SEPTEMBER 2025

STRATEGIC PLAN
to address maternal and infant health disparities

Maternal and Infant Health Task Force

Maternity Community Advisory Council

Anne Arundel County, Maryland

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Special thanks to the Department of Health members who prepared this report.
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LETTER FROM THE CO-CHAIRS

Community members and partners:

In Anne Arundel County, we want all birthing persons, parents and infants to be healthy, safe and thriving. We know that families have to make many important decisions along the way, both challenging and exciting, from pre-pregnancy through birth and postpartum. As leaders of the county's health and public health systems, we do not want our practices or information contributing to challenges or the mistreatment of families. On a national scale, that is far too often the reality. Women of color in the U.S. and their infants are at far greater risk of complications or perishing due to pregnancy-related causes. These harms are unacceptable.

To address these issues locally, we are championing change in Anne Arundel County through improvements to our care and education. We recognize that inequities persist, but acknowledge the impact our countless county stakeholders have had on improving health outcomes during prenatal, delivery and postpartum. In November of 2023, we formed the Maternal and Infant Health Task Force, a coalition of cross-sector partners to track data, identify opportunities for shared work and efficiencies across our systems, and develop a plan to address community needs. This plan is the culmination of that team's efforts, informed by our Community Advisory Council and modeled around a birth equity framework.

We look forward to what's next. The strategies in this plan provide a roadmap to focus resources and expertise. Progress on these strategies will require a shared commitment from those working on behalf of women and families. We must also make space to uplift and empower the community's experiences. Working together, this plan outlines the process for impacting birth outcomes and supporting family care, knowledge, mental health and trust. We hope you will join us in advancing this important work.

In partnership,

Tonii Gedin, RN, DNP
Health Officer of Anne Arundel
County Department of Health

Monica Jones, MD, MSc, FACOG, FACS
System Chair of Luminis Health
Women's and Children's Services Line

INTRODUCTION

Through a strategic planning process that began in November 2023, the Anne Arundel County Department of Health (DOH) set out to understand the current state of perinatal care in the county. Community members, hospital leadership, program managers, doulas, midwives, mental health practitioners, health care partners and public health professionals investigated the successes, shortfalls and opportunities for maternal and infant health. Through this process, stakeholders mapped out how programs and health care systems are delivering quality, accessible care and where services are failing to meet the essential needs of expectant parents, mothers, birthing individuals and their infants.

The onset of this cooperative effort was the formation of the Maternal and Infant Health Task Force (MIHTF) in November 2023 as the vehicle to identify shared priorities and opportunities for intervention. The DOH established the Task Force under shared leadership with Luminis Health, a nonprofit health system serving county residents and the surrounding region. Dr. Tonii Gedin, Health Officer, and Dr. Monica Jones, Luminis Health Women's and Children's Services Chair, Task Force Co-Chair.

The MIHTF's role is to provide oversight for maternal and infant health outcomes, elevate priorities that will improve indicators for reducing rates of morbidity and mortality, and develop strategies to improve health outcomes. The culmination of this partnership is the creation of this strategic plan to address county needs and community priorities. To that end, the Task Force has collated shared data, explored disparities using state and national health indicators, and identified opportunities for shared work across the coalition. Further, this process has prioritized the perspectives of those with lived experience through a series of community listening sessions that formed the basis for a maternity Community Advisory Council (CAC), which operates in parallel to the coalition and informs the county's priorities.

To understand the state of Anne Arundel County's services and providers, Task Force members assessed causes, strengths and gaps. The Task Force sought to understand whether services provided to residents were adequately addressing the ongoing disparities surging in local health data. The results mapped out providers and programs that meet community needs, as well as areas where services are underutilized due to resource gaps, lack of awareness and inaccessibility. These opportunities for improvement form the core objectives.

Learn more at aahealth.org/maternal-infant-health

In pursuit of insights from those with lived experience, the Task Force coordinated conversations with community members to collect their perceptions on needs and solutions. From April to May 2024, the MIHTF hosted four listening sessions with birthing persons who had been pregnant or given birth in the county within the past five years, members of their support network and community advocates. The listening sessions employed a tool called a data walk to facilitate a conversation about maternal and infant health disparities. Attendees brainstormed barriers and solutions related to the trends and compared the data to their own birthing experiences.

These listening sessions laid the foundation for the formation of the maternity CAC to uplift the lived experience of those who had been pregnant or given birth in the county. Their perspectives help the Task Force better understand how to support mothers, infants, expectant parents and members of their support networks. The current CAC includes seven women who convened for two planning meetings in late 2024 to prepare for the launch of the Council in January 2025. The first phase was an orientation to data, policy, historical context and best practices. In the second phase, CAC members will develop solutions, inform the work of the Task Force and participate in community events. The DOH continually recruits for the Council to build a cohort of community leaders who are compensated for their subject matter expertise.

The input of the Task Force and Council has provided a roadmap for collective action to address maternal and infant health needs in the county, including the significant disparities for women and infants of color. There are an average of 18 births every day in the county. Ensuring each of those is safe, informed and uplifted is the charge of the Task Force. To fulfill this mission, the MIHTF has outlined a plan to empower and educate birthing individuals and their support networks, promote empathetic and equitable care, and remove barriers to perinatal services.

Source: Maryland Vital Statistics Administration birth files (2018-2022))

TONII GEDIN, RN, DNP

Health Officer
Anne Arundel County Department of Health

MONICA JONES, MD

Chair of Women's and Children's Services
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PURPOSE

The Maternal and Infant Health Task Force is committed to advancing the health and well-being of expectant, pregnant, and birthing individuals and their support networks. The Task Force believes in empowering all families to have safe and positive perinatal experiences, nurturing healthy infants through the critical first few months and beyond. In partnership with county agencies, community organizations and health care systems, the MIHTF leads a coordinated effort to uplift birthing individuals and families during the pre-pregnancy, prenatal, birth, and postpartum period.

Vision

We envision a county community where all women, birthing persons and their families feel heard, informed, supported and have access to equitable, empathetic care during the entire perinatal period.

Mission

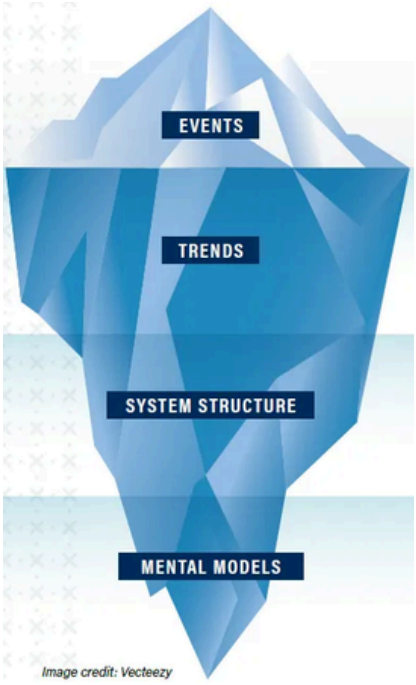
To leverage community resources, address barriers to accessing care and drive change in health care practices and perinatal education to improve health outcomes of women, birthing persons and babies.

The MIHTF recognizes the persistent and deeply rooted disparities in maternal and infant health. The mortality rate for Black infants is 1.7x higher than that for white infants. One in six women experiences a severe complication during pregnancy, while for Black and Asian women, that rate is one in five. Black women are more likely to suffer from severe maternal morbidity, particularly chronic and pregnancy-associated hypertension, deliver via cesarean section, and deliver pre-term and low birthweight babies. Asian and Hispanic women are more likely to experience gestational diabetes. Hispanic women are less likely to initiate prenatal care in the first trimester, missing nutrition and risk assessments critical during the early stages of pregnancy.

The inequities in health care outcomes for birthing individuals and infants are due to multiple converging factors and gaps in how care is administered, information exchanged between patients and providers, and environmental factors that restrict individuals' access to medical and non-medical services. There are also embedded and persistent inequities within these institutional and societal structures. Structural racism impedes improvements to maternal and infant health as women of color are at increased risk of being underserved, dismissed or discriminated against regardless of their education level or socioeconomic status. The Task Force is an advocate for solutions that condemn these structural inequalities and challenge the institutions that perpetuate them.

Sources: Maryland Vital Statistics Administration death files and CDC WONDER bridged-race and single-race population estimates. (2018-2022 five-year averages); Maryland Vital Statistics Administration birth files (2018-2022 for pregnant women ages 25-34 who are county residents); Health Services Cost Review Commission Inpatient and Outpatient files and Maryland Vital Statistics Administration birth files (2018-2022).

Birth Equity Iceberg Model



Events

- Lived experience that is not respected and uplifted
- Negative, harmful birthing experiences

Trends

- Health insurance and payment systems limit choices and access to care
- Lack of data, commitment and accountability to equity
- Limited investment in basic health, social and economic supports

System Structure

- Persistent, worsening disparities in infant and maternal mortality
- Decreasing workforce and health care facilities
- Decreasing economic support and community services

Mental Models

- Implicit bias among providers and lack of empathy
- Resistance to change and focus on the problem

CONTRIBUTING FACTORS

Insufficient Information-Sharing

The perinatal period includes a flurry of communications between the birthing individual and their health care providers, birthing team and support network. The flow of information can, at times, be overwhelming for the birthing person, contributing to confusion around their care plan and hesitancy in discussing concerns or alternatives. To help ease anxieties, health care providers focus visits on the most immediate and relevant care needs. However, compartmentalized information may leave patients feeling ill-informed about risks of complications and symptoms that may be signs of larger issues. Self-advocacy can positively influence the type of care that women and birthing persons receive, but this isn't true of all experiences, particularly for Black women and women of color. Even when concerns were raised, providers sometimes dismissed or discredited them, which in some cases led to severe complications or even death.

Birth Equity Iceberg Credit: Association of Maternal and Child Health Programs (AMCHP), UNC Gillings School of Global Public Health, and the Pritzker Children's Initiative.

Inadequate Health Care Quality

The ideal care experience involves a health care system where patients receive the highest quality of care, close to where they live, and catered to their needs. In reality, patients are constrained by insurance coverage, availability of care in their geographic area, and cultural humility of their providers, among other health care factors. Even for birthing individuals who attend prenatal appointments, inadequate care can contribute to an emergency care visit. This is especially true for Black women, who are three times more likely to go to a hospital for pregnancy and postpartum reasons. Health care quality can also be measured by access to varied models of care, including doulas and midwives. They play a vital role in offering trauma-informed, culturally humble care to advocate alongside and in support of the emotional and informational needs of birthing individuals. These unique services have been found to be especially beneficial for women of color. However, this option is not available to all, as midwives are not always recognized as valued care providers by hospitals and are not covered by insurance. In Maryland, doula care can be covered for individuals with Medicaid and TRICARE who work with an in-network provider.

Negative Environmental Factors

Even within systems that adequately meet the information and care needs of birthing individuals, external factors can impede timely access to resources and proper adherence to health care recommendations. Beginning prenatal care with an appointment in the first trimester supports the best outcomes for the birthing person and their infant. However, not everyone seeking to attend appointments has the means to do so. This can be due to environmental obstacles, such as lack of transportation, inability to bring other children to appointments or secure childcare, access to local, nutritious food, language barriers, inability to take time off from work, and insufficient funds or insurance coverage. These surrounding factors diminish the birthing experience of individuals and families, and can threaten the health and well-being of both the birthing individual and infant. They also create challenges in the pre-conception phase through postpartum, as families lack access to nutritional food, paid leave, safe living and working conditions, and a living income to cover expenses.

These factors contribute to confusion, discouragement and distrust of families during a time when they should feel supported. To that end, the Task Force has laid out this plan to address these obstacles head-on through collective action and robust solutions that advance birth outcomes in Anne Arundel County.

Source: Health Services Cost Review Commission Inpatient and Outpatient files and Maryland Vital Statistics Administration birth files (2017-2023).

MATERNAL AND INFANT HEALTH DATA

Indicators of Need

Anne Arundel County tracks several key indicators of morbidity, including maternal and infant death; mortality, or the top causes of severe complications; and other risk factors for poor pregnancy and birth outcomes. These measures provide a roadmap to direct efforts to have the greatest impact on local disparities.

The 2024 Maryland (MD) State Health Improvement Plan outlines measures for improving women's health with indicators for maternal and infant health outcomes. Compared to the state, the county has made progress, with room for improvement in some aspects and is inadequate in others.

Maryland State Health Improvement Plan Goals

- **Initiation of Prenatal Care:** MD aims to increase the percentage of birthing persons starting prenatal care in the first trimester to **82% by 2029**. AA Co. does not currently meet that goal, and the percentage is even lower for non-Hispanic Black and Hispanic women.
- **Preterm Births:** MD aims to decrease the number of preterm births **below 9.4% by 2029**. AA Co. does not currently meet that goal overall, and the percentage of preterm births among non-Hispanic Black infants is higher than the goal.
- **Preterm Births and Low Birthweight Births:** MD aims to decrease the number of low birthweight births **below 8.5% by 2029**. AA Co. currently meets that goal overall, but the percentage of low birthweight births among non-Hispanic Black infants is higher than the goal.
- **Infant Mortality Rate:** MD aims to decrease the infant mortality rate to **5.2 per 1,000 live births by 2029**. AA Co. currently meets that goal overall, but the rate for non-Hispanic Black infants is higher than the goal.

Informed by these data trends, the MIHTF is prioritizing solutions to address the root of poor health outcomes for birthing individuals, infants and families. They are focusing on improvements to care and education during the prenatal period to address the percentage of pregnant women who do not receive prenatal care beginning in the first trimester. While not quantified as extensively, the Task Force also recognized the critical role of mental health, particularly in the postpartum period, and has prioritized education and care coordination to meet those needs.

Source: 2024 Building a Healthier Maryland State Health Improvement Plan.

Preconception

Pre-Pregnancy Obesity

36%
of Anne Arundel County birthing people were obese prior to pregnancy

Birthing people with pre-pregnancy obesity have higher rates of gestational diabetes and pregnancy-associated hypertension. The infant is more likely to be preterm and low birthweight.

In the county, pre-pregnancy obesity is higher for:

50% **Black NH** **41%** **Hispanic** **40%** **40+ years**

Data source: MDH VSA 2023 Birth Certificate Files

Birth Spacing

8%
of Anne Arundel County birthing people had an interbirth interval shorter than 18 months

Shorter interbirth intervals are associated with increased health risks, including a higher risk of preterm birth.

In the county, interbirth intervals less than 18 months are higher for:

10% **Black NH** **14%** **20-24 years**

Data source: MDH VSA 2023 Birth Certificate Files

Pregnancy

Initiation of Prenatal Care

4%
of Anne Arundel County birthing people received late or no prenatal care during pregnancy

Prenatal care is important for reducing the risk of pregnancy complications and for monitoring the health of the birthing person and fetus.

In the county, initiating prenatal care late or not at all is higher for:

10% **<25 years old** **8%** **Hispanic**

Data source: MDH VSA 2023 Birth Certificate Files

Gestational Diabetes

10%
of Anne Arundel County birthing people had gestational diabetes

Gestational diabetes causes high blood sugar that can affect a pregnancy and a baby's health. It can increase the risk of preterm birth and high birthweight in infants.

In the county, gestational diabetes is higher for:

23% **Asian NH** **20%** **40+ years** **12%** **Hispanic**

Data source: MDH VSA 2023 Birth Certificate Files

Pregnancy-Associated Hypertension

14%
of Anne Arundel County birthing people had pregnancy-associated hypertension

Birthing people with pregnancy-associated hypertension (high blood pressure) can develop preeclampsia. It can also cause low birthweight and premature birth.

In the county, pregnancy-associated hypertension is higher for:

19% **<20 years** **18%** **40+ years**

Data source: MDH VSA 2023 Birth Certificate Files

Pregnancy-Related Hospital Visits

1.6 visits
to the hospital or ED for every live birth to Anne Arundel County residents

In 2023, there were over 10,000 hospitalizations and emergency department (ED) visits related to pregnancy among county residents.

In the county, the ED visit rate per live birth is higher for:

2.5 **<20 years** **2.0** **Black NH**

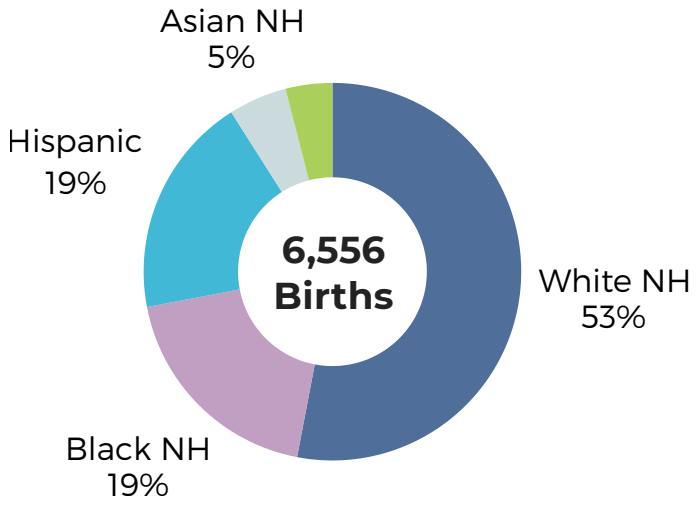
Data source: HSCRC Inpatient and Outpatient Files, 2023

Birth Demographics

Number of Births

6,556
births to Anne Arundel County residents in 2023

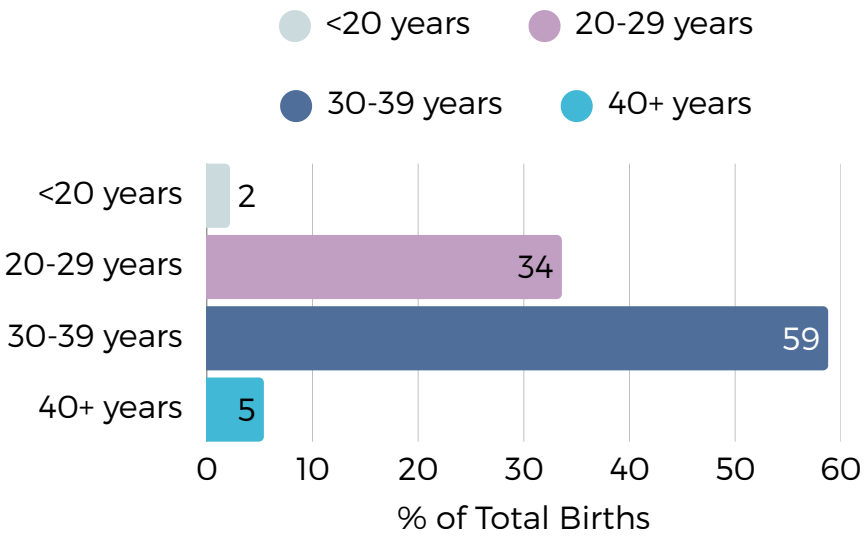
Percentage of Births by Race/Ethnicity, Anne Arundel County, 2023



In 2023, about half the births were white non-Hispanic. However, births to Hispanic residents have increased and comprise one in five births, and births to Black, non-Hispanic residents are also one in five births.

About 5% of births were Asian non-Hispanic, and 4% were of another race/ethnicity.

Percentage of Births by Age of Birthing Person, Anne Arundel County, 2023



In 2023, over half (59%) of the births in Anne Arundel County were to birthing people ages 30-39 years old. About one in three births were to ages 20-29 years.

Only about 2% of births were to those less than 20 years old, and 5% were to those 40 and older.

Data source: MDH VSA 2023 Birth Certificate Files

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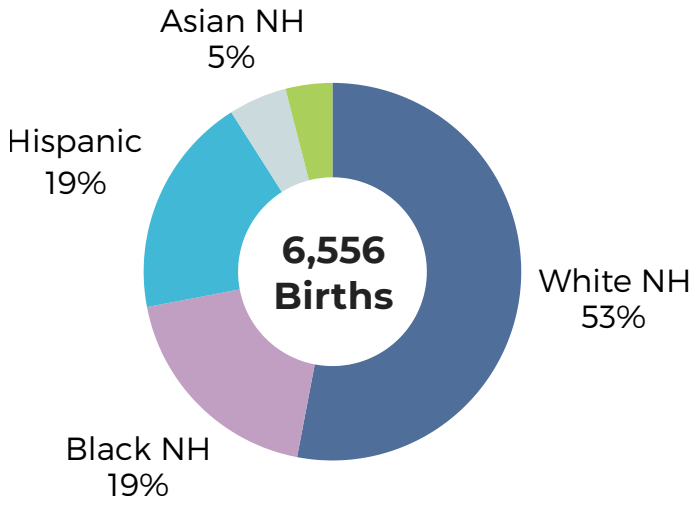

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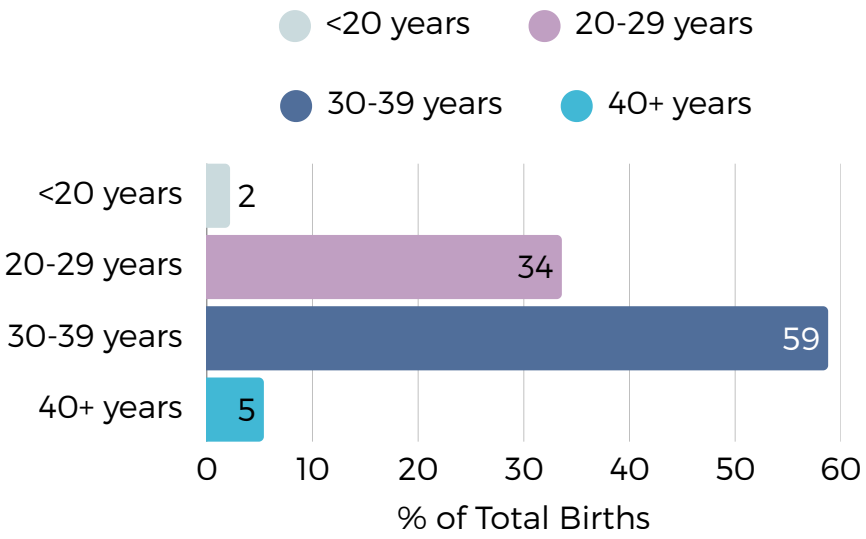

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Data source: MDH VSA 2023 Birth Certificate Files

Birth Outcomes

Preterm Births

10%
of Anne Arundel County infants were born preterm

Preterm births are births that occur before 37 weeks of gestation. Preterm births are associated with poor health outcomes for infants and a higher risk of mortality.

In the county, preterm birth is higher for:

15% **40+ years** **14%** **<20 years** **12%** **Black NH**

Data source: MDH VSA 2021-2023 Birth Certificate Files

Low Birthweight

8%
of Anne Arundel County infants were born with low birthweight

Low birthweight means that an infant was born weighing less than 2500 grams (about 5.5 pounds). Low birthweight is associated with poor health outcomes and even mortality for infants.

In the county, low birthweight is higher for:

11% **Black NH** **14%** **<20 years** **12%** **40+ years**

Data source: MDH VSA 2021-2023 Birth Certificate Files

Birth Outcomes

Cesarean Sections (C-Sections)

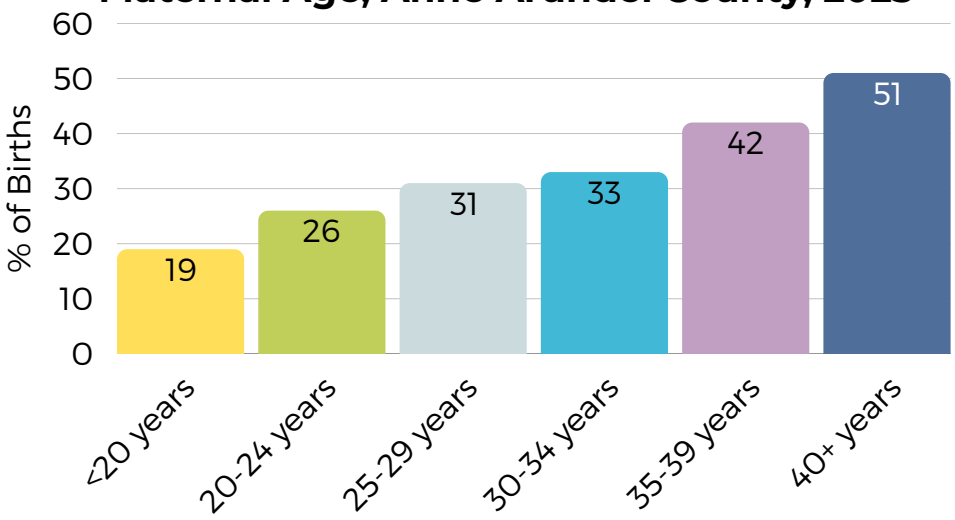
35%
of Anne Arundel County birthing people had deliveries by C-section

A C-section (or cesarean birth) is a surgical procedure used to deliver a baby. C-sections are often done when vaginal delivery is considered unsafe. C-sections do have a higher risk than vaginal deliveries and they have a slightly longer recovery period.

41% **Black NH** birthing people have higher rates of C-sections compared to other race/ethnicity groups

Data source: MDH VSA 2023 Birth Certificate Files

Percentage of C-Section Deliveries by Maternal Age, Anne Arundel County, 2023



The proportion of deliveries by C-section also increases with maternal age, from 19% of births to residents less than 20 years old to half of births to residents 40 years and older.

Data source: MDH VSA 2023 Birth Certificate Files

Length of Hospital Stay

2.2 days
was the average amount of time Anne Arundel County birthing people spent in the hospital for their delivery

Maternal length of hospital stay for delivery is usually between 24-48 hours for uncomplicated vaginal deliveries.

In the county, the length of stay is longer for:

2.6 days **Black NH**

2.7 days **40+ years**

3.0 days **C-section**

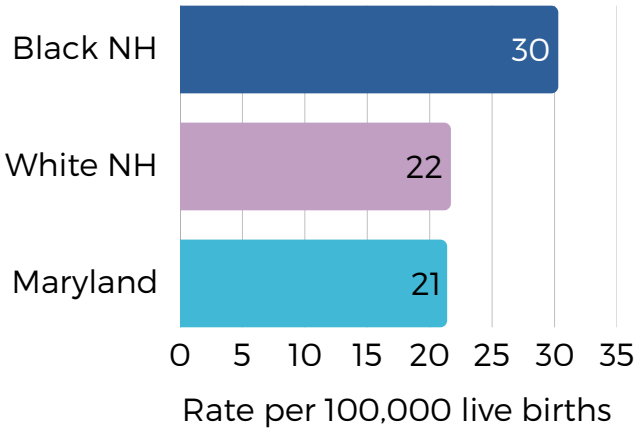
Data source: HSCRC 2024 Inpatient Files

Mortality Rates

Maternal Mortality

21 Deaths
of birthing people within 42 days of the end of their pregnancy **for every 100,000 live births**

Maternal Mortality Rate by Race/Ethnicity, Maryland, 2019-2023



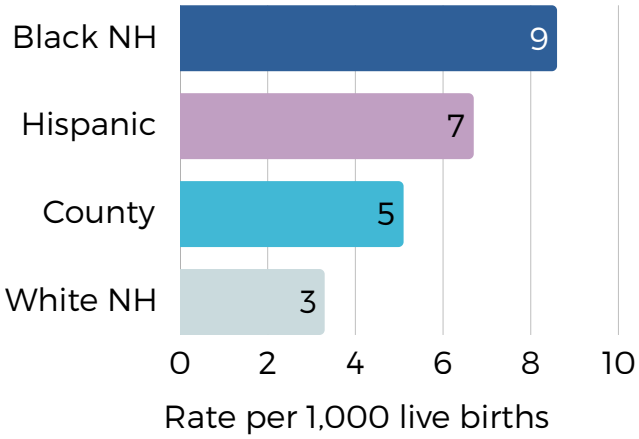
In Maryland, the maternal mortality rate is higher among Black NH birthing people compared to white NH birthing people.

Data source: CDC WONDER Natality and Underlying Cause of Death, 2019-2023

Infant Mortality

5 Infant Deaths
before their first birthday **for every 1,000 live births**

Infant Mortality Rate by Race/Ethnicity, Anne Arundel County, 2021-2023



In Anne Arundel County, the infant mortality rate is more than 2.5 times higher among Black NH infants compared to white NH infants.

Data source: MDH VSA 2021-2023 Birth Certificate Files

PROCESS

Root Cause Analysis

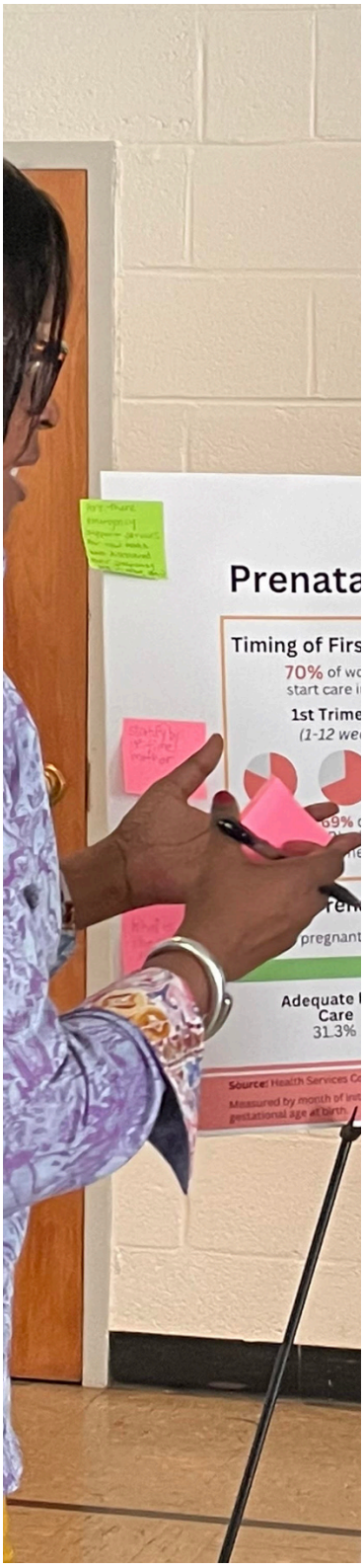
To kick off the work, the Task Force explored the underlying causes of maternal and infant health disparities in the county. In small groups, the team used a fishbone structure to identify the people, information, processes and systems causing the higher rates of mortality and risks of morbidity disproportionately affecting women and infants of color. This discussion produced a list of contributing factors that led to confusion, diminished care for families and limited their access to resources. The activity introduced Task Force members to one another while highlighting the many shared challenges partners and community members face around this issue.

Needs Assessment

The results of the root cause analysis formed the basis for the team's needs assessment. In early 2024, the Task Force brainstormed our strengths, including assets that each of the organizations on the team brought to the table, as well as the contributions of other programs throughout the county. The team then mapped out areas where services could be improved or better utilized. Framing these weaknesses as opportunities, we used this list of needs as the starting place for activities and interventions where the Task Force could lead collaborative efforts towards the larger aim of improving maternal and infant health.

Gap Analysis

Using a gap analysis, the Task Force connected the needs of county residents with statistics highlighting the disparities in birthing individuals. For each data point, the team reflected on the current state of services and information, as well as our desired future state. The differences between these two states – the gaps – provided a path forward to achieve a future of health and well-being for all parents.

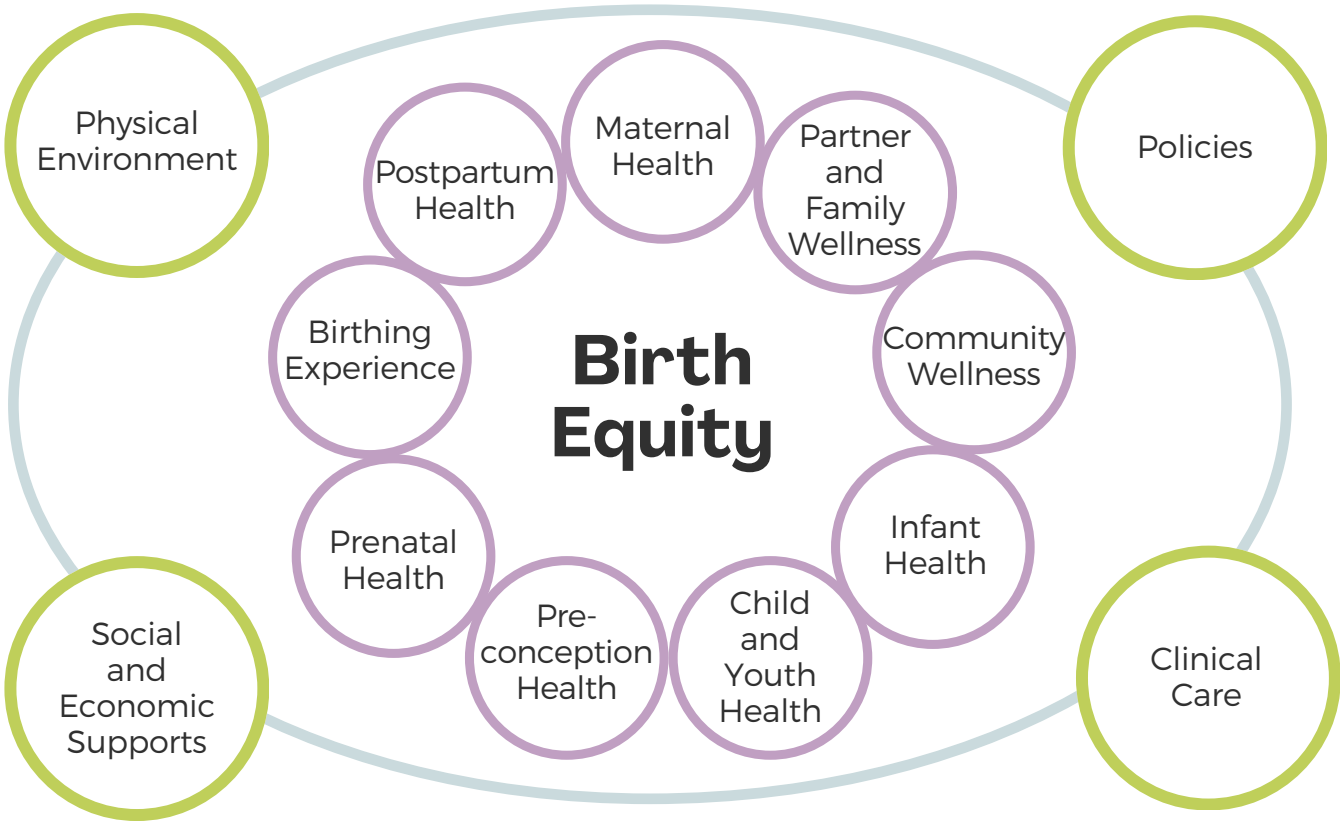


Prioritization

The compilation of the Task Force's investigation into the state of maternal and infant health in the county revealed the complex and interwoven circumstances contributing to the deep-rooted inequities experienced by birthing individuals. Taking in the whole picture, the team acknowledged that there are many barriers within the system structures and mental models of maternity care in the United States. Larger issues tied to women's rights, access to care, diverse workforces, implicit bias and racism impede change.

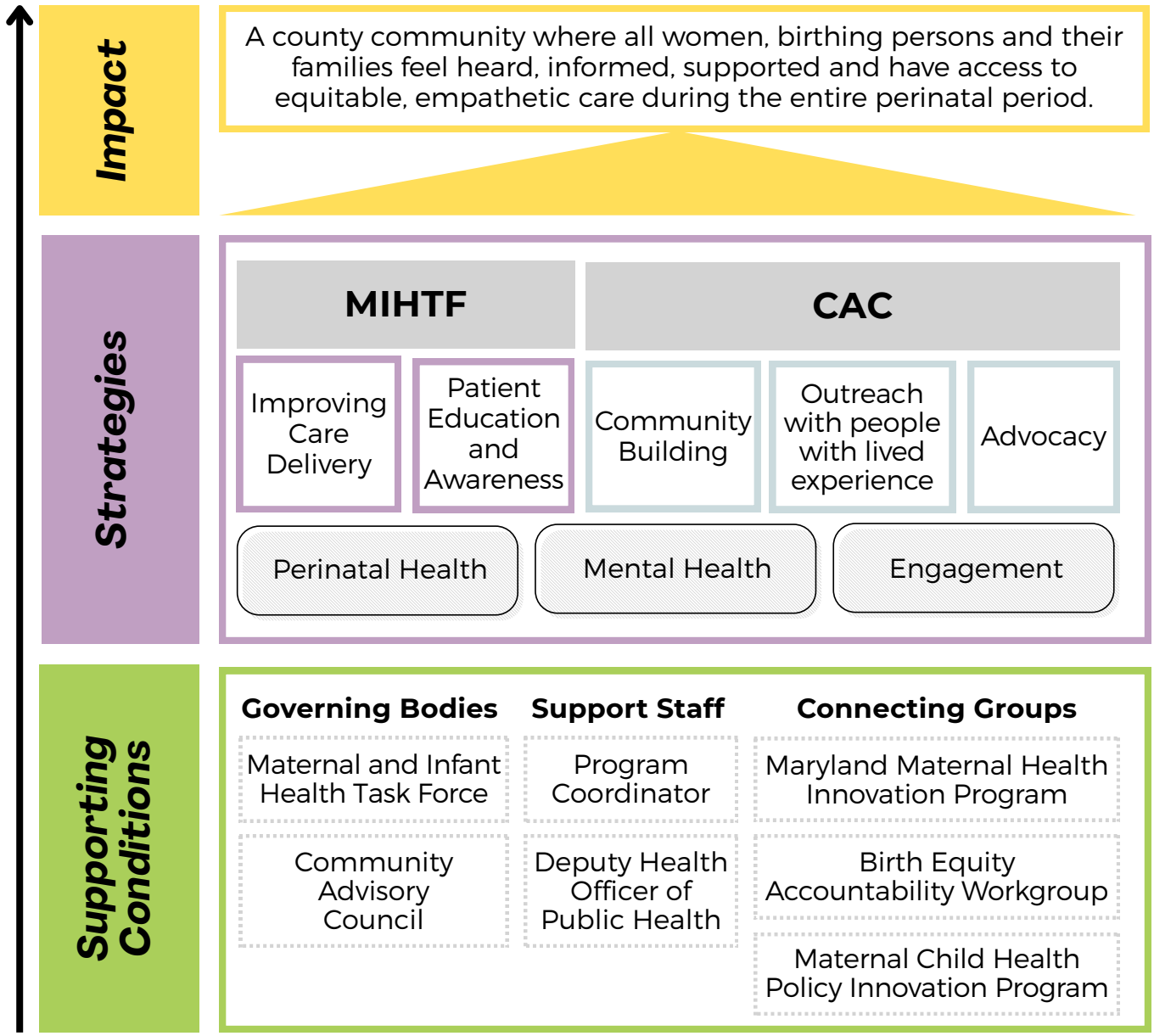
In the face of these broader systemic challenges, the Task Force has decided to prioritize strategies that meet the needs of Anne Arundel County families and align with the capacity, expertise and resources of our team. Through thoughtful conversation, the team identified seven objectives to improve perinatal care and education that would move the needle on the disparate health outcomes of our residents. In conjunction with the priorities of the Community Advisory Council, the Task Force's objectives align with a birth equity ecosystem framework to address multi-faceted areas of need.

Birth Equity Ecosystem



Birth Equity Ecosystem Credit: Association of Maternal and Child Health Programs (AMCHP), UNC Gillings School of Global Public Health, and the Pritzker Children's Initiative.

Framework for Change



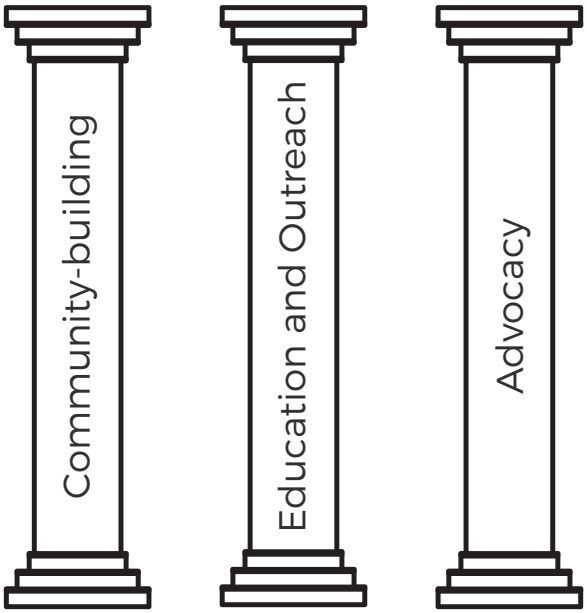
COMMUNITY ADVISORY COUNCIL

The maternity Community Advisory Council (CAC) launched in January 2025 as a space for Black women and members of their support network to share their experiences and develop strategies for change. Members of the CAC serve as local experts on maternal health needs, informing the work of the MIHTF and DOH programs and meaningfully engaging in solutions. There are seven active members on the CAC who attend monthly meetings and participate in events to engage and educate the community. Members receive training and compensation for their time and expertise.

At the onset, DOH staff led CAC members through a series of training sessions covering topics that provided baseline knowledge and skills on maternal health topics. This orientation provided a foundation for the group to develop priorities and strategies around the goals they sought to achieve. In transitioning to the second phase of the group's function, CAC members will take on more direct leadership roles to build out action plans for activities that advance community building, advocacy, education and outreach. They have signed on to a year of participation on the team to move the needle on the group's priority areas, provide recommendations to the Task Force and receive ongoing support through their shared lived experience.

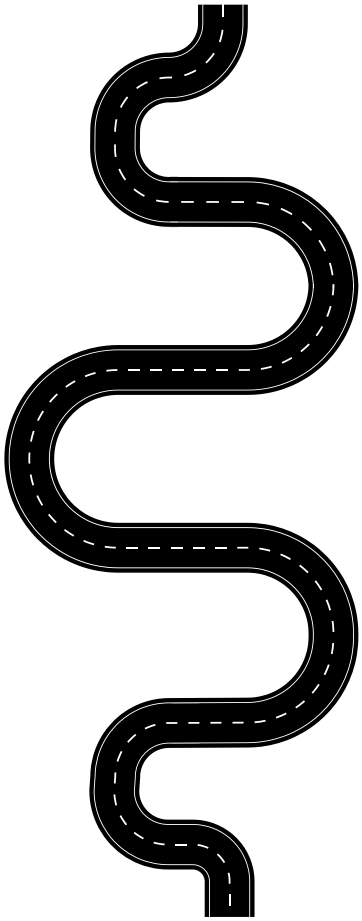
Purpose

To collaborate alongside the Task Force to prioritize efforts related to community outreach, education, advocacy and community building, and amplify the voices and experiences of women, parents and birthing people of color in Anne Arundel County.



CAC Roadmap

Phase 1: Training Orientation



Overview

- Drivers of maternal health disparities
- Building the CAC

Data, Policy and Historical Context

- Local data trends
- State policy
- History of maternal health disparities

Best Practices

- Models for equitable maternal health
- Root causes

Planning Skills

- Goal-setting and action planning

Phase 2: Action Planning and Implementation

Maternal and Infant Health Task Force

GOAL 1: IMPROVE CARE

Improve care coordination and delivery to prevent and provide timely response to pregnancy-associated morbidities, mortalities and mental health needs.

Objective A

Coordinate care for perinatal mental health needs.

Objective B

Improve prenatal care availability, quality and coordination.

Objective C

Coordinate care after delivery to provide support out to one year postpartum.

Objective D

Provide culturally-informed care that is person-specific and rooted in trust.

Maternal and Infant Health Task Force

GOAL 2: EDUCATION AND AWARENESS

Provide perinatal education and information to ensure families, members of their support network and their providers are informed and supported.

Objective A

Educate and screen for perinatal mental health needs.

Objective B

Increase education about postpartum issues, warning signs and resources.

Objective C

Streamline data collection, reporting and communications across health systems.

NEXT STEPS

The charge of the MIHTF and CAC moving forward will be to execute the priorities of this plan. As with the planning process, implementation will require innovative thinking, careful strategizing and collaborative action. The CAC will continue to provide community perspective and insight into how to prioritize the work of the plan. The Task Force will leverage and build resources, connections and workflows to achieve the plan's objectives. Both teams will continue to meet on a monthly basis to stay informed about data trends, local needs, opportunities for solutions and obstacles to progress. The teams will also meet collectively to share successes and challenges.

To provide a vehicle for implementation, the MIHTF will form working groups to focus expertise around the team's priorities. One team will drive improvements to care, including targeted strategies around prenatal, postpartum and mental health care delivery. This work will be anchored in culturally informed and humble practices to build trust between care providers and their patients. Another team will explore opportunities to increase community awareness and education on perinatal topics, including warning signs and support availability for mental health and postpartum needs. A primary objective for this team will involve enhancing communication sharing across providers, partners and community members so the flow of information is clearer to everyone involved. Each working group will develop a plan of action that outlines the strategies, timeframe, parties responsible and resources needed to achieve each objective.

The teams aim to center transparency in this next phase of the work. Progress updates will be housed on the Anne Arundel County Department of Health's website, alongside maternal and infant health data dashboards that will offer the latest health trends.

DEFINITIONS

Birth Equity - The assurance of conditions necessary for optimal births for all people, achieved through a sustained effort to address racial and social inequalities and dismantle systemic barriers that prevent equitable birth outcomes.

Birthing Person - An individual who is giving birth.

Caesarean Section - A surgical procedure in which a baby is delivered through a cut in the abdomen and uterus (also called a C-section).

Culturally Informed and Humble Care - The practice of providing health and mental health services that are considerate of and responsive to a person's identity, beliefs, practices and language needs.

Hypertension - Persistently high blood pressure, either gestational or chronic.

Low Birthweight - An infant born weighing less than 2500 grams (about 5.5 pounds).

Obese - A body mass index (BMI) of 30 or higher.
BMI = [weight (lb) / height (in)^2] x 703.

Perinatal - The time period surrounding birth, including pregnancy, birth and the time immediately after.

Postpartum - A term meaning after birth, up to one year (also referred to as post-birth).

Postpartum Anxiety - Characterized by intense and persistent worry, racing thoughts and overwhelming feelings of dread after childbirth that interfere with daily life and a parent's ability to care for their baby.

Postpartum Depression - Depression after childbirth characterized by mood swings, crying spells, anxiety and difficulty sleeping.

Premature - Births that occur before 37 weeks of gestation (also called preterm births).

Prenatal - A term meaning before birth.

Trimester Definitions

Trimester - A time span of three months during pregnancy, each marked by different phases of fetal development.

First Trimester - The first 13 weeks of pregnancy.

Second Trimester - The time from 14 weeks to 27 weeks of pregnancy.

Third Trimester - The time from 28 weeks of pregnancy onwards.

Full Term - A pregnancy duration where birth occurs between 39 weeks, 0 days and 40 weeks, 6 days.