

GOAL 2 Action 2.6

WHITE HOUSE
BLUEPRINT
EVIDENCE TO
ACTION BRIEFS

Train providers on implicit biases, culturally and linguistically appropriate care and behavioral health needs of pregnant and postpartum women



Maternal Health
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THE WHITE HOUSE BLUEPRINT
FOR ADDRESSING THE
MATERNAL HEALTH CRISIS



The [White House Blueprint for Addressing the Maternal Health Crisis](#) (White House Blueprint) has identified goals and actions to reduce the rates of maternal mortality and morbidity, eliminate disparities in maternal health outcomes, and improve the overall experience of pregnancy, birth, and the postpartum period for people across the United States.

The following Evidence to Action brief highlights Action 2.6 of the Blueprint, part of the effort to “Ensure those giving birth are heard and are decisionmakers in accountable systems of care” (Goal 2 of the Blueprint).

Maternal Health Action 2.6

Train providers on implicit biases, culturally and linguistically appropriate care and behavioral health needs of pregnant and postpartum women, including screening and referral for abuse and maltreatment.

Contribution to Quality of Life

The [White House Blueprint](#) is a “whole-of-government approach to combating maternal mortality and morbidity” so that all people in the United States who are capable of becoming pregnant and giving birth are healthy and safe.

Reports of poor care during childbirth are too high, and are significantly worse for people of color.¹ Racism, bias, and structural inequities all play a role in this treatment. Enhanced health care team member training on implicit biases, culturally and linguistically appropriate care, and respectful care are essential to improving maternal health in the US. An entire integrated health care team that works with birthing families should be equipped to provide care that is not only non-harmful but also accommodating and uplifting.

Basic Facts

The United States has higher rates of maternal mortality and morbidity than peer countries, and poor outcomes are disproportionately seen among Black birthing people (see Figure 1 and Figure 2). Factors that contribute to the inequities and the country’s overall dismal maternal health status are high rates of chronic diseases and poor quality of care. Both influences reflect systemic racism—and particularly anti-Black racism—and differential outcomes are present even when Black individuals give birth in high-quality hospitals and when controlling for comorbidities. These facts should draw attention away from mother-blame narratives and toward strengthening systems of care.

Respectful maternity care is an approach that calls for growing aspects of obstetric practice that are working well and consistently offering health care services that are just and supportive, thereby minimizing inequities in birth outcomes.² It is a concept based on human rights that has been championed by advocates around the world. In the US, providers trained in respectful maternity care are educated about the history of unethical experimentation on marginalized populations and strive to meet the needs and preferences of birthing people, their companions, and newborns.^{3,4} Addressing implicit (as well as explicit) bias is a central component of respectful maternity care. Likewise, eliminating discrimination is a part of ethical, joyful practice.

Implicit bias refers to unconscious attitudes and beliefs that impact behaviors, body language, tone of voice, receptivity, or decision-making.⁵ In a health care setting, implicit bias can affect assumptions and treatment decisions, and cause harm.⁶ These beliefs are part of a White-supremacist legacy, which has treated Black individuals as less valuable than other people. A 2016 study found that around half of White medical students and residents surveyed believed biological myths about racial differences between Black and White patients and demonstrated that these beliefs predicted racial bias in the treatment of pain.⁷



Implicit bias is manifested in maternal and child health care through various provider-led interactions and further implicates populations that are at an increased risk for poor health outcomes. For example, differential pain assessment and management in the postpartum period is documented—and solutions were articulated in 2022 by Black obstetricians and multidisciplinary collaborators.^{8,9,10} Siden et al. reported that 1 in 10 Black mothers said they were “treated poorly” because of their identity during inpatient postpartum care; in comparison, 3 in 100 White mothers said they were “treated poorly.”⁶ Another study found that even when controlling for clinical characteristics, Black women are less likely than White women to undergo labor induction or receive regular cervical examinations during labor; they also are more likely to undergo cesarean delivery under general anesthesia.¹¹ Overall, Black women have higher exposure to structural and individual racism, which is associated with adverse maternal and birth outcomes.¹²

Hispanic women also report lower trust in their doctors than do other ethnic groups, and language-concordant care is not consistently achieved in maternity care.¹³ In addition, American Indian/Native American women have experienced and continue to face decades of “racism and discrimination in the form of genocide, forced migration, and cultural erasure,” which results in distrust between themselves and their health care providers.¹⁴ This lack of trust between provider and patient can result in negative or poor maternal and infant health outcomes.¹⁴

Given the urgency of the maternal health crisis, health systems are seeking ways to effectively address implicit bias. Although implicit bias trainings for health care professionals are widely available, recent reviews of the literature do not provide evidence that they are effective.¹⁵ Many groups, including the Alliance for Innovation in Maternal Health, the American College of Obstetricians and Gynecologists, and the Society of Maternal Fetal Medicine, have made it a priority to reduce maternity care clinicians’ implicit bias, and these national organizations can provide actionable and accessible resources to help develop implicit bias trainings. Methods for measuring outcomes and for piloting and evaluating implicit bias initiatives also should be developed.

There is emerging evidence that some techniques, such as exposure to counter-stereotypical archetypes, offer the most promise in reducing implicit bias.¹⁵ Evidence also suggests that training based on social psychology that includes perspective taking, building partnerships (or shared in-group identities), and emotional regulation (e.g., mindfulness-based stress reduction) tends to be most effective.¹⁶ Experts in the diversity and equity field continue to call for provider trainings that focus on cultural humility, with the goal of equalizing the provider-patient relationship by encouraging providers to reflect on their own biases and how their culture impacts a patient, thereby improving communication and quality of care.¹⁷

Culturally and linguistically appropriate services (CLAS) are another component of respectful maternity care. CLAS is defined as care delivered in a language the patient understands and care that is responsive to a patient’s cultural, religious, or other individual preferences. Care provided in this way is intended to address cultural and linguistic barriers while enhancing equity, patient experiences of care, and outcomes. Evidence suggests that patient outcomes are responsive to CLAS; however, evidence also reveals a lack of understanding in hospitals of culturally competent care.^{18,19} A systematic review of culturally competent health care interventions identified strategies used to improve health care for culturally and linguistically diverse patients, which included integration of community health workers, telemedicine, outreach methods, and creation of community health networks.²⁰

To support those giving birth being heard and respected as decision-makers in accountable systems of care (Goal 2 of the White House Blueprint), the federal government commits to training providers in culturally and linguistically appropriate care, safety programs in perinatal care, and implicit biases. To deliver on this commitment, the US Department of Health and Human Services (HHS) will

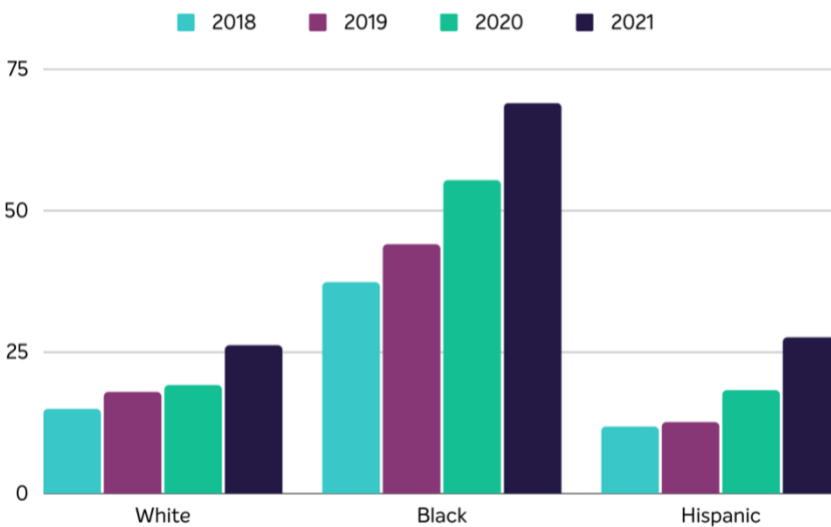


promote an accredited free e-learning program, “Culturally and Linguistically Appropriate Services (CLAS) in Maternal Health Care.” The program is designed for providers and students to build knowledge and skills related to CLAS, cultural competency, cultural humility, person-centered care, and combating implicit bias. HHS will also expand the Agency for Healthcare Research and Quality’s Safety Program in Perinatal Care to train providers to deliver care that empowers individuals to assert their rights and advocate for themselves. Finally, HHS will support the development and implementation of implicit bias training for clinicians who provide maternal health care services. These HHS efforts may also include making recommendations for incorporating bias recognition in clinical skills testing for accredited schools of medicine.

How are we doing?

Below we highlight data related to Action 2.6. Racial, ethnic, geographic, and socioeconomic disparities emphasize where efforts should focus to improve health outcomes related to the action.

Figure 1: Maternal Mortality (per 100,000 births) by Race/Ethnicity in the US, 2018–2021

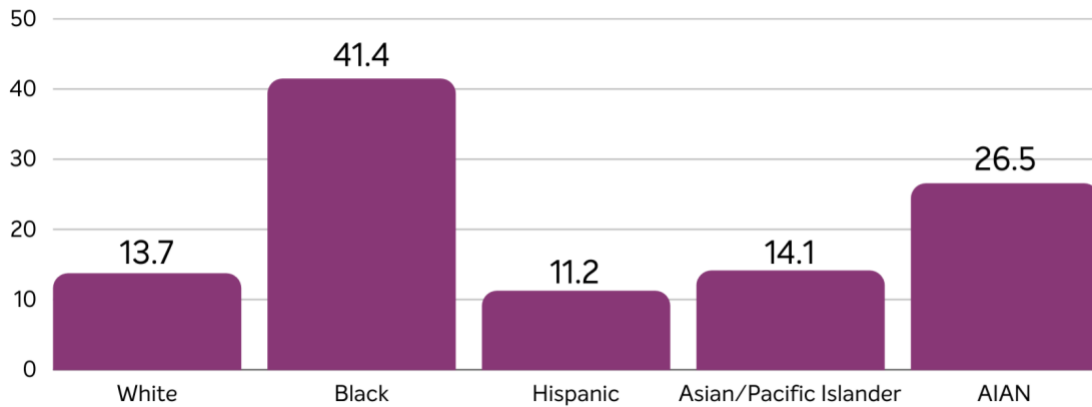


The COVID-19 pandemic exacerbated maternal mortality racial disparities. Black women had the highest maternal mortality rates across all racial and ethnic groups during 2020 and 2021, as well as the largest increase compared with the year before the pandemic (2019).

Source: Hill L, et al. [Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them](#). Kaiser Family Foundation. 1 November 2022. Accessed September 18, 2023.



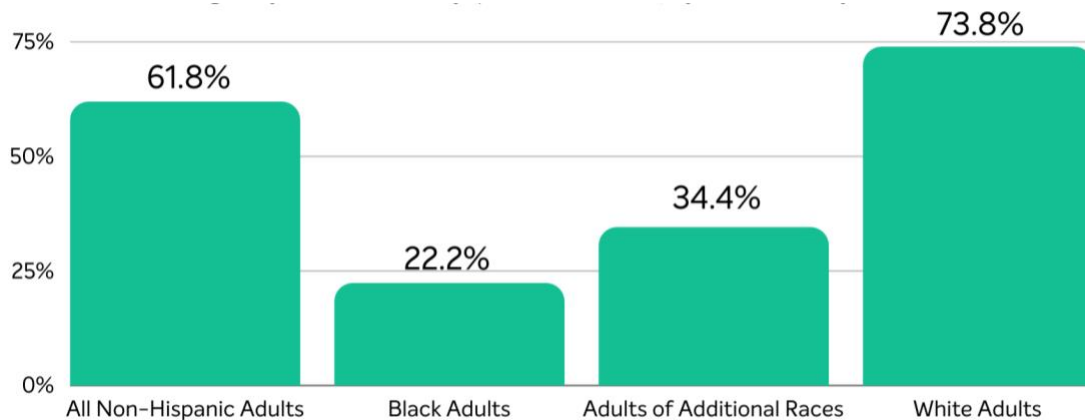
Figure 2: Pregnancy-related Mortality (per 100,000 births) by Race/Ethnicity in the US, 2016–2018



Black and American Indian/Alaska Native (AI/AN) women have 2 to 3 times higher rates of pregnancy-related mortality compared with that of White women. These racial disparities increase by maternal age and persist across education levels. Pregnancy-related mortality for Black women who completed college is 5.2 times higher than that for White women with a college education and 1.6 times higher than the rate for White women with less than a high school diploma.

Source: Hill L, et al. [Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them](#). Kaiser Family Foundation. 1 November 2022. Accessed September 18, 2023.

Figure 3: Racial Concordance between Black and Non-Hispanic/Latino Patients and Their Usual Providers, April 2021



Among non-Hispanic adults, Black adults were least likely to report that they were the same race as their provider (22%). In comparison, 74% of White adults reported racial concordance with their usual providers.

Source: Gonzalez D, et al. [Racial, Ethnic, and Language Concordance between Patients and Their Usual Health Care Providers](#). Washington, DC: Urban Institute. 2022. Accessed September 18, 2023.



Story Behind the Data: Factors Affecting Progress

Insufficient diversity in the health care workforce is one barrier to reducing health disparities and enhancing respectful maternity care. Data from the 2021 Health Reform Monitoring Survey from the Urban Institute shows that Black adults were less likely to report being the same race as their health care providers (22%) than White adults (74%)²¹ (see Figure 3). Similarly, less than 1 in 4 Hispanic adults reported sharing a racial, ethnic, or language background with their usual health care provider.¹⁸

While instituting language services into health care is required by federal mandate, without oversight to ensure accountability, availability of such services in hospitals has been inconsistent.¹⁸ A lack of financial incentives and limited Medicaid reimbursement funds for language services are other barriers to institutionalizing CLAS in health care systems.

Implicit bias is widely recognized as a threat to quality health care and obstetric care, yet there is little evidence-based guidance for health systems and clinicians about effective interventions.⁶ In the US, some states, such as California, Maryland, Michigan, Minnesota, and Washington, have passed legislation that mandates implicit bias training for at least some health care professional categories. Other states are at various stages of developing and passing similar legislation.¹⁶ In addition, there are no standard measures of bias and quality of care, which hinders efforts to measure progress. Moreover, evaluations of implicit bias interventions have found them to be ineffective. This limitation likely reflects the multilevel constraints on health care team members, including lack of safe staffing levels. Likewise, trainings in cultural competence have been documented primarily to increase provider knowledge, attitudes, and skills, but have had little or no established effect on patient satisfaction or on patient health outcomes.¹⁷

Another barrier to reducing implicit bias in health care is its presence in evidence-based practice. For example, race-based indications in protocols for diagnosing anemia may bias maternity care providers, leading to lower treatment rates of iron-deficiency anemia and explaining the disproportionately high rates of blood transfusion at birth for Black women.⁶ In addition, despite the disrespect in labor and delivery care instigated by racism and bias, there are limited tools to measure disrespect or support provider behavior change.²²

Moving toward more respectful maternity care requires an ongoing cycle of meaningful partnerships.^{23,24} Maternal and child health experts from [The Bloom Collective](#), [Bridges to Bond](#), and [Reproductive Health Impact](#) stated “shifting power through partnerships that value lived experience, build trust, and provide a seat at the table allow[s] communities, organizations, and healthcare systems to authentically and effectively advance respectful maternity care and health equity.”²⁵ Using the *Cycle to Respectful Care* tool is one way to begin shifting power and building authentic relationships.²³ The tool was developed through qualitative research in US communities identified as having a high density of Black births. Black birthing individuals’ birthing experiences were used to design the framework for an actionable, cyclical tool for training in anti-racist maternity care.

Targeted trainings are a tool that can make it easier for evaluators to test the effectiveness of implicit bias and anti-racist training mandates by measuring changes in specific metrics across specific populations.¹⁶ Targeted or tailored trainings focus on particular populations or clinical issues, avoiding a generic focus that may dilute the effects of an implicit bias training. Targeted trainings may also be more acceptable to health care providers, because the training may be more relevant to their challenges and identified needs.¹⁶

Finally, attention should focus on the systemic forms of bias that persist in medical training and practice.⁵ Solutions include but are not limited to removing obstructions in the physician pipeline to



address the limited racial diversity in that workforce; reforming medical school curricula and training to eliminate unscientific racial stereotypes; and investing in initiatives to reduce Black-White maternal health disparities and pilot testing them before widespread implementation to ensure that they improve inequalities.

What can be done to address the issue?

The [White House Blueprint](#) identifies actionable steps to address Action 2.6. In addition, experts from the maternal and child health field have identified innovative, evidence-informed strategies from several databases and national repositories.

Maternal and Child Health (MCH) Innovations

MCH experts selected the following resources for action after a review that included: the [MCHbest Database](#), a database developed to aggregate evidence-based strategies that can be used as is or adapted to fit local and state-level contexts; the [Association of Maternal & Child Health Program's Innovation Hub \(AMCHP\)](#), a searchable repository of local and state practices, policies, and community-based innovations considered to be “what’s working” in the MCH field; the [Robert Wood Johnson Foundation's What Works for Health \(RWJ\)](#) database, a tool that helps local communities to identify policies and programs that fit within their context and match their priorities; the [Maternal Health Learning & Innovation Center](#), a national resource for improving maternal health inequities; and a search of leading organizations and agencies working in this field.

CALL TO ACTION

Removing racism and bias from the US health care system is integral to reducing maternal death. Health care leaders and funders are called upon to prioritize the piloting, measurement, and evaluation of initiatives that comprehensively address implicit bias mitigation, enhance respectful maternity care, advance equitable care, and ensure that all people receive culturally and linguistically appropriate care.

- [Alliance for Innovation on Maternal Health](#). AIM is a national maternal safety and quality improvement initiative that provides implementation and data support for the adoption of evidence-based patient safety bundles. AIM works through state teams and health systems to align national, state, and hospital-level efforts to improve overall maternal health outcomes and can provide technical assistance and implementation support for states implementing the safety bundles.
- [Black Mamas Matter Alliance](#). This cross-sectoral network led by Black women centers Black mothers and birthing people to advocate, drive research, build power, and shift culture for Black maternal health, rights, and justice.
- [Colorado Birth Equity Bill Package](#). This policy package in Colorado addresses discrimination, mistreatment, harm, and poor birth outcomes and inequities during the perinatal period and may support culturally appropriate health care among providers. (AMCHP)
- [Culturally Adapted Health Care](#). This scientifically supported strategy tailors care to patients’ norms, beliefs, values, language, and literacy skills. Culturally adapted care can include matching specialists to patients by race or ethnicity; adapting patient materials to reflect patients’ cultural, language, or literacy skills; offering education via community-based health advocates; and implementing patient involvement strategies. (RWJ)
- [Cultural Competence Training for Health Care Professionals](#). This scientifically supported training provides facts about patient culture, the inclusion of more complex interventions such as intercultural communicational skills training, exploration of potential barriers to care, and institution of policies that are sensitive to the needs of patients from culturally and linguistically diverse backgrounds. There is strong evidence that this improves providers’ knowledge, understanding, and skills for treating patients from culturally, linguistically, and socioeconomically diverse backgrounds. Further research is needed to determine the effect on patient care outcomes. (RWJ)



- [Health Equity Impact Assessment](#). An emerging practice, an HEIA creates a structured process to guide a diverse group of stakeholders (including those with lived experience) through development, implementation, and evaluation of policies and programs that impact population health, with the goal of reducing health disparities and inequities. (AMCHP)
- [Mandated Implicit Bias Trainings for Health Care Professionals](#). This policy intervention can ensure that the time and resources required for widespread training are being used to achieve the goals of reducing bias and promoting equitable care. Simultaneously, it is recommended that health leaders enhance the evidence base on the effectiveness of implicit bias trainings and establish qualifications for trainers. California, Maryland, Michigan, Minnesota, and Washington recently passed legislation mandating implicit bias training for at least some categories of health professionals.
- [March of Dimes. Awareness to Action: Dismantling Bias in Maternal and Infant Healthcare](#), an in-person or virtual implicit bias training from the March of Dimes, provides content for health care professionals and nursing and medical students caring for women before, during, and after pregnancy.
- [Postnatal Patient Safety Learning Lab](#). Located at the University of North Carolina at Chapel Hill, this research team has developed a series of digital stories to build empathy around birthing people's experiences of health care. The open-access animations can be used to increase awareness and promote more patient-focused care.
- [Racial Equity Learning Series \(RELS\)](#). National Healthy Start Association and the Alliance for Innovation on Maternal Health—Community Care Initiative developed this training series on racial equity. RELS is accredited by the American Public Health Association and allows the learner to earn 10 continuing education credits for the entire series at no cost.
- [Respectful Care eModules](#). The American College of Obstetricians and Gynecologists has developed and offers free online courses to address race and equity in OB-GYN care. Modules cover three topics: race and equity, respectful care, and historical foundations of obstetric racism.
- [Respectful Maternity Care Implementation Toolkit](#). The Association of Women's Health Obstetric and Neonatal Nurses developed this toolkit to support clinicians and organizations to provide respectful maternity care.
- [Think Cultural Health](#). This program from the U.S. Health and Human Services Office of Minority Health provides health care professionals with information, continuing education opportunities, and resources to implement CLAS and National CLAS Standards.

State Maternal Health Innovations from the Health Resources & Services Administration (HRSA) Maternal and Child Health Bureau (MCHB) Grantees

The [State Maternal Health Innovations \(MHI\)](#) initiative, funded by [HRSA's MCHB](#), currently provides funding to 18 states to develop, implement, and evaluate state-level equity-centered innovations. Below we highlight innovations from the MHI cohorts (2019–2024) that address Action 2.6:

- [Illinois](#). The Illinois Perinatal Quality Collaborative (ILPQC) developed an [Implicit Bias Training Inventory](#) for potential use by health care providers in response to Illinois Public Act 102-0004, which requires implicit bias awareness training for health care professionals' license or registration renewals beginning January 1, 2023.
- [Maryland](#). As part of the Maryland Maternal Health Innovation Program (MHI) training center, Maryland implemented the [Awareness to Action: Dismantling Bias in Maternal and Infant Healthcare](#) implicit bias training. It has been offered to more than 35,000 health care professionals.
- [North Carolina](#). Through partnerships with the NC Area Health Education Centers, Office of Minority Health and Health Disparities, and March of Dimes, the North Carolina MHI program developed and provides trainings for physicians, midlevel practitioners, nurses, and others that relate to health equity, implicit bias, and social determinants of health.



- [Ohio](#). In 2022, the Department of Health’s Pregnancy Associated Mortality Review Program offered a free live-virtual training, “Managing Implicit Bias and Maternal Health,” for health professionals. Continuing nursing education contact hours were awarded to nurses who attended all sessions, completed the Cultural Intelligence (CQ) assessment before the training, and submitted a completed evaluation at its conclusion.

Evidence-based Strategy Measures from the [MCH Evidence Center](#) Related to Action 2.6

Throughout the country, state-level [Title V MCH](#) agencies develop measures to help track their efforts around improving the health and well-being of women, children, and families. Below is a measure related to improving equitable maternal and child outcomes that can support Action 2.6.

- Reduce the number of women who report experiencing implicit bias or discrimination in Pregnancy Risk Assessment Monitoring (PRAMS). ([District of Columbia](#))

Resources from the [MCH Evidence Center’s Digital Library](#)

The [MCH Digital Library](#) is a digital repository of evidence-based and -informed toolkits, briefs, white papers, and more with seminal and historic resources. The following may support Action 2.6.

- National Institute for Children’s Health Quality. [Implicit Resource Guide: A Resource to Increase Health Equity and Address Implicit Bias](#). 2019. Boston, MA.

Strategy Development Criteria to Consider for State and Local Implementation

To select impactful strategies for local implementation, an organization may consider using the following criteria, based on the Results-Based Accountability framework outlined in the book *Trying Hard Is Not Good Enough* by Mark Friedman.

- **Specificity:** Ensure strategies are clearly defined, including responsible parties and timelines.
- **Leverage:** Evaluate how strategies can improve data quality and reliability.
- **Values:** Assess alignment with community and organizational values.
- **Reach:** Consider feasibility and affordability at the required scale.

Using these criteria can aid in developing feasible and impactful strategies. Visit maternalhealthlearning.org/Blueprint for more details.



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