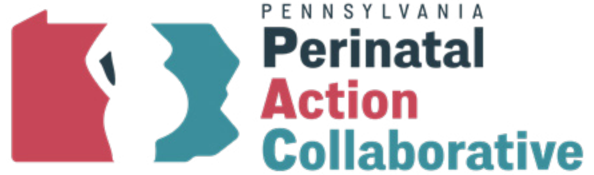
PA MATERNAL HEALTH Symposium 2026

May 19-20, 2026 | Altoona, PA



BROWN MAMAS · 2026 MATERNAL HEALTH SYMPOSIUM

CARE Collective

A Warm-Handoff System for Maternal Wellness, Trust, and Community Care

A Brown Mamas + Healthy Start partnership supporting Black mothers and families in the Pittsburgh region

● LAUNCHING PHASE ONE · SUMMER 2026

IN PARTNERSHIP WITH HEALTHY START

The Why: Black Moms Should Not Have to Navigate Alone

In Pittsburgh and Allegheny County, Black mothers and babies continue to experience deep maternal and infant health disparities. The CARE Collective is Brown Mamas' community-rooted response — helping mothers find trusted support earlier, with less confusion, less stigma, and more care.

97% Black maternal mortality in Pittsburgh higher than 97% of similar cities

4× Black infant mortality in Allegheny County more than 4× higher than white infant mortality

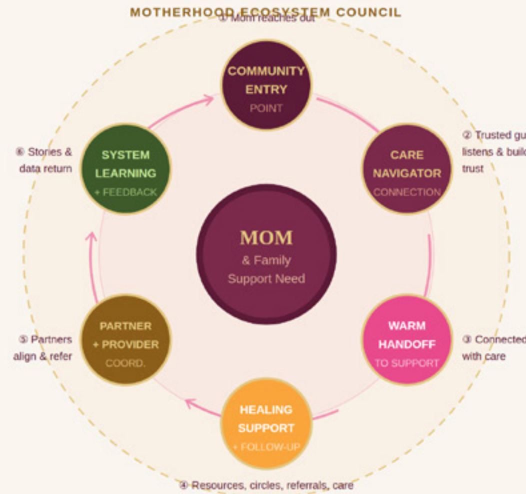
2× Black birthing people experience nearly 2× preterm births & more than 2× low-birth-weight babies

What Moms Are Navigating

Fragmented systems · Cultural mistrust · Economic strain · Parenting stress · Mental health stigma · Isolation · Navigation overwhelm · Suppressed stories · Emotional loneliness · Transition stress · Visibility wounds · Narrative disempowerment

The What: The CARE Collective System

A trained workforce and community care model — trusted navigators who welcome moms in, facilitate healing-centered spaces, and provide one-on-one navigation so moms connect to the right resources and next steps. **Both a support hub and a connection hub.**



Built from Community Voice — In 2026, Brown Mamas and Healthy Start conducted focus groups to understand postpartum emotional and mental wellness needs. Moms asked for holistic, flexible, local, nonjudgmental, and accessible support.

> *"The CARE Collective helps moms move from 'I don't know where to go' to 'I have a trusted person helping me find the right next step.'"*

The How: How the Model Works

- **Low-Barrier Entry:** website, word of mouth, postcards, Facebook, Healthy Start, partner referrals
- **Peer Venting + Normalization:** honesty, nonjudgmental responses, connection
- **Care Navigation:** trained navigators help moms identify needs and find the right next step
- **Warm Handoffs:** moms connected to people, programs, services, and providers with support
- **Workforce Layer:** stipended navigators, support group leaders, community health advocates
- **Generational Wisdom Loop:** lived experience, advisory support, community guidance

Partnership with Healthy Start

The CARE Collective is being developed in partnership with Healthy Start Inc. Pittsburgh. Together, Brown Mamas and Healthy Start are using community voice, focus group findings, and maternal health expertise to build a care navigation model responsive to the emotional, mental, logistical, and social needs of Black mothers and families.

CURRENT + EMERGING PARTNER ECOSYSTEM

Healthy Start Inc. Pittsburgh · Dept. of Human Services · ELRC · Family Support Centers · Local Churches · Neighborhood Orgs · Mental Health Providers · Doulas + Midwives · Healthcare Orgs

What We Heard From Moms

> *"I want somebody to help me navigate this paperwork."*

> *"Just do it. Don't make it hard for me to access."*

> *"After you have a baby, everybody forgets about you as the mom."*

> *"People don't believe us."*

Who Does the Work

- CARE Collective Director
- Care Navigation Specialist(s)
- Outreach Specialist
- Healthy Start Community Health Advocates
- Support Group Leaders
- Community-Based Care Navigators

NAVIGATOR TRAINING INCLUDES

Asset Mapping · Mental Health First Aid · Life Coaching · Warm Handoff Practices · Care Navigation · Referral Tracking · Culturally Responsive Support

What's Next · Phase One

Phase One launches in Summer 2026, focused on training care navigators, building warm-handoff pathways, supporting mothers through trusted navigation, and convening the Motherhood Ecosystem Council.

- Launch CARE Collective, Summer 2026
- Train community-based care navigators
- Funnel Healthy Start CHAs into care navigation roles
- Strengthen warm-handoff referral pathways
- Convene the Motherhood Ecosystem Council
- Track needs, gaps, and where systems can improve

Results We're Working Toward

SHORT-TERM

Increased help-seeking · Reduced isolation · Stronger peer networks · Maternal confidence · Better nav literacy · Awareness of services

LONG-TERM

Earlier mental health access · Improved wellbeing · Strengthened families · Community-owned care · Intergenerational wisdom

Biggest Lesson Learned

● FROM BROWN MAMAS' SOCIAL IMPACT AMBASSADOR MODEL

*Moms do not just need more referrals. They need **trusted people who can walk with them** toward the right support. Warm handoffs, cultural trust, and community-based care navigation make support easier to access.*

The CARE Collective is not just a referral program. It is a partnership-powered, community-owned care navigation system built on trusted relationships, trained navigators, warm handoffs, and provider collaboration.

Brown Mamas builds community for Black moms as a public health access hub that connects mothers to one another and to the services they need to thrive, fostering a cyclical culture of support, referral, and generational wisdom.

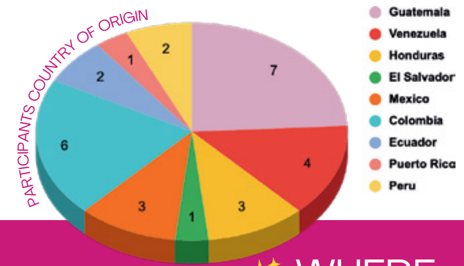
www.brownmamas.com | hello@brownmamas.com

Sources: City of Pittsburgh Gender Equity Commission · Allegheny County BIRTH Plan · Brown Mamas + Healthy Start CCPP community findings · Brown Mamas 5-Year Programmatic Plan

Naciendo Juntos

EMPOWERING EXPECTANT LATINAS IN PITTSBURGH THROUGH EDUCATION & SUPPORT

Presented by Vilmarie Estrella-Lokay



PROGRAM SUMMARY

The *Naciendo Juntos* program **supports Latino expectant mothers in Pittsburgh by providing education on resource navigation, pregnancy stages, pre- and post-natal care, and newborn care.** The program includes 8 weekly workshops and individual case management to ensure safe childbirth.

FALL 2024 - SPRING 2026

29 WOMEN

06 SESSIONS

HOW WE STARTED:

We assigned a program coordinator who is also a trusted case manager to lead the sessions. **Outreach through internal referrals, social media and word of mouth**

WHERE:

Participants living in the **greater Pittsburgh area**. Sessions held at the Carnegie Public Library in **Beechview**, a neighborhood with a growing Latino presence with access to public transportation (by bus and metro).

8 CLASSES 3 TIMES A YEAR :

1. Introduction and Ice Breakers
2. Mental Health Support & Community Health Programs at Casa San José
3. WIC & Navigating Important Documents and Applications
4. What to Expect Post-Partum & Dispelling Myths
5. Pediatrician Visit and Baby's First Year
6. A Doula's Role and Creating a Birth Plan
7. Spanish-Language Hospital Tour
8. Baby Shower Including Games & Gifts

KEY INTERVENTIONS:

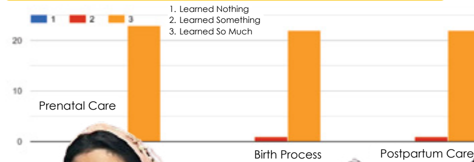
- CONNECTING WITH SPANISH-SPEAKING PROVIDERS
- CASE MANAGEMENT AND MENTAL HEALTH SUPPORT OFFERED TO ALL PARTICIPANTS
- ACCESSING LOW-COST OBGYN IF CARE HAD NOT YET BEEN ESTABLISHED

ALL RECEIVE A CAR SEAT, PORTABLE CRIB, DIAPERS, WIPES, & OTHER ESSENTIALS

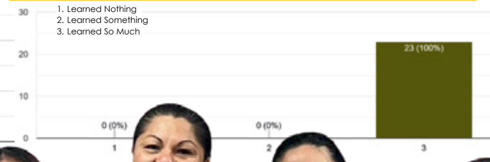
WHY IS THIS NEEDED?

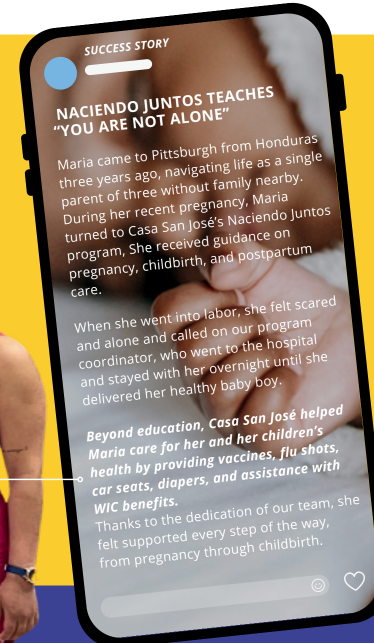
In the Pittsburgh area, there is a shortage of Spanish-speaking providers for the small (4.5%) but rapidly-growing Latino community. Many pregnant women are unfamiliar with the U.S. healthcare system or mistrust it, and have language, transportation and economic barriers, leading to hesitance in attending regular prenatal care screenings.

How much new information did you learn about the following:



How much did the program help connect you with other mothers?





WHAT'S NEXT?

The key takeaway is that **social connection was the most valued outcome for participants, who initially felt isolated**. Post-program surveys indicated that connecting with other women in similar situations boosted their confidence.

RESULTS

- **Feeling less alone, meeting women like them**
- **Being able to access resources they didn't know were available to them**
- **More confident in their childbirth journey**

SOCIAL CONNECTION PRIORITY

- **Continued community-building through Spanish-language baby-and-me sessions**
- **Ongoing connection in WhatsApp group**

www.casasanjose.org

Patients R Waiting - The Diversifying Doulas Initiative®

INTRODUCTION

The Diversifying Doulas Initiative (DDI) aims to train women of color (WOC) to become Doulas, provide expectant birthing people of color across Lancaster, York, Dauphin, and Berks counties, with fully subsidized Doula services, provide community programming to families, and conduct research on maternal health outcomes as a result of this initiative; **all to address the maternal mortality crisis in the United States for WOC.**

Our initiative directly correlates with the objectives of the Jewish Health Care Foundation because we are providing free educational resources to birthing and expectant people of color in the form of Doula services, Doula training, and community programming. We provide fully subsidized Doula training for women of color to educate and serve expectant families of color with evidence based Doula care, childbirth education, and other necessary resources related to maternal health. This initiative provides expectant people of color with the proper education needed to enter their birthing experience and make informed, thoughtful, and empowered decisions for their and their babies' health.

Black women are three to four times more likely to die during childbirth than white women, and Latinx women fall closely behind this alarming statistic. In addition, prenatal care is universally covered by health insurance, though inadequate for birthing people of color, while postpartum care is often neglected and ignored. Lack of compensated postpartum care leaves birthing people more susceptible to complications, both mentally and physically, after giving birth. Our initiative is lead by two Black OBGYNs, who value the importance of Doula care for their patients, so they developed DDI. DDI services are fully subsidized for eligible clients, making the program accessible to all socioeconomic classes, especially low-income families. DDI Doulas provide certified, evidence-based, high-quality care to clients, and client feedback is collected after services are completed to help strengthen and improve the program for the future.

For years 2024 and 2025, the Diversifying Doulas Initiative responded to the call of the community. We provided 172 birthing people of color with fully subsidized Doula services up to and including January 31, 2026. The 172 clients include those completed an intake form, delivered with a DDI Doula, and met eligibility for services up to and including January 31, 2026. JHF Innovation funding assisted in providing subsidized Doula care to 50 clients. Doula services include prenatal sessions, birth support, breastfeeding support, nutrition counseling, and postpartum support.

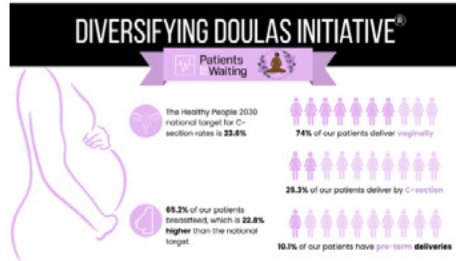
For the years 2024 and 2025, DDI trained 28 Doulas of color at the DDI home site in Lancaster, PA. On March 29, 2026, DDI completed training for its 9th cohort of Doulas, reaching the milestone of 102 Doulas trained. The average cost to train a Doula through the Diversifying Doulas Initiative and DONA is approximately $3,600 including membership fees, textbooks, certification fees and instructor fees. Upon completion of training, Doulas receive their Doula certification, postpartum certification, certified breastfeeding support certification, and mental health first aid certification.

Our community programming was provided through Community Perinatal Doula Education (also referred to as FUBD: For U By Doulas). This is a group session facilitated by a Doula and clinicians to educate families and provide modules including Knowing your Birth Rights, Childbirth Education, Lactation support, and Comfort Measures. JHF funding supported community sessions offered in Lancaster, Harrisburg and virtually. Additionally, the research pillar of DDI held DADvocates listening sessions in preparation for the development of a training program for men of color to be perinatal support people for Black fathers. Lastly, DDI engaged Doulas in development sessions such as DDI Community Doula Circles and the DDI Chat and Chew held multiple times a year with labor and delivery nurses at UPMC Lititz hospital.

PROGRAM OUTCOMES

Doula Training: As of March 2026, DDI has fully trained 102 Doulas of color. The Doula training currently consists of over 40 hours of didactic and hands-on training. In addition to certified training, each Doula receives mental health first aid training, Certified Breastfeeding Specialist (CBS) training, CPR training, and HIPAA training.

Doula Services: DDI tracks a number of outcomes for the birthing client and baby, specifically C-Section, pre-term delivery, and breastfeeding rates. DDI client interventions show outcomes for birthing people of color at rates higher than national averages outlined by Healthy People 2030.



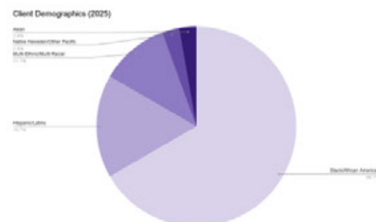
Community Education: At the beginning of each FUBD session, attendees are queried about their knowledge of Doula support and what they believe could improve maternal health outcomes. **A common trend in responses showed the value of involving the entire family in helping improve maternal health outcomes.** There was a request to "call in" fathers to the sessions. DDI heard the community and responded by creating the DADvocates Initiative.

CLIENT EXPERIENCE

DDI received a client through the *For U By Doulas* program who initially had limited awareness of the role of Doulas and how Doula support could benefit her experience during pregnancy. After completing the class, the client submitted an intake form and was matched with a Doula within 48 hours. Less than 48 hours later, the Doula met the client at the hospital, as she had been placed on bed rest and remained hospitalized until delivery. After the baby was born and admitted to the NICU for several weeks, the Doula continued to provide consistent support to both mother and baby, visiting at the hospital throughout the NICU stay, and assisting with the transition home once the baby was discharged.

By attending the FUBD session, and completing an intake form, this client was able to have multiple touchpoints with the DDI program. This is just an example of how DDI delivers meaningful outcomes as a maternal health equity intervention.

DDI reached 102 Doulas trained in 6 years on March 29, 2026 and has expanded client services from 1 service county (Lancaster) and hospital served to 4 PA counties and multiple PA hospitals in the Central PA region.



PROGRAM EXPANSION

DDI Massachusetts: Given the expanded reach of Patients R Waiting as an organization, DDI is operating in Massachusetts. Dr. Cherise Hamblin, co-founder of DDI, is currently teaching and practicing at UMASS Chan Medical School. She coordinates the DDI program at the site and we have now trained 2 Doula cohorts serving clients in Worcester County, Massachusetts. 39 Doulas have been trained in the past 2 years. JHF funds were NOT used for this expansion.

Menopausal Health: Though often discussed separately, advancing maternal health equity includes considerations across the lifespan. In October of 2025, DDI co-sponsored a menopausal health event alongside the PA Governor's Advisory Commission on Women. DDI Founder, Dr. Sharee Livingston, and menopausal health expert, Dr. Sharon Malone, discussed women's health at the Forum in Harrisburg. The event received 400 registrants. Attendees were given a free copy of Dr. Malone's book entitled, "*Grown Woman Talk: Your Essential Companion for Healthy Living*".

DADvocates: This initiative came directly from the call of the community as highlighted in the previous response. Birthing people are looking for more opportunities for support of the whole family during pregnancy, particularly fathers. The mission of DADvocates is to address the maternal health crisis by empowering the family as a whole. To improve the Black maternal health crisis, the Black family must be centered and supported. DDI is preparing train a cohort of Black men in June 2026. The training will be developed from information gathered from listening sessions with Black men about their needs as fathers and support people.

Doula Compensation: Beginning July 1, 2025, DDI began compensating each Doula $1,500 per client to remain congruent with national trends regarding Doula compensation and Medicaid reimbursement.

Please scan the QR code to learn more about Patients R Waiting and the Diversifying Doulas Initiative

CHALLENGES AND SOLUTIONS

Program Challenges:

- Systemic underfunding and undervalued community based Doula services, particularly those led by and serving communities of color.
- Economic pressures that require Doulas to secure additional, supplemental pay, having an impact on long term Doula care and program engagement. **Structural barriers have limited access to business, capital, and financial literacy for communities of color.** Supporting community Doulas with entrepreneurship and business development is critical to long-term program sustainability.
- **The program operates under a lean personnel model and continues to produce strong outcomes.** As program demand and responsibilities increase, compensation adjustments are necessary to sustain staff capacity and prevent burnout. However, this creates ongoing pressure on operating resources despite high level performance.
- **Challenges maintaining client contact during the postpartum service period** due to demands on the family, scheduling barriers, or other limitations outside of Doula's control (client loses phone service, unstable housing, transportation issues, mental health concerns, partner restrictions)

Solutions:

- Scaled up Doula business and professional support including ongoing training, mentorship, and enrichment opportunities to include Medicaid certification support for Doulas through application guidance and potential coverage of associated fees.
- Beginning July 1, 2025, DDI increased compensation to $1500 per client, aligning with Medicaid reimbursement rates; however, national trends indicate experienced Doulas earn closer to $2000 per client, demonstrating the continued need for sustainable funding. PRW began an organizational fundraising campaign (FY 2026) to diversify revenue and support long term sustainability for programs such as DDI.
- Expanded postpartum support, including partnerships with local mental health professionals and Doulas to facilitate a family centered support group for DDI clients and birthing community members. Beginning the DADvocates program to engage fathers and partners to strengthen family support systems and improve postpartum outcomes.

CONCLUSION

Community Doulas serve a distinct role from private hire Doulas. DDI Community Doulas provide culturally responsive, full scope support to birthing families facing a number of systemic barriers (i.e. economic, housing, food insecurity) that extend far beyond labor and delivery support. Care coordination, advocacy, and resource navigation are a significant part of the work. Community Doula work is essential to advancing maternal health equity but requires additional resources (time, training, and compensation). Client fees do not sustain Community Doulas in the same manner as private hire Doulas. **Investing in the Community Doula workforce is imperative to retention, continuity of care, and better outcomes for the populations served.**

Family Village
Helping Delaware County Families Thrive

Maternal Care Innovation Grant: Doula Initiative 2024

1 Who we are: Family Village supports pregnant, postpartum, and parenting families

Family Village houses the Foundation for Delaware County's public health programs. We've been supporting families with young children for over 25 years.

Each year, we serve more than **8,500** Delaware County residents, connecting them to: case managers, nurses, civil legal attorneys, housing experts, social workers, and more.

2 What we did: Expanded and enhanced doula care

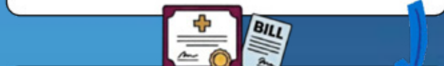
The doula initiative strives to improve maternal health outcomes in priority populations impacted by economic and racial inequality in Delaware County.

She educated me and my partner prior to my childbirth and continued to educate us throughout the delivery. She catered to my birthplan and assisted me and my partner throughout. She made my birth experience wonderful, and I was so grateful to have her as my doula.

3 How we did it: Expanding Doula Care

BUILT WORKFORCE

8 BIPOC community-based doulas recruited and trained in comprehensive labor and post-partum care.



STRENGTHENED CREDENTIALS

7 of 8 doulas were additionally trained and certified as **Community Health Workers.**

All were supported in pursuing **Medicaid billing.**

DELIVERED CARE

- **250** prenatal visits
- **226** postpartum visits
- **116** births supported

Data shown here captures activity between March 2024 and November 2025.

4 Why it matters: Filling a critical gap in maternity and infant care

- Within 4 years, our county went from **3 birthing hospitals to 1.**

- The remaining hospital was not equipped to serve the growing number of Medicaid-eligible, uninsured, or medically complex patients.
- Hospital closures disrupted key partners like, our local FQHC, further intensifying the needs.

5 Lesson Learned: The Value of Building Clinical Collaborations

As a result, our next steps include:

Expanding partnerships with health systems to create "doula-friendly" hospitals.	Growing the doula workforce through training and certification.	Launching a public doula registry & providing MA reimbursement technical assistance.

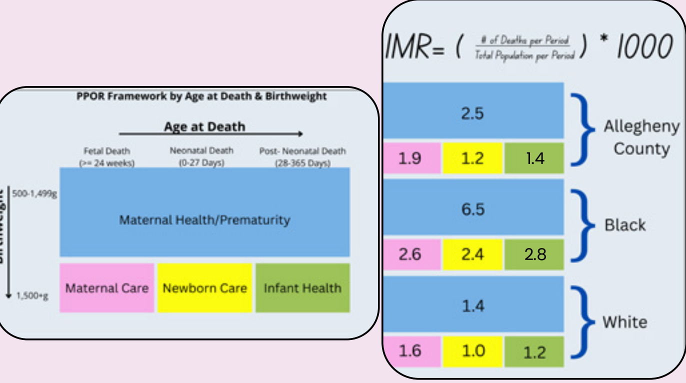
Bridging The Gap:

Clinical and Community Collaboration for Black Maternal Health in Allegheny County, Pennsylvania

Leslie Howze, BPA- EMS, Candidate for MPH, Drexel University, Community Project Manager- Project Butterfly
Jessica A. Davis, PhD, RN, IBCLC, Clinical Partnership Liaison, Chair- FIMR Clinical Action Collaborative

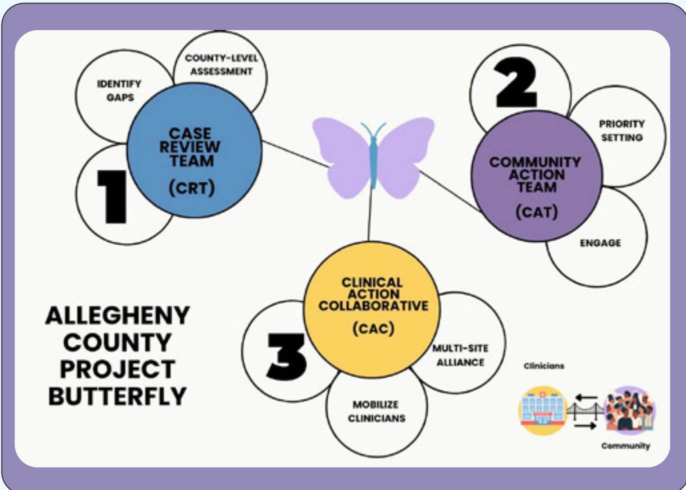
Mind The Gap

The 2020 Allegheny County Perinatal Periods of Risk Report (PPOR) showed that the Black infant mortality rate was nearly 3 times higher than the White infant mortality rate in 2019, despite the overall county rate meeting the Healthy People 2030 benchmark of 5.0 per 1,000 livebirths.



FIMR and Excess Mortality by PPOR Study Group and Period of Risk

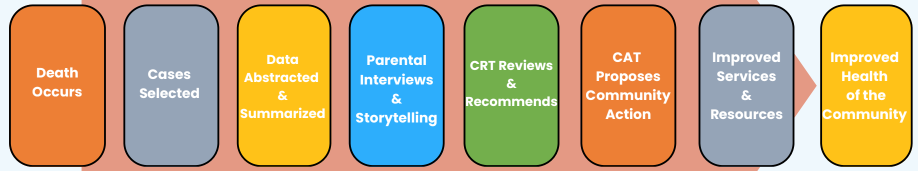
	Maternal Health/ Prematurity	Maternal Care	Newborn Care	Infant Health	Fetal-Infant Mortality Rate
Allegheny County	2.54	1.93	1.21	1.41	7.08
Reference Group	1.16	1.51	0.86	1.11	4.64
Excess Mortality	**1.38**	**0.42**	**0.35**	**0.3**	**2.44**
	Maternal Health/ Prematurity	Maternal Care	Newborn Care	Infant Health	Fetal-Infant Mortality Rate
Black	6.51	2.6	2.37	2.76	14.25
Reference Group	1.16	1.51	0.86	1.11	4.64
Excess Mortality	**5.35**	**1.09**	**1.51**	**1.65**	**9.61**
	Maternal Health/ Prematurity	Maternal Care	Newborn Care	Infant Health	Fetal-Infant Mortality Rate
White	1.36	1.63	0.96	1.16	5.11
Reference Group	1.16	1.51	0.86	1.11	4.64
Excess Mortality	**0.2**	**0.12**	**0.1**	**0.05**	**0.47**



Bridge Builders in Action

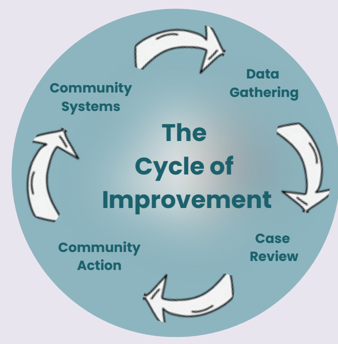
The Fetal and Infant Mortality Review works to understand and prevent stillbirth, pregnancy loss, and infant death by examining individual cases and identifying systemic gaps. Multiple data sources are used.

The Case Review Team analyzes each case to uncover where systems may have failed the family. Findings are prioritized and shared with the remaining teams, who make upstream recommendations to prevent future losses.



The Bridge Built by Us

- **Storytelling:** This unique component of our process centers the voices of families who've experienced loss to guide compassionate, systems-level change.
- **Count the Kicks Campaign:** Educates expectant parents on fetal movement to prevent stillbirth and promote self-advocacy.
- **Community Blood Pressure Education:** Advances heart health literacy for Black families during pregnancy and postpartum.
- **Trauma-Informed Care:** Collaborates with multidisciplinary partners to implement best practices that promote safety, empathy, and healing.
- **Centering Black Births:** Every initiative uplifts the voices of Black families, experiences, and outcomes through education, advocacy, and actions.



Sources:
1.Allegheny County Health Department. (2020). Perinatal Periods of Risk (PPOR) Report. Allegheny County, PA. https://www.alleghenycounty.us/files/assets/county/v/1/services/children-and-families/documents/2020-ppor-report.pdf
2.Allegheny County Health Department. (n.d.). Fatality Review Programs. Allegheny County, PA. https://www.alleghenycounty.us/Services/Children-and-Families/Family-and-Child-Health-Programs/Fatality-Review-Programs
3.Healthy Communities Institute. (n.d.). Low birth weight indicator for Allegheny County, PA. Pittsburgh Community Health Indicators. https://pittsburgh.thehcn.net/indicators/index/view?indicatorId=4375&localeId=2297

Food is Medicine in Maternal Health: A Pilot Program for Gestational Diabetes

Tonya Cooper,[1] Haley Walsh[1]

[1]Metropolitan Area Neighborhood Nutrition Alliance (MANNA), Philadelphia, PA [2]Jefferson Einstein Healthcare Network, Philadelphia, PA, [3]Helen O. Dickens Center for Women's Health, Philadelphia, PA

OBJECTIVE

The Metropolitan Area Neighborhood Nutrition Alliance (MANNA) is a community-based organization (CBO) providing medically tailored meals (MTMs) and nutrition counseling to individuals with critical illness in the Philadelphia, PA region. In partnership with Jefferson Einstein Healthcare Network and the Helen O. Dickens Center for Women's Health, MANNA implemented a gestational diabetes pilot program to improve access to nutrition support during pregnancy and postpartum. Pregnant individuals with gestational diabetes face an increased risk of adverse maternal and infant outcomes. The objective of this study was to evaluate the feasibility and preliminary impact of a comprehensive nutrition intervention—MTMs, counseling, and coordinated care—on dietary intake, health-related quality of life, self-management, and healthcare engagement among high-risk pregnant individuals.

METHODS

MANNA implemented a two-year pilot program providing MTMs and nutrition support to pregnant and postpartum individuals with gestational diabetes. Participants completed a baseline nutrition assessment and food frequency screener at intake. Clients received either 14 or 21 MTMs per week through approximately two months postpartum, along with optional nutrition counseling and tailored education.

Program evaluation was guided by predefined SMART objectives. Dietary intake was assessed using a validated fruit and vegetable screener at baseline and follow-up, and health-related quality of life was measured post-partum using the PROMIS Global Health-10. Program satisfaction and self-management were addressed during exit surveys. Descriptive analyses were conducted to evaluate changes in dietary intake, health outcomes and participant experience.

RESULTS

Between December 2023 and November 2025, MANNA served 60 pregnant and postpartum individuals with gestational diabetes and 62 dependents.

Participant-reported outcomes indicate meaningful perceived benefit. Among exit survey respondents (n=9), 100% reported improved ability to manage their condition, 100% reported eating healthier, and 89% reported improved overall health. Additionally, 78% of respondents reported satisfaction with variety.

Participants reported good glucose management, normal infant birth weight, and high engagement in care during and after pregnancy.

Medically tailored meals can serve as an effective, community-based intervention to support positive maternal health outcomes and improve engagement in prenatal and postnatal care for patients with gestational diabetes.

Healthcare engagement was strong, with 92% of participants completing a prenatal visit within four weeks of diagnosis and 81% completing a postpartum visit within six weeks of delivery. Clinical indicators include high rates of blood glucose control and the majority of infants born within a healthy weight range.

Table 1. Did Pt have well-controlled blood glucose levels during their participation in the program? (n=26)

Yes/No	N	%
Yes	20	76.9%
No	6	23.1%
Grand Total	**26**	**100%**

Note. "Well-controlled blood glucose" defined as fasting blood glucose <95 mg/dL and 2-hour postprandial blood glucose <120 mg/dL. Pt = patient.

Table 2. Was infant birth weight within recommended range per accepted medical standards? (n=26)

Yes/No	N	%
Yes	21	80.77%
No	5	19.23%
Grand Total	**26**	**100%**

Note. "Recommended birth weight range" defined as >5 lb 8 oz and <8 lb 13 oz per standard pediatric guidelines.

Table 3. Did Pt complete at least one medical appointment with their healthcare provider within 4 weeks of their gestational diabetes diagnosis? (n=26)

Yes/No	N	%
Yes	24	92.3%
No	2	7.7%
Grand Total	**26**	**100%**

Note. "Medical appointment" includes any visit with a licensed healthcare provider. Time frame defined as within 4 weeks of gestational diabetes diagnosis. Pt = patient.

Table 4. Did Pt complete at least one post-partum appointment with their healthcare provider within 6 weeks of delivery? (n=26)

Yes/No	N	%
Yes	21	80.8%
No	5	19.2%
Grand Total	**26**	**100%**

Note. "Postpartum appointment" includes any visit with a licensed healthcare provider following delivery. Timeframe defined as within 6 weeks (42 days postpartum. Pt = patient.

CONCLUSIONS

Medically tailored meals are a feasible, community-based strategy to support individuals with gestational diabetes during pregnancy and postpartum. Integration with healthcare partners likely improved self-management, dietary behaviors, and engagement in prenatal and postpartum care. Barriers to follow-up data collection limited outcome assessment. These challenges may be addressed through further feasibility testing of follow-up outcome collection methods. Overall, findings support continued use and expansion of MTM programs as part of comprehensive maternal health interventions.

Improving Maternal Health through Expanded Mentoring, Workforce Development, and Engagement

The Midwife Center, Pittsburgh PA

Purpose

TMC aimed to addressed systemic challenges in maternal health by expanding efforts to mentor health professionals, including doulas and midwives, to better reflect a diverse clientele

Goals

- **Mentoring:** Increase the number of providers trained in evidence-based birth center care.
- **Workforce Development:** Enhance staff and board knowledge to provide culturally congruent services.
- **Engagement:** Reach diverse populations to increase the impact of positive birth center outcomes.

Target Location & Population

- Western Pennsylvania, specifically targeting neighborhoods in Pittsburgh including Garfield, East Liberty, Lincoln-Larimer, Homewood, North Side, and the Hill District.
- Communities vulnerable to poor health outcomes, specifically focusing on BIPOC (Black, Indigenous, and People of Color) clients and individuals utilizing Medicaid

Problem

- **Maternal Mortality Crisis:** The U.S. has the highest maternal mortality rate in the industrialized world
- **Maternity Deserts:** In Pennsylvania, 24.2% of counties lack full access to maternity care
- **Workforce Shortage:** There is a critical lack of government funding to recruit and train midwives and doulas specifically for birth center settings.
- **Disparities:** Black women nationally experience significantly higher preterm birth rates (13.77%) compared to those served by the birth center model (4.97%).

On this topic, the biggest lesson learned that we want to share is that broader system-level change and sustained financial investment are required for meaningful progress; while this project was successful on a small scale, birth centers continue to operate on thin margins without federal support, leading to the closure of vital facilities across the Commonwealth.

Key Interventions

- **Expanded Mentoring:** TMC served as a clinical site for students and successfully trained Midwife Fellows in specialized services such as IUI/ICI family building, ultrasounds, and Centering Pregnancy.
- **DEI Integration:** Collaborated with consultants to update HR policies, create a DEI Action Plan, and conduct staff-wide cultural competency training.
- **Community Outreach:** Executed digital ad campaigns and participated in over 50 community events to increase awareness of midwifery care.

Results

- **Impact Outcomes:** TMC maintained a preterm birth rate of 2.05% and a C-section rate of 7.33%, significantly lower than national averages of 10.4% and 32.4%, respectively
- **Workforce Growth:** Successfully hired two Midwife Fellows into permanent positions at nonprofit birth centers
- **Next Steps:** TMC is advocating for systemic payment reform and legislative changes, such as the Midwives for Moms Act, to ensure long-term sustainability.

mid-atlantic mothers' milk bank

Expanding the power of human donor milk

The mother of all nutrition: pasteurized human milk

- Promotes growth
- Boosts immune systems
- Protects babies from infection
- Contains important antibodies
- Helps avoid serious illness
- Reduces hospital stays
- Supports eventual exclusive maternal breastfeeding success

up to 70% of moms with an infant in the NICU are unable to provide enough milk for their child, at least initially

around 1 in 10 babies are born prematurely in Pennsylvania

Black babies are 3x more likely to be born premature and experience NICU complications at a higher rate than their white peers

Overcome barriers
to ensure all babies have what they need to thrive

Among medical professionals

- Evidence-based, safe, recommended by AAP
- Standard of care in NICUs
- Survey identified gaps in understanding
- Need support to provide consistent evidence-based patient education

Among families

- Facilitate families being equipped to make informed feeding decisions
- Create understanding, especially in underserved populations
- Highlight the safety measures taken, including screening of volunteer donors along with milk testing and pasteurization
- Raise awareness among potential donors

Meet Nico: It starts with education

- Animated two-minute video: English, Spanish, Mandarin, Arabic, Nepali, Russian, Haitian Creole
- Suite of companion materials: posters, info cards, clings, stickers, reimagined web interface
- New bridge milk and outpatient education, including safe milk storage and handling instructions
- Clinician Webinar with 300+ registrants addressed proper milk handling, milk safety, staff reluctance and concerns increased usage and protocol changes

Awareness is everything

Multi-media campaign

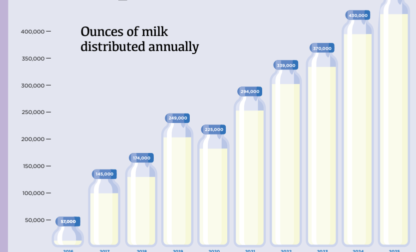
- Growth geographies: Central and Eastern Pennsylvania
- Resulted in 5.2 million impressions, 10,000+ website clicks, sustained 20% increase in donor screenings
- Added text-messaging to drive greater success in donor screenings

Let's go grow

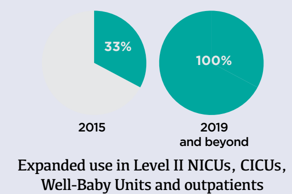
- Expand "Donor Milk in the Neighborhood" donor and dispensary network to create greater access

- Develop additional family-centric videos
- Further clinician communication for education among both inpatient and outpatient providers
- Expand digital infrastructure

Impact Since Birth



Donor milk in NICUs
Level III and IV NICUs in PA and WV



Expanded use in Level II NICUs, CICUs, Well-Baby Units and outpatients

Family Check-Up–Prenatal at The University of Pittsburgh

Promoting the Behavioral and Physical Health of Mothers and Young Children

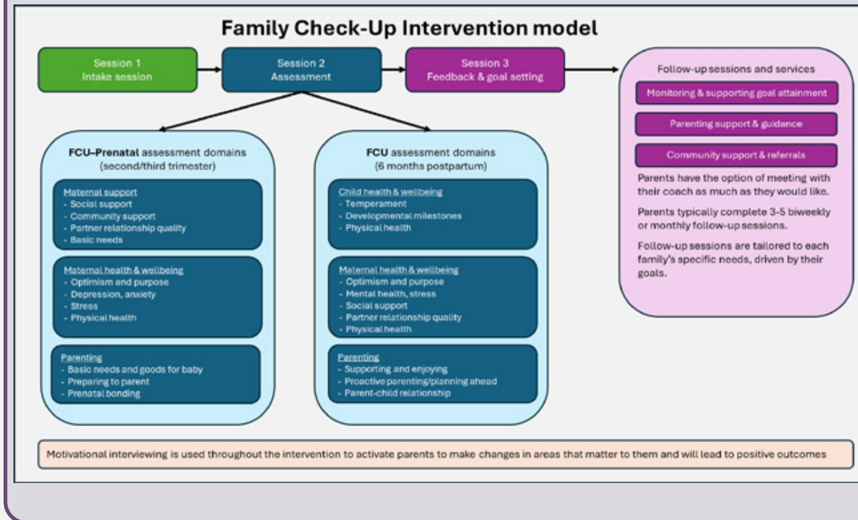
The problem

- Maternal and infant health disparities are mediated by social determinants of health (SDOH), inequity, poverty, and racism
- The Family Check-Up Prenatal (FCU-P) Home Visitation Program offers a promising strategy to support maternal and infant behavioral and physical health

Project goals

- To improve the behavioral and physical health of mothers and their children with low income during pregnancy
- *Hypothesis:* delivering support using an established, evidence-based home visiting program focusing on the postpartum years will improve the physical and behavioral health of mothers and infants

Intervention



Population of focus

- Pregnant mothers who are Medicaid-eligible
- Recruited through Magee Womens Hospital, WIC, and community events for expectant mothers

Outcomes

- If you build it well, they will come. Parents were enthused about enrolling in the program; We have enrolled 461 expectant mothers in less than 2 years, with our original goal being 100-120
- Parents have been most interested in obtaining support related to parenting, housing stability, and physical health, as well as social support

Table 1. FCU-Prenatal Expectant Parent Goals (N=34)

Goal category	% choosing goal	Total % of goals
Housing stability	44%	17.6%
Parenting	47%	18.8%
Mental health	32%	12.9%
Physical health	47%	14.1%
Social support	44%	17.6%
Preparing for baby	26%	10.6%
Career planning	21%	8.2%

- We are building on this success, obtaining funding at the county, state, and federal level, to offer the program to more families while continuing to follow current sample

Sustainability

- Continued grant funding through local, state, and federal agencies to sustain and further evaluate the intervention
- Sustaining partnerships with local and state Departments of Health and Human Services
- Establishing relationships with payers towards Medicaid reimbursement

AUTHOR
SYREETA GORDON

The persons that added to this work was community partners such as Nikia Lawson DONA Certified Birth Doula Trainer, Marcia Danielson App Developer, Infinite Lifestyle Solutions, Mommy Beauty Cutie Foundation, Brooks Childcare, Mommy & Me Haven, Everyday's A Sunday Catering, Smoke & Blessing Catering, University of Pittsburgh Medical Student Interns Chiazam Omenyi, Mommy Concierge, Community Birthworkers

FOLLOW UNSHAKEABLE MOTHERHOOD & @BIRTHKANGAROO

UNSHAKEABLE motherhood (IN PARTNERSHIP WITH NEW SUN RISING)

A community-rooted, tech-enabled maternal support ecosystem designed to bridge gaps in postpartum care, education, and recovery.

AFFILIATIONS

With the 2021 inception, Kangaroo Birthing and Maternity c/o Unshakeable Motherhood's outreach marketplace called the NurturHer App has partnered with Allegheny County Health Department's in collaboration with the Nurse Family Partnership over the past six years. Also, we have partnered with Health Start Pittsburgh by beta testing the app with fifteen families alongside their birth doula program starting in 2022. We partnered with AHN First Steps & Beyond that partnered to reach over 60 postpartum families with the app. In developing the workforce, we partnered with Chi Eta Phi Nursing Sorority to contribute to training and developing birth doula careers.

01. Introduction

Since the launch in 2021, Unshakable Motherhood partnered with the Allegheny County Health Department to beta test (15) families with the NurturHer app project in partnership with the *Pittsburgh: A Safer Childbirth City* project. The Jewish Healthcare Foundation (JHF) and its operating arm, Women's Health Activist Movement Global (WHAMglobal), recently launched *Pittsburgh: A Safer Childbirth City*, an initiative that aims to transform the city into a safer, more equitable, and accessible place to give birth. In continuation, the Maternal Innovation-Black Maternal Vitality: NurtureHer App project served as a beacon of hope where women of color can find the guidance, resources, and community they need to thrive. We partnered with community initiatives and businesses as vendors with cutting edge technology to offer direct access to care that supplies diverse range of supportive activities: mommy concierge support, direct doula access, emergency resources, postpartum meals. transportation to prenatal care, and emergency childcare.

02. Project Summary & Goals

Core Goals

- To ensure that mothers and babies in communities of need, have access to vital resources and items that contribute to their health, safety, and well-being to improve postpartum recovery outcomes
- Increase access to culturally competent care by training and developing doulas and health workers in order to offer comprehensive and personalized support to women of color during their motherhood journey, fostering a sense of community, empowerment, and well-being.
- To offer reliable emergency childcare, increasing food access and transportation solutions for mothers facing unforeseen situations, ensuring the safety of their children while allowing them to address urgent need when it matters the most.

03. Area of Service & Target Population

Geographic Focus:
Allegheny County / Pittsburgh region (with emphasis on underserved communities)

Target Population:

- Postpartum mothers in food deserts
- Black and Brown mothers disproportionately impacted by maternal health disparities
- Low-income families with limited access to postpartum care
- First-time mothers needing structured guidance and support

Service Environment:

- **In-Home Support Via (doulas)**
- **Digital Access through app**
- **Community-based partnerships**

04.Problem Statement & Need

Why The Maternal Innovation Fund Was Needed:

To innovate beyond traditional care models by combining:

- Technology (app-based support)
- Direct service (doula + meals + resources)
- Direct Education (functional nutrition + online tutorials)

Core Problem:

There is a significant gap in postpartum care, especially after hospital discharge, where mothers are expected to recover without adequate physical, emotional, or nutritional support.

Maternal Health Needs Addressed:

- Postpartum recovery support
- Access to healing foods & emergency resources
- Education on managing conditions like hypertension
- Mental and emotional support
- Navigation of fragmented care systems

Key Interventions:

- **1. Doula Support**
  Physical, emotional, and recovery care in the home
- **2. Food Justice Access**
  Family-sized prepared meals
- **3. NurturHer App**
  Central hub for care, resources, and connection

05. How We Did it?

A hybrid model combining:

✓ In-home postpartum doula care

✓ Fresh food + meal delivery (up to 3 months postpartum)

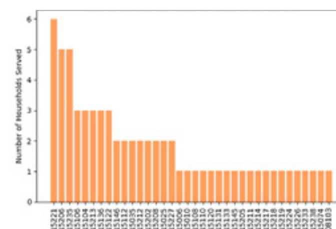
✓ Functional nutrition education

✓ App-based care coordination

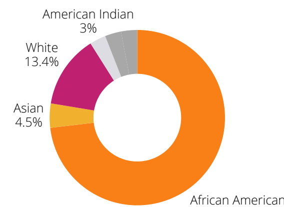
✓ Strong community partnerships

06. Analysis

In the analysis of the survey information and the data collected from 2024-2026 it allowed us to see who we are serving specifically, the neighborhoods that we serviced at our core was East End, Wilkinsburg and Penn Hills area within high poverty communities that are hit persistently with inequities in birth outcomes and lack of fourth trimester support. There was a strong suburban outreach to the McKessport and West Mifflin surrounding the (15122, 15136, 15104) areas. Our data reflects that the services most in demand are the Postpartum and Mommy Concierge support along with the meals and laundry service to our predominately African American women in the age bracket of 25–34 years highlighting that our services are particularly impactful for younger mothers navigating the challenges of pregnancy, childbirth, and postpartum recovery.



The NurturHer App has demonstrated concentrated service delivery across Allegheny County, with the highest utilization in East End and inner-ring suburban ZIP codes such as 15221, 15206, and 15235—areas often associated with elevated maternal health disparities and resource gaps.



Race & Ethnicity Distribution (as collected through survey distribution)

The NurturHer App predominantly serves Black or African American families, who comprise over two-thirds (69%) of program participants, reflecting a targeted reach into communities disproportionately impacted by maternal health disparities

07. Conclusion

What We Learned:

- Mothers are more likely to engage when support is brought directly to them
- Nutrition + education + care must be integrated, not siloed
- Technology works best when paired with human connection (doulas)
- Integration App Platform Improvement to operational infrastructure can effectively impact maternal support services that must remain highly responsive to real-time community needs.

Next Steps:

- *Scale the NurturHer App to reach more families*
- *Expand food and meal delivery capacity*
- *Deepen data collection and impact tracking*
- *Strengthen partnerships for sustainability*
- *Continue workforce development for doulas*

SCAN THE NURTURHER APP!

PA MATERNAL HEALTH Symposium 2026

papqc.org
perinatalactioncollaborative.org
jhf.org