change possible. ▪ Transition of people and turnover is a challenge. Sometimes an element of the program is built around specific people. It is important to institutionalize the idea and work. ▪ Identify the existing structures, resources, and people that already have interest in doing the work early on in the process to identify, create and sustain political will. ▪ Consider this work in the context of a "public health social movement." Bring the concept to other stakeholders to learn how they might want to be involved, their interest, and commitment. Get people invigorated and excited to do the work together. Build the movement by gathering political will – this can include sharing with the media, meeting with local leaders and representatives (for example, council people, the mayor) so they know what is going on and buy into it. This is part of sustainability as well as embedding the ideas and slowly changing the system. ▪ Communicate and share information regularly. Learning collaboratives allow everyone to share what is working and what is not. ▪ Incorporate small win opportunities early in the project to sustain morale and momentum. ▪ Leverage existing programs and resources.

PHASE	Planning: **Missouri Foundation for Health Infant Mortality Initiative**
PROGRAM DESCRIPTION	PURPOSE: Place-based effort to reduce infant mortality in Bootheel and St. Louis, Missouri by mobilizing, facilitating, coordinating, and increasing engagement of multi-sector partners and community members. STRATEGIES: ▪ Learn and share knowledge among "backbone" organizations, through learning collaboratives and site visits to other national program models (such as the Wisconsin Lifecourse Initiative for Healthy Families program) ▪ Build lead organization capacity ▪ Determine each community's focus and priorities so that the projects are community driven Based on early planning discussions, the Foundation anticipates the initiative may focus on the prenatal time period as well as on access to health care, racism, and fathers. FUNDING & TIMELINE: It is a one year planning process with lead organizations with one-year renewable grants. The foundation has a total of five years of funding set aside for the initiative. The total budget is not known from review of publically available websites and documents.
PARTNERS	"Backbone" organizations: Maternal, Child, and Family Health Coalition in St. Louis; Bootheel Network for Health Improvement; Missouri Bootheel Regional Consortium.
LESSONS LEARNED	Program is in process of capacity building with the "backbone" organizations. Early lessons include: ▪ Allow sufficient time for planning and promoting sufficient reflection to ensure community process and buy-in. ▪ Anticipate varying levels of capacity and existing infrastructure from backbone organizations. This also impacts timeline. ▪ Allow for funder reflection and flexibility related to their role in the initiative. The initiative is changing the Foundation's staff roles to be more focused on convening and facilitating.

PHASE	**Early Implementation: Alameda County Building Blocks Collaborative (BBC)**
PROGRAM DESCRIPTION	PURPOSE: 1) To recognize overt disparities in health, wealth, and education that limit the ability of all Alameda County children to realize their potential. 2) To ensure a sustainable multi-sector commitment to improve overall well-being for communities and the people who live in them, throughout all stages of life, beginning at the earliest. STRATEGIES: ■ Partner engagement: BBC has one steering committee and two work groups. BBC has engaged over 50 diverse partner organizations. Partnership is central to planning and implementation. ■ Cross-sector maternal and child health projects that advance health equity: While the BBC is countywide, projects are focused in geographic areas of highest need as supported by data. Project selection guiding principles include: clear linkage to the BBC "Bill of Rights;"[199] ability to be sustainable, build capacity, work toward system change; opportunity for broad involvement and buy-in for the community and BBC; ability to be achievable and likelihood to succeed. Three "incubation" projects are currently being implemented. Food for Families provides food for pregnant women from local food businesses where community youth are employed. The Alameda County Prosperity Project aims to improve health by supporting financial well-being through providing help with navigation of predatory financial landscapes and identification of alternatives. The Best Baby Zone develops solutions to neighborhood issues and builds collaborations to ensure a healthy future for children.[200] FUNDING STRUCTURE/TIMELINE: In 2008, Alameda County Public Health Department (ACPHD) staff established a learning community to review local population data, study the life course perspective, and discuss promising interventions. A client survey was also conducted. The learning community process helped ACPHD realize they could not do the work alone. In fall 2009, ACPHD sponsored a convening called "Building Blocks for Healthy Babies, Healthy Families, Healthy Communities." It was focused on building cross-sector collaborations. National life course and health equity leaders were also invited. After the strong interest generated from the convening, they launched the countywide BBC. The BBC had three initial phases. 1) Launch. The launch phase included establishing monthly meetings, a "Bill of Rights" to reflect their shared vision, and a steering committee. 2) Learning, sharing, and orienting for a paradigm shift. This phase included regular meeting to share and learning from and with other partners as well as linking participants to activities outside the meeting such as trainings, symposiums, and workshops. 3) Incubating projects. (See description in strategies section above.) The BBC's total budget and project budgets are not known from review of publically available BBC websites and documents. The BBC received a planning grant from the Kresge Foundation. The BBC's projects received funding support from the Kresge Foundation, the Robert Wood Johnson Foundation, California Wellness, and the Walter & Elise Haas Foundation. The BBC is also part of the Kellogg Foundation's Best Baby Zone as one of the national programs sites.
PARTNERS	Alameda County Public Health Department is the project leader. Other partners include the local economic development agencies, city and county government, community clinics, food access projects, housing agencies, parks and recreation, and universities.[201]

[199] Please see the following article for the BBC "Bill of Rights." Shrimali, B. P., Luginbuhl, J., Malin, C., Flournoy, R., & Siegel, A. (2014). The building blocks collaborative: advancing a life course approach to health equity through multi-sector collaboration. *Maternal and Child Health Journal*, *18*(2), 373–379. doi:10.1007/s10995-013-1278-x

[200] Oakland, California is one of the Best Baby Zone sites. Oakland is located in Alameda County with the project falling under the BBC umbrella.

[201] Please see the following article for a full list of BBC partners. Shrimali, B. P., Luginbuhl, J., Malin, C., Flournoy, R., & Siegel, A. (2014). The building blocks collaborative: advancing a life course approach to health equity through multi-sector collaboration. Maternal and Child Health Journal, 18(2), 373–379. doi:10.1007/s10995-013-1278-x

LESSONS LEARNED

Early lessons and key principles include:[202]

- "Shifting a paradigm is slow…investments in learning, creating space for inspiration and possibility, building new relationships and partnerships, and testing new apaches lays the groundwork for lasting change."[203]
- "…embrace the ambiguity needed to develop new approaches, and welcome the contradictions inherent in challenging the status quo."[204]
- Local health departments are important conveners of an initiative to address health equity. They should be a voice for change, take risks on untested and new approaches; use their influence to invite partners to collaborate; dedicate resources including funding, staff, and time.
- Build collective, broad goals. An open approach was conducted in order to understand and build on all partners strengths as well as existing community priorities.
- Build trust, shared ownership, and collective vision among partners. Specific strategies utilized included community partners being actively involved in planning meetings, facilitating agendas, recruiting new members, and hosting meetings.
- Ensure that there is dedicated staff to plan, facilitate, and manage regular meetings with partners, trainings, collective funding opportunities, implementation projects, and on-going communications.
- Create a flexible partnership structure. A tiered engagement structure was created to provide for different levels of involvement. "Members" are more deeply involved and complete a partnership commitment form. "Members" facilitate communication between the BBC and their organization, leverage resources and networks, attend meetings and training, and contribute to workgroups. "Supporters" receive regular email information and attend meetings less frequently than "members."
- Support partners' capacity. BBC lead ACPHD offered grant writing trainings to support partners' future grant development. ACMPHD also provided scholarships for partners to attend symposiums and trainings.

[202] "The Building Blocks Collaborative" Advancing a Life Course Approach to Health Equity Through Multi-Sector Collaboration" Bina Patel Shrimali 2013. Shrimali, B. P., Luginbuhl, J., Malin, C., Flournoy, R., & Siegel, A. (2014). The building blocks collaborative: advancing a life course approach to health equity through multi-sector collaboration. Maternal and Child Health Journal, 18(2), 373–379. doi:10.1007/s10995-013-1278-x

[203] "The Building Blocks Collaborative" Advancing a Life Course Approach to Health Equity Through Multi-Sector Collaboration" Bina Patel Shrimali 2013. Shrimali, B. P., Luginbuhl, J., Malin, C., Flournoy, R., & Siegel, A. (2014). The building blocks collaborative: advancing a life course approach to health equity through multi-sector collaboration. Maternal and Child Health Journal, 18(2), 373–379. doi:10.1007/s10995-013-1278-x

[204] Shrimali, B. P., Luginbuhl, J., Malin, C., Flournoy, R., & Siegel, A. (2014). The building blocks collaborative: advancing a life course approach to health equity through multi-sector collaboration. Maternal and Child Health Journal, 18(2), 373–379. doi:10.1007/s10995-013-1278-x

PHASE	Early Implementation: **Wisconsin Lifecourse Initiative for Healthy Families (LIHF)**
PROGRAM DESCRIPTION	PURPOSE: 1) Improve infant health and survival, 2) Improve the health status of African-American women, and 3) Eliminate racial disparities in birth outcomes. Funds are directed towards LIHF Collaboratives in the cities of Milwaukee, Racine, Kenosha and Beloit to address key policy, systems and environmental issues identified in LIHF Community Action Plans (CAP). STRATEGIES: Grantees:[205] ▪ Maintain and manage highly effective multi-sector collaborative partnerships to address CAP priorities ▪ Plan and implement broad-reaching high-impact strategies that utilize policy, systems and environmental change approaches to advance the goals of the CAP ▪ Translate and integrate data into process improvement and in the selection of intervention strategies and issues ▪ Develop and implement sustainability plan to ensure sustained partnerships and health impacts after grant ends Grantee projects fall into four main categories: 1) Centering pregnancy, 2) Expanded home visitation, 3) Birthing Project USA sister friend, and 4) Fatherhood programs. Some grantee programs include more than one of these elements. All grantees are required to partner with a University of Wisconsin School of Medicine and Public Health faculty to help them conduct evaluation and research related to their project. Maternal Child Health (MCH) faculty members oversee collaboratives and provide leadership. LIHF also has regional offices to support each specific geographic area. Grantees receive technical assistance from the central office, regional office, and academic partner. The level of TA varies by grantee. Community Coalitions: As part of the planning process the program formed large community coalitions for each geographic area. The coalitions have worked together for two to three years. The coalitions are continuing to be funded and to focus on policy. The grants are focused on direct services while these coalitions are focused on policy. Policy areas of focus are fatherhood, racism, and coordination of home visitation to avoid duplication. They are looking toward the tobacco community work as a model. The program provides the coalitions support and technical assistance. FUNDING STRUCTURE/TIMELINE: Planning was conducted from 2009-2012 and had a $2 million budget. Implementation began in 2012 and will last for 5 years and has an $8 million budget. Grants are for up to five-years with annual grant renewals based on achievement of performance goals and targets. By the end of year two, and in each subsequent grant year, grantees must provide an increasing combination of cash, extramural support and cost-sharing. Grantee budgets are not known from review of publically available websites and documents.
PARTNERS	University of Wisconsin School of Medicine and Public Health (lead), MCH staff, Wisconsin Pregnancy Risk Assessment Monitoring System, Wisconsin Medicaid Program, local health departments, and grantees.

[205] Grants are provided to collaboratives. Collaboratives are multi-sector and include local health departments, key state and local governmental representatives, community-based organizations and agencies, African-American community members, funders, health systems and providers, the faith and business communities and local LIHF project grantees.

LESSONS LEARNED

Early lessons and key principles include:

- Conduct continuous quality improvement. "Maternal and child health lifecourse activities, as with any new and emerging approach, are best implemented in conjunction with formal and informal continuous quality improvement to assess how well efforts are working and adjust as needed"[206]
- Planning takes considerable resources, deep commitment from the University leader, and partners. Turn-over in community leaders was a challenge.
- Anticipate there may be a power struggle early on. The University wants the initiative to be community-driven but they hold the money. This caused a lot of tension at the beginning.
- Open parameters with unlimited potential directions can be a challenge for some grantees and coalitions. The openness also impacted timeline. If they had been more prescriptive the initiative could have moved forward more quickly but would not have been community-driven.
- Being community-driven was a risk and organizational culture shift for the University.
- Communication is essential. The program connected with over 500 people in the planning phase. It is important to have clear communication about the goals and outcomes. Regular communication with partners during implementation is also key.
- Apply learning from this planning process to other initiatives. They are applying their learning to a new obesity initiative focused on community systems of change.
- Work closely with local and state public health as well as private philanthropy. They required grantees to work with local public health and to have private philanthropy at the table to spread the funding and buy-in.
- Allow for sufficient education time and training about the life course perspective. Even after presentations and education, local public health providers needed help incorporating the life course perspective into their daily work. Use the train the trainer model to help build their capacity and knowledge.
- Gaining buy-in from collaborators can be a challenge at the beginning since the life course perspective has a wide range of risk, protective factors, and critical periods.
- Measuring progress and tracking system change is a challenge. They are overcoming this by measuring individual program efforts and larger system change.
- Community coalitions planning process was clear but now the coalitions are struggling to see themselves as able to change policy and be concrete around a policy agenda and plan.

[206] Rohan, A. M., Onheiber, P. M., Hale, L. J., Kruse, T. L., Jones, M. J., Gillespie, K. H., et al. (2014). Turning the ship: making the shift to a life-course framework. Maternal and Child Health Journal, 18(2), 423–30. doi:10.1007/s10995-013-1225-x

PHASE	Later Implementation (since 1999): **Magnolia Project**
PROGRAM DESCRIPTION	PURPOSE: To improve the health and well-being of women during their childbearing years (15–44 years old) in Jacksonville, Florida. The goal is to work with women to address risk factors (pregnancy intervals, nutrition issues, substance/alcohol abuse, psychosocial problems, family planning, and other issues) that impact their health and may affect a future pregnancy. The program is working to make women well and to reduce infant mortality. STRATEGIES: The program is targeted to preconception women in a specific geographic area that also meet specific risk criteria.[207] The program has the following activities: ▪ Health education (i.e., community garden and nutrition education "Soul Food Pyramid Guide") ▪ Clinical services including well-woman and prenatal care (including Centering Pregnancy), family planning, STI treatment, primary care, and free pregnancy tests. The program's case management focuses on development of a life plan, which includes economic and social equity goals, and provides groups on specific health and social determinants (e.g., group topics on financial planning and GED preparation).[208] All women participate in case management and are offered participation in groups based on their self-determine goals and needs. ▪ Community council: It is made up of current clients, former clients, and some family members. They participate in a 12 week leadership training and then act as an advocacy group for community issues. ▪ Men's program: The program is piloting a men's group. Magnolia staff received fatherhood program training from BootCamp for Dad. FUNDING STRUCTURE/TIMELINE: The program has been funded since 1999 through the federal Healthy Start program. The total budget is not known from review of publically available websites and documents. Magnolia is one project within the Northeast Florida Healthy Start Coalition (NFHSC). NFHSC's mission is to reduce infant mortality and improve the health of children, childbearing women, and their families in Northeast Florida. According to the NFHSC online 2011 annual report, NFHSC's total 2011 expenses were $6.3 million.
PARTNERS	Duval County Health Department (core partner), Northeast Healthy Start Coalition (core partners), faith-based community, March of Dimes, Northeast Florida Area Health Education Association, Jacksonville Housing Authority, Florida Department of Health, War on Poverty, CDC, City Match, National Healthy Start Association, school districts, hospitals, colleges, dental services, local day cares, beauty salons, check cashing stores, community convenience stories, neighborhood housing complexes, among others.

[207] For further information see: http://nefhealthystart.org/for-women/magnolia-project

[208] Brady, C., & Johnson, F. (2014). Integrating the life course into MCH service delivery: From theory to practice. Maternal and Child Health Journal, 18(2), 380–388. doi:10.1007/s10995-013-1242-9

LESSONS LEARNED

2006 evaluation: "Clients who received preconception and interconception case management showed improved birth outcomes following case management including decrease in low birth weight and infant death and decrease in failed interconceptional periods…Strengths of their interventions were: linking culturally/linguistically sensitive healthcare, including accessible location, and access to quality health care with case management that encourages the clients to take personal responsibility for their health and well-being."[209]

Lessons learned to date include:[210]

- Focus on preconception and lifecourse model. It is very important to impact women before pregnancy to improve birth outcomes.
- Provide a system of care - reproductive health services, health education, case management. They all are needed.
- Cultural sensitivity is vital. The program is located within the community it serves, which helps minimizes cultural barriers and increase awareness of the community and its needs.
- Be in an accessible location. The program has a storefront location and walk-in services. They are located by a bus line. WIC and an immunization provider are next door.
- Provide access to quality healthcare and case management. All services are in the same building. They are a "one stop shop for multiple services."
- Ensure staff understand the needs of the community. They are trusted by the community. It is a safe place.
- Provide walk-in services and be open nontraditional hours. They are open until 7pm and on the weekend. Case managers also work nontraditional hours.
- "Meet people where they are"
- Provide two levels of case management. Level #1: Everyone begins at level one, which is every week for 90 days. Level #2: Once a month case management and groups.

[209] For further information see: http://nefhealthystart.org/wordpress/wp-content/uploads/2011/02/Final-MP-Annual-Report-Web-Version1.pdf

[210] Lessons learned are primarily based on the interview with program leadership.

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Appendix C: Interviews

Harder + Company conducted phone interviews with individuals knowledgeable about promising practices and programs for 1) improving healthy disparities in birth outcomes and 2) fatherhood (see Exhibit 3).

Exhibit 3: List of Interview Participants

National Expert Interviews	Dr. Bowen Chung, Co-Principal Investigator NICHD Fatherhood Project, Assistant Professor In-Residence, Department of Psychiatry, UCLA School of Medicine
	Dr. Calvin Hobel, Attending Physician, Division of Maternal Fetal Medicine, Department of Obstetrics and Gynecology, Cedars-Sinai Medical Center
	Loretta Jones, CEO and Founder, Healthy African American Families II
	Dr. Alonzo Plough, Vice President for Research and Evaluation, Robert Wood Johnson Foundation
National Program Interviews	Catherine Frey, Former Associate Director, Wisconsin Partnership Program
	Wendy Hussey, Program Manager, Best Babies Zone
	Faye Johnson, Project Director, Magnolia Project
	Deja Kono, Project Coordinator, Best Baby Zone Oakland, Alameda County Public Health Department
	Melissa Longsdon, Program Officer, Missouri Foundation for Health
	Bina Patel Shrimali, Health Equity Innovation Manager, Building Blocks for Health Equity Unit, Alameda County Public Health Department
Local Expert Interviews	John Bamberg, Senior Program Officer, First 5 Los Angeles-Best Start Program
	Susan Bostwick, Maternal Child Health Interim Director, Los Angeles County Department of Public Health
	Marvin Espinoza, Senior Program Officer, First 5 Los Angeles-Best Start Program
	Janice French, Project Director, Los Angeles Best Babies Network
	Alan-Michael Graves, Program Director, Children's Institute, Inc.
	Cindy Harding, Chief Deputy Director, Los Angeles County Department of Public Health
	Michelle Kiefer, Executive Director, Antelope Valley Partners for Health
	Breanna Morrison, Policy Analyst, Community Health Councils-Project Health Impact Assessment
	Geraldine Perry-Williams, Maternal Child Health Director, Pasadena Department of Public Health

Appendix D: Advisory Workgroup

In addition to the partnership with the First 5 LA Research & Evaluation Department, Harder + Company met with a First 5 LA advisory workgroup to hear their learning priorities for the study as well as feedback on the draft report. Please see Exhibit 4 below for participants.[211]

Exhibit 4: Advisory Workgroup Meetings Participants (February 2014-March 2014)

Advisory Workgroup Participants	
Grants Management	Tara Ficeck, Senior Program Officer
	Tina Chinakarn, Program Officer
Policy	James Lau, Director
	Stacy Lee, Policy Manager
Program Development	Reena John, Senior Program Officer
	Lee Werbel, Senior Program Officer
	Diana Careaga, Program Officer
	Bill Gould, Program Officer
	Nancy Watson, Program Officer
Research & Evaluation	Armando Jimenez, Director
	Mario Snow, Senior Research Analyst
	Kelly Goods, Research Analyst

[211] A person is included in the advisory workgroup if they attended at least one of the two meetings.

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