

GOALS

**WHITE HOUSE
BLUEPRINT
EVIDENCE TO
ACTION BRIEFS**

**Strengthen Economic and Social
Supports for People Before,
During, and After Pregnancy**



Maternal Health
Learning & Innovation Center™
MaternalHealthLearning.org

**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 experience of pregnancy, birth, and the post-partum period for people across the United States.

The following Evidence to Action Brief highlights Goal 5 of the White House Blueprint.

Maternal Health Goal 5

Strengthen economic and social supports for people before, during, and after pregnancy.

CONTRIBUTION TO QUALITY OF LIFE

The [White House Blueprint](#)¹ 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.

Maternal health outcomes are greatly impacted by where a person is born, lives, works, plays, and prays—these factors are known as the social determinants of health (SDOH) and include access to safe housing, adequate healthy food, transportation, education, employment opportunities, safe and clean air and water, and protection from intimate personal violence, discrimination, racism, and violence (see Figure 1). The SDOH affect the health and well-being of pregnant and birthing people.² Ensuring systematic, multifaceted approaches to addressing these factors has the potential to improve maternal mortality and severe maternal morbidity.

BASIC FACTS

Many factors influence health, and the health care system cannot compensate for all of them. Chronic exposure to social and economic disadvantages can contribute to an accelerated decline in physical health outcomes.³ This is known as the “weathering hypothesis,” and may partially explain the racial disparities seen in an array of health conditions.

Pregnant and birthing people are more likely to have positive maternal and infant birth outcomes if they have access to education, stable housing, a reliable food source that offers nutritious foods, transportation (e.g., sidewalks, public transportation, and safe spaces for physical activity), social and economic opportunities, and social services. Research shows that together, these social determinants of health account for as much as half of the county-level variation in health outcomes and are major drivers of health disparities in this country.^{4,5} Because medical care accounts for only a small fraction of modifiable health influences, to advance maternal health, a holistic approach that improves social and economic factors throughout a woman/birthing person’s life must be considered. (See Figure 2.)

Housing Security

People with unstable housing are at increased risk for preterm birth, preterm labor, delivering a low-birth-weight infant, having a longer stay in a hospital after a birth, visiting an emergency room within three months of birth, and developing preeclampsia, anemia, and/or hemorrhage during pregnancy.^{6,7} Being unhoused also contributes to other comorbidities, such as anxiety, depression, and substance use disorders.⁷

Policy interventions to support maternal and infant health through housing initiatives are emerging and demonstrate promising outcomes.⁸ Examples include: direct targeted housing assistance, housing mobility programs (e.g., subsidized vouchers), and community planning and improvement strategies in neighborhoods that experience increased risk. Evaluations of initiatives in New York and Texas support housing and health care collaborations that utilize a state’s Medicaid reform initiative to increase access to supportive housing for people at increased risk for poor health outcomes.⁹

Food Security and Nutrition

More than 1 in 10 people in the US has experienced food insecurity during pregnancy.¹⁰ Food insecurity may increase stress hormones and thereby increase a pregnant person's risk for high blood pressure and preterm birth.¹¹ Research shows that both food insecurity and poor diet can have detrimental effects on maternal health and pregnancy outcomes, increasing a pregnant person's risk of developing gestational diabetes, delivering a low-birth-weight infant, or delivering a baby with a birth defect such as spina bifida or cleft palate.¹¹ One study found that women/birthing persons with food insecurity delivered infants that were statistically more likely to be admitted to the NICU compared with those with food security.⁹ Women/birthing persons who were food insecure were also found to have higher median pregnancy body mass index, attend less than 10 prenatal visits, and have had a previous cesarean delivery.⁹ Women veterans of the US military are at particular risk: In 2018, almost 30% of women veterans experienced food insecurity compared with non-veterans.¹²

Policy interventions such as the Supplemental Nutrition Assistance Program and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) directly support families to meet their food and nutrition needs. Evidence suggests that the earlier and longer a family's engagement with WIC, the more likely the family is to experience food security (see Figures 2 and 3).¹³ Evidence also suggests that nutritional education is an effective mechanism for improving food security and may include group prenatal care, nutrition-focused antenatal care, and nutritional supplementation combined with an education program that builds a family's nutritional knowledge.^{14,15,16,17} Efforts to make families more economically secure are also important, given that the risk of experiencing food insecurity is highest among families with self-reported income in the lowest income bracket.¹⁸

Environmental Safety

Environmental stressors such as air pollution, pesticides, metals, and per- and polyfluoroalkyl substances (PFAS) are common in the US and increase the risk for poor maternal outcomes. Exposure to environmental stressors before, during, and after pregnancy is associated with fibroids, infertility, and increased risk of polycystic ovarian syndrome—all of which can increase the risk for hypertensive disorders of pregnancy; these stressors also can result in low birth weight, preterm delivery, congenital malformation, and neonatal mortality.^{19,20} (See Table 1.)

Identifying and reducing exposures in the critical pregnancy window can mitigate the toxic effects of environmental stressors.¹⁹ Educating workers about occupational hazards, improving environmental health literacy, and creating culturally relevant health messages are all interventions that aim to empower individuals and communities to avoid environmental exposures.²¹ Efforts to enhance economic security are also critical, as poverty places people at a disproportionately higher risk for environmental exposure.

Economic Security and Workplace Protections

Financial instability and a lack of workplace supports (such as affordable childcare) have been shown to have adverse effects on maternal health outcomes. The US is one of only a handful of high-income countries *without* a national paid maternity leave policy of any kind, which leaves more than 100 million people (or 80% of the US workforce) without paid time off after the birth or adoption of an infant/child.^{22,23} This gap persists despite evidence that comprehensive paid family leave is critical for decreasing the financial burden on new families and increasing bonding between newborns and their parents.²⁴ (See Figure 4.)

Policies that address economic security—such as paid family and medical leave and paid sick days—have been found to play an important role in reducing racial disparities and improving maternal and

infant outcomes, including both physical and mental health outcomes.²⁴ Evidence also supports investing in lactation support in the workplace to improve maternal and infant outcomes. In addition, many advocates are urgently calling for an increase in the US federal minimum hourly wage from \$7.25 to \$15. Though the federal minimum wage has not been raised in more than a decade, a wage increase has been shown to have a positive effect on health, with some evidence suggesting lower prevalence of low birth weight among newborns whose parents receive a wage increase.²⁵ Evidence also suggests an association between an increase in minimum wage and reduced racial and ethnic disparities in income.²⁵

The earned income tax credit (EITC) helps low-to-moderate-income workers and families reduce taxes owed or potentially increase their refund.²⁶ The federal EITC is estimated to lift nearly 5 million working Americans above the poverty line each year; many workers are unaware of this benefit, however, and do not claim the credit. In response, local leaders across the US have implemented initiatives to promote the EITC and connect low-to-moderate-income taxpayers to free tax assistance.²⁶ Another example, the city of San Francisco's guaranteed-income pilot, offers cash assistance to Black and Pacific Islander women during pregnancy and after giving birth.²⁷ The program provides participants with an unconditional monthly income supplement of \$1,000 for the duration of their pregnancy and the first six months of their baby's life.²⁷

Personal Safety

Crime, violence, and discrimination have all been shown to have negative, even fatal, consequences on people during the perinatal period. High levels of stress in the perinatal period are associated with maternal depression, miscarriage, preterm delivery, low-birth-weight infants, and higher rates of cesarean sections.²⁸ Research has found that pregnant and postpartum persons are at greater risk of intimate partner violence, sexual assault, and other forms of gender-based violence. An estimated 20% to 50% of women with children who become unhoused do so as a direct result of escaping domestic violence.²⁹ (See Figure 4.)

Distressingly, women/birthing people in this country are more likely to be murdered during pregnancy, or soon after, than to die from the three leading causes of maternal mortality (hypertensive disorders, hemorrhage, or sepsis).³⁰ The National Center for Health Statistics found there were 3.62 homicides per 100,000 live births among pregnant or postpartum (up to 1 year) compared to 3.12 homicides among nonpregnant and non-postpartum females during the two-year period of 2018–2019 (see Table 2).³⁰ Evidence suggests that these pregnancy-associated homicides are linked to the lethal combination of firearms and intimate partner violence in the US.³⁰ Some of the intimate partner violence interventions with the greatest potential to prevent violence include: social-emotional learning programs for youth, establishing men and boys as allies in prevention, preschool enrichment with family engagement, improved organizational policies, strengthened household financial security, and survivor-centered services.³¹ Stricter gun laws are a policy intervention that many advocates champion for reducing the risk of intimate partner homicide.¹⁸

The [White House Blueprint](#) commits the federal government to improving maternal and infant health outcomes by strengthening the economic and social supports for people before, during, and after pregnancy through the following actions:

Action 5.1. Streamline enrollment in benefit programs for housing, childcare, financial assistance, and food by building better linkages between these programs so that pregnant and postpartum women can more easily obtain services that address their needs outside the doctor's office.

Action 5.2. **Address social determinants of maternal health**, supporting projects to expand maternal mental health access, increase access to digital tools, and expand models that train maternal health care providers and students on how to address implicit bias and racism and screen for social determinants of health.

Action 5.3. **Increase awareness of workplace benefits and protections for pregnant and postpartum women**, like access to private lactation rooms and break time to pump, through a comprehensive outreach campaign to make both workers and employers aware of these protections.

Action 5.4. **Prevent and address violence against pregnant and postpartum individuals** with the implementation of state-level pilot programs incentivizing providers to receive training on pregnancy and postpartum intimate partner violence.

Action 5.5. **Standardize leave recommendations for pregnancy loss and neonatal health complications for the Military Health System**. The military must standardize the leave process to ensure equitable treatment of service members.

Action 5.6. **Screen veterans of childbearing age experiencing homelessness, food insecurity, intimate partner violence, and depression and other factors** during primary care visits.

Action 5.7. **Identify and address adverse effects on maternal health from climate change** and other environmental stressors, by working with Environmental Protection Agency (EPA) and key partners on messages for pregnant women about the risks of extreme heat.

Action 5.8. **Educate providers on the impact of environmental exposures on maternal health** by working with the EPA and the Pediatric Environmental Health Specialty Units (PEHSUs) to educate obstetricians and other maternal health care providers on environmental risks, exposures, and innovations.

Action 5.9. **Replace lead service lines** as they can cause serious health effects to a developing fetus and infants, increase the likelihood of learning and behavioral problems, and increase a mother's risk for miscarriage.

Action 5.10. **Communicate wildfire risks** by relaunching EPA's wildfires web page to make it easier for the public to find user-friendly information on taking action before, during and after wildfires to reduce smoke exposure. EPA is also working to make more information on wildfire health risks available in Spanish and will continue to coordinate closely with the CDC on these public health messages.

Action 5.11. **Eliminate barriers to well-being, retention, and career advancement for female service members** by updating policies to remove unnecessary universal pregnancy work and training limitations that may adversely impact a service member's career.

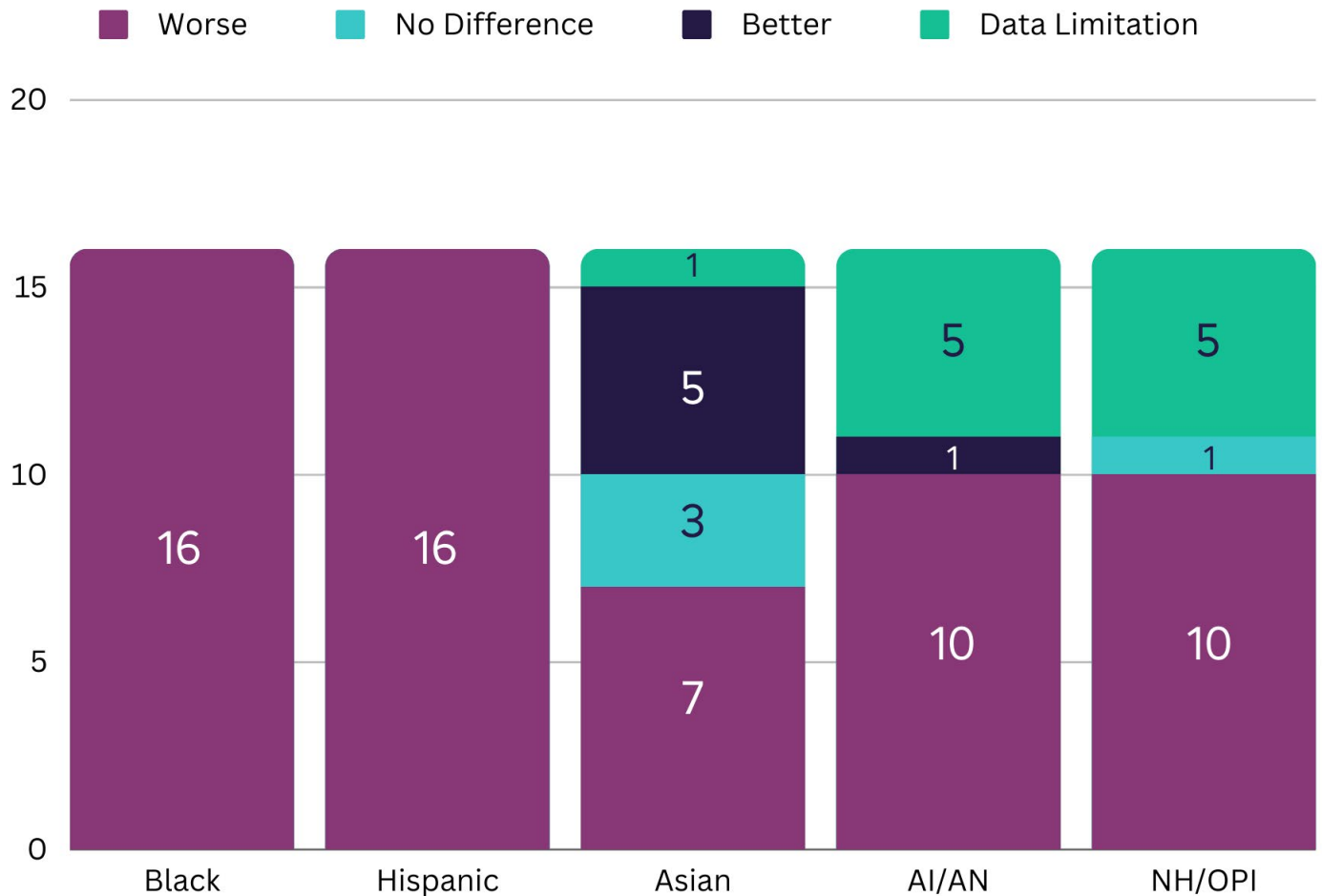
Action 5.12. **Hold a White House Conference on Hunger, Nutrition, and Health** to end hunger, improve nutrition and physical activity, reduce diet-related disease, and close the disparities around them.

Evidence supports addressing housing status, food security and nutrition, environmental risk, economic security, and personal safety to improve maternal health outcomes.

HOW ARE WE DOING?

Below we highlight selected data related to Goal 5. Racial, ethnic, geographic, and socioeconomic disparities emphasize where efforts should focus to improve health outcomes related to the goal.

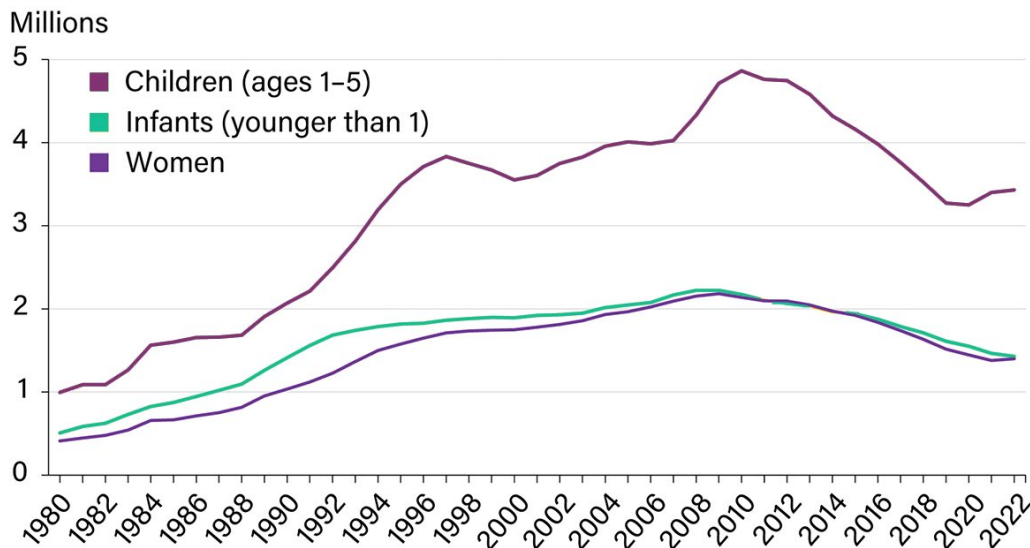
Figure 1: Social Determinants of Health (SDoH) among People of Color Compared with White People
The number of measures for which group fared better, the same, or worse compared to White people



Socioeconomic status, education, immigration status, language, neighborhood and physical environment, access to health care, and social support encompass the SDOH. When examining these measures of the SDOH, Black, Hispanic, American Indian/Alaska Native, and Native Hawaiian/Other Pacific Islander people fared worse compared to White people.

Hill L, et al. [Key Data on Health and Health Care by Race and Ethnicity](#). Kaiser Family Foundation. March 15, 2023. Accessed August 2, 2023.

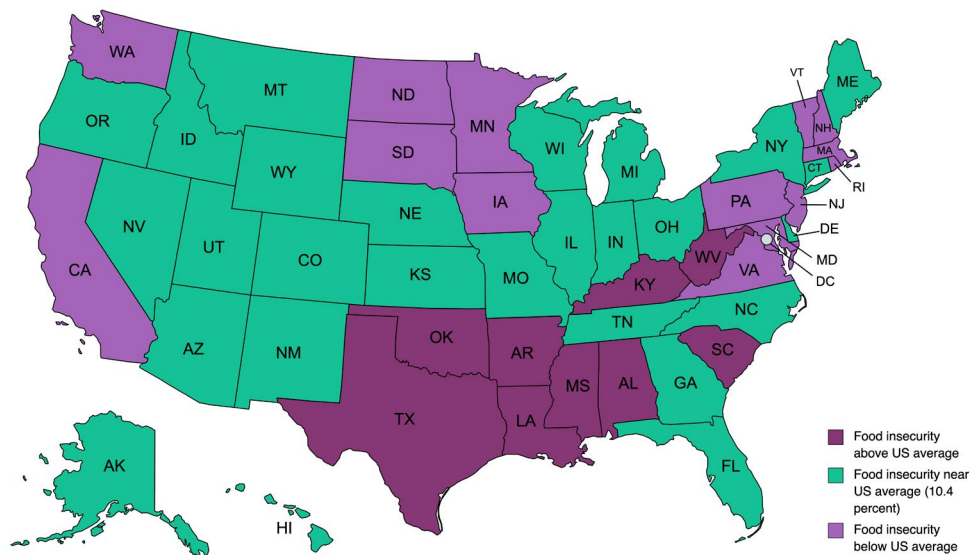
Figure 2: Average Monthly Participation in WIC, 1980–2022



The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) serves to safeguard the health of low-income pregnant and postpartum women, infants, and children younger than 5 years who are at nutritional risk. WIC served about 6.3 million participants each month in fiscal year 2022, including an estimated 39% of all infants in the US. Federal program costs for WIC totaled \$5.7 billion in fiscal year 2022.

Source: U.S. Department of Agriculture. [Monthly Average WIC Participation](#). Last updated July 19, 2023. Accessed August 2, 2023.

Figure 3: Average Prevalence of Food Insecurity by State, 2019–2021



Average rates of food insecurity vary in the US by geographic region. Southern states (TX, OK, AR, LA, MS, AL) have above average food insecurity compared with other parts of the country. Northeastern states (NH, VT, MA, RI) experience food insecurity below the national average. In Mississippi, for example, the rate of food insecurity was 15%, compared with 5% in New Hampshire.

Source: Coleman-Jensen A, et al. [Household Food Security in the United States in 2021](#), ERR-309, U.S. Department of Agriculture, Economic Research Service. September 2021. Accessed August 2, 2023.

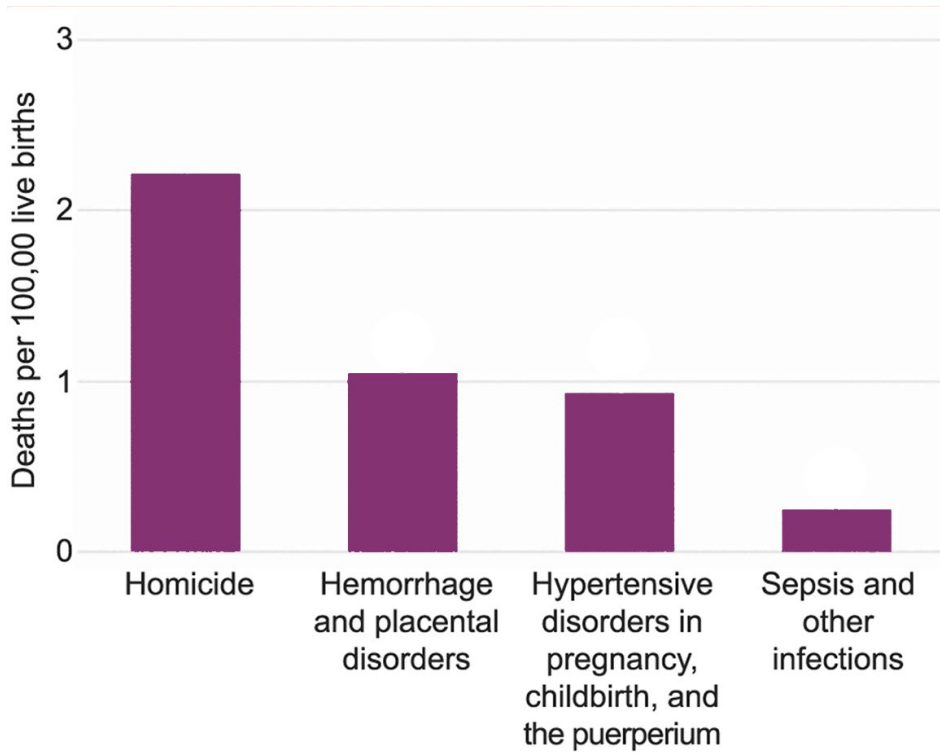
Table 1: Examples of Environmental Stressors Linked to Maternal Health Outcomes and Potential Moderating Factors

Environmental Stressors	Maternal Outcomes
Air Pollution	Hypertensive disorders of pregnancy Polycystic ovarian syndrome Subfertility Miscarriage ART failure
Metals	Hypertensive disorders of pregnancy Uterine fibroids Subfertility Miscarriage Cardiometabolic health
PFAS	Breast development and lactation Breast cancer Cardiometabolic health
Persistent Pesticides (DDT and DDE)	Lactation impairment Breast cancer risk in mother and female offspring
Persistent Pollutants (dioxin/PCBs)	Breast cancer risk in mother by 50 years of age Mammary development and lactation
EDCs (e.g., phthalates, phenols)	Uterine fibroids Thyroid function, glucose metabolism and obesity, fertility, and carcinogenesis
Potential moderators Race/ethnicity	Cardiometabolic health Uterine fibroids

The environment has a direct role as well as an indirect impact on health effects later in life and co-morbidities. The table summarizes the environmental stressors associated with a variety of immediate and long-term maternal health impacts. Most exposures in the table were associated with more adverse outcomes; the strength and the direct effect varies.

Source: Boyles AL, et al. [Environmental Factors Involved in Maternal Morbidity and Mortality](#). J Women's Health. 2021;30(2):245-250.

Figure 4: Cause-specific Mortality Ratios (deaths per 100,000 live US births) Among Females During Pregnancy and up to 42 Days from the End of Pregnancy, 2018–2019



Researchers estimated the national homicide mortality ratio during pregnancy or within 42 days of the end of pregnancy. Homicide exceeded all the leading causes of maternal mortality, including hypertensive disorders, hemorrhage, and infection, by more than twofold. The prevalence of pregnancy-associated homicide was highest among non-Hispanic Black females and females younger than age 25.

Source: Centers for Disease Control and Prevention. [NVSS—Mortality Statistics](#). Last reviewed July 19, 2023. Accessed August 2, 2023.

CALL TO ACTION

To address the US maternal health crisis, it no longer is sufficient to implement clinical and behavioral interventions alone. Innovations must go beyond the clinic, hospital, or local health care system and include the voices of people with lived experience and key partners in other arenas such as housing, employment, education, the justice system, social services, and government. Leadership at all levels from all sectors must take action and show commitment to an upstream, collaborative, multilevel, and systematic approach.^{3,5}

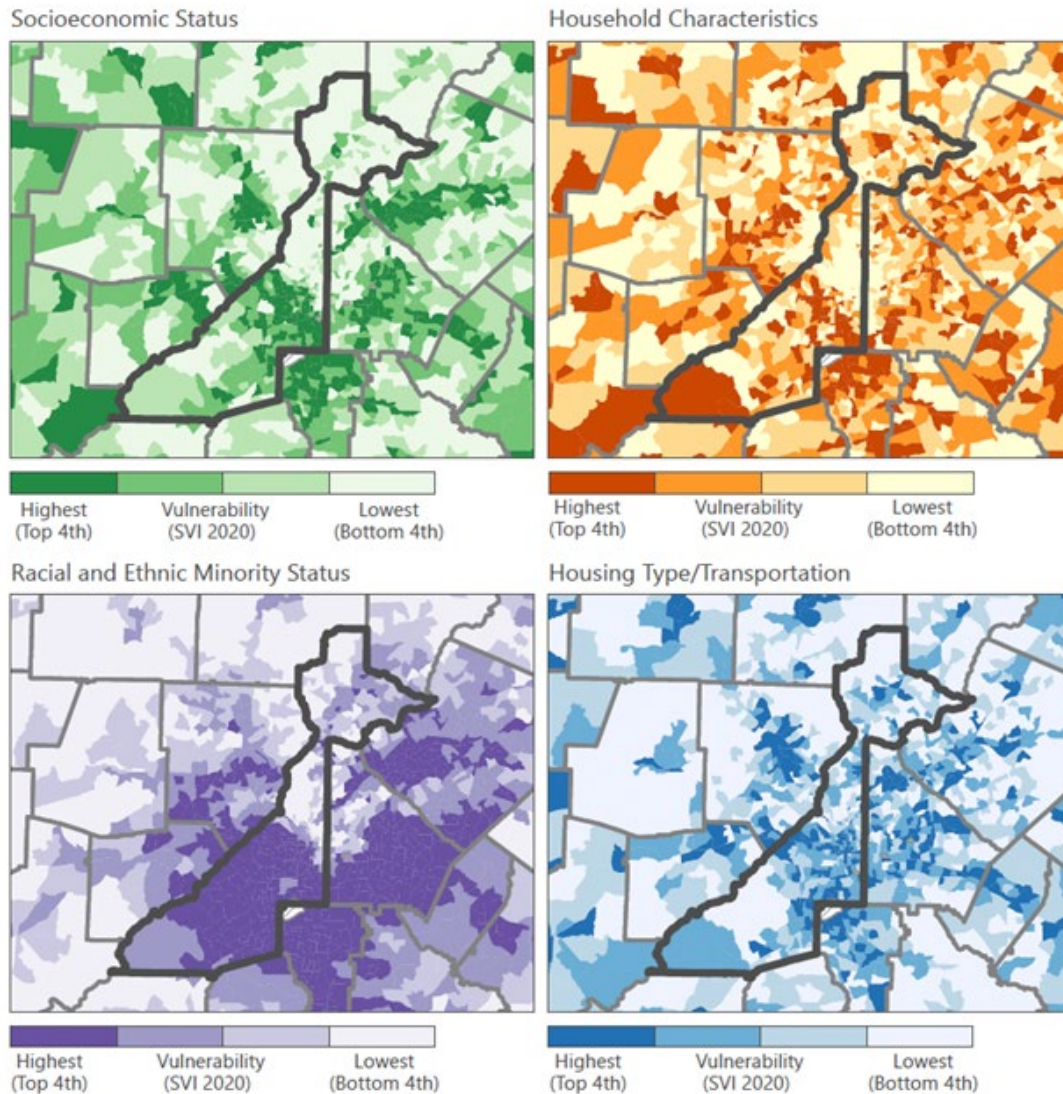
Table 2: US Female Homicide Victims Ages 10 to 44 by Pregnancy Status, 2018–2019

Characteristic	Pregnant or Within 1 year Postpartum (n=273)	Neither Pregnant Nor Within 1 year Postpartum (n=4,432)
Total homicides	273 (100)	4,432 (100)
Race and ethnicity		
Non-Hispanic White	82 (30.0)	1,621 (36.6)
Non-Hispanic Black	137 (50.2)	1,812 (40.9)
Hispanic	26 (9.5)	441 (10.0)
Other	28 (10.3)	558 (12.6)
Age (y)		
10–19	36 (13.2)	628 (14.2)
20–24	97 (35.5)	803 (18.1)
25–29	57 (20.9)	841 (19.0)
30–34	49 (18.0)	799 (18.0)
35–44	34 (12.5)	1,361 (30.7)
Time of Death		
Pregnant	129 (50.9)	--
Within 42 days from the end of pregnancy	28 (10.3)	
43 days to 1 year from the end of pregnancy	106 (38.8)	--
Firearm Involvement		
No	84 (30.8)	1,481 (33.4)
Yes	189 (69.2)	2,951 (66.6)

Among pregnancy-associated homicide victims, most were non-Hispanic Black and almost half were younger than age 25 at the time of their death. Most of the fatalities involved firearms.

Source: Centers for Disease Control and Prevention. [NVSS–Mortality Statistics](#). Last reviewed July 19, 2023. Accessed August 2, 2023.

Figure 5: CDC ATSDR Social Vulnerability Index (SVI) Themes Applied to Census Tracts in Fulton County, Georgia—Learning from an Example



The CDC/ATSDR Social Vulnerability Index (CDC/ATSDR SVI) uses 16 US Census variables to help local officials identify communities that may need support before, during, or after disasters. These maps are an example of the range of vulnerability in Fulton County, Georgia for the 4 themes: socioeconomic status, household characteristics, racial and ethnic minority status, and housing type/transportation.

Note: The CDC/ATSDR SVI uses U.S. Census data to determine the social vulnerability of every census tract. Census tracts are subdivisions of counties for which the census collects statistical data. The CDC/ATSDR SVI ranks each tract on 16 social factors, including poverty, lack of vehicle access, and crowded housing, and groups them into 4 related themes.

Source: Agency for Toxic Substances and Disease Registry. Centers for Disease Control and Prevention. [Fact Sheet: Place and Health](#). Accessed September 27, 2023.

STORY BEHIND THE DATA: FACTORS AFFECTING PROGRESS

In the US, poverty and racism adversely affect the social determinants of health, directly and indirectly impacting maternal health outcomes. Black, Indigenous, or a person of color and poor is associated with food and housing insecurity, less personal safety, and greater environmental risk. These factors contribute to the starkly different health outcomes seen among pregnant and postpartum people belonging to different racial, ethnic, geographic, and socioeconomic groups.

Those who identify as a person of color (specifically Black and/or Hispanic), are employed part-time, are hourly workers, or have low-paying jobs (most of whom identify as women and people of color), plus those living in rural areas in the US, bear the brunt of inequities.²³ In the US, female-headed households that identify as non-Hispanic Black are more likely to be unhoused.²⁹ Similarly, female-headed households identifying as non-Hispanic Black or Hispanic, with incomes below 185% of the federal poverty level, are the most likely to experience food insecurity compared to non-Hispanic White female-headed households.³⁶ In terms of environmental risk, racial and ethnic minority groups, those living at or below the federal poverty level, those living in urban areas, and those working in certain occupations have an increased risk of exposure to negative environmental stressors compared with higher-income, White persons.⁹ There also is disparity in economic security: In a review of the literature, earning minimum wage was associated with being Hispanic, younger, female, and having less education.²⁵

Geographic disparity in the US is another challenge. There are vast differences in food security by state and by rural, urban, and suburban areas.³⁸ Regionally, the prevalence of food insecurity in the Northeast (9%), Midwest (10%), and West (10%) is lower than the prevalence in the

South (11%). Food insecurity is also significantly lower in suburbs outside principal cities (9%) than in urban areas (12%) and rural areas (11%). Looking at maternal health more broadly, there are stark geographic differences in the mortality rates of women of reproductive age: those living in the Southern region of the US have significantly higher rates of mortality.³⁹ (See Figure 6.)

The history of systemic racism in this country lies at the root of these disparities and continues to shape the social determinants critical to ensuring the health and well-being of all people, and especially pregnant and postpartum people of color. For example, segregated neighborhoods were at one time the norm and in many places still exist. Such neighborhoods are more likely to have an overrepresentation of various environmental risks, ranging from lead exposure to poor air quality.⁸ With regard to housing security, different forms of housing discrimination, such as racial zoning, predatory lending, and redlining, were prevalent for decades and shape the health outcomes of people who are underserved today. Evidence can be seen when examining areas of New York City that were redlined prior to 1940: In 2020, these same areas had the highest US rates of preterm birth.^{40,41} Today, adverse impacts from gentrification also are apparent. The practice is known to foster negative conditions associated with poorer health outcomes, such as disrupted social networks from residential displacement and increased stress.⁴² (See Figure 5.)

This broader view of maternal health, one that takes into account the variety of factors that impact a person's reproductive health, calls for solutions that exist beyond the health care system.¹

WHAT CAN BE DONE TO ADDRESS THE ISSUE?

The [White House Blueprint](#) identifies actionable steps to Goal 5. In addition, experts from the maternal and child health field have identified innovative, evidence-informed strategies from several databases and national repositories.

Maternal & Child Health (MCH) Innovations

MCH experts selected the following resources for action after a review that included: the [MCH-best 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.

- [Housing and Health Collaborations](#). The Urban Institute’s Health Policy Center developed an issue brief to highlight key issues within the emerging practice of integrating housing and health care interventions to improve housing security.
- [Increasing the Minimum Wage](#). This literature review by the Urban Institute describes the evidence that supports a policy change to raise the federal minimum wage as a pathway to improving the health of workers and their families. (RWJ)
- [Mothers Rising Home Visiting Program](#). The MRHV program in Washington, DC, is a cutting-edge practice that “integrates social and health intervention methods employing social proximity, cultural congruence, MV Perinatal Health Worker training, and a 3-generation approach to yield improved perinatal outcomes and social conditions for [B]lack women, creating stability for the family unit, and improving trajectories for multiple generations and the greater community.” (AMCHP)
- [NCCARE360](#). This is the first statewide network for both health care and human services organizations that utilizes shared technology to coordinate community-oriented, person-centered approaches for health care. NCCARE360 helps providers in North Carolina electronically connect those with needs to community resources and allows for follow-up and feedback.
- [Preventing Intimate Partner Violence Across the Lifespan](#). The CDC developed a technical package of programs, policies, and practices designed to help communities and states implement evidence-based intimate partner violence prevention strategies.
- [Reducing Risk in Occupational Settings](#). Emory University created a web-based training tool with information on pregnancy health, pesticide safety, heat stress, and protective behaviors for women farmworkers in Florida. The online training provides a cost-effective and accessible way to promote healthy, protective behaviors among female farmworkers, especially during pregnancy.
- [Women's Health Education Navigation \(WHEN\) Program](#). A promising practice, WHEN includes preconception/interconception health education, case management, patient navigation, and linkage to community-based services for women and infants who are justice-involved to increase the incidence of healthy pregnancies, positive birth outcomes, and healthy infants. (AMCHP)

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 Goal 5.

- Centers for Disease Control and Prevention, [Social Determinants of Health Data Exchange for Chronic Disease Prevention Initiative: Public Health Use Case Package](#). Version 1.2. National Center for Chronic Disease Prevention and Health Promotion. 2022. Accessed September 27, 2023
- Center for Open Data Enterprise. [Leveraging Data on the Social Determinants of Health](#). Roundtable Report. 2019. Accessed September 27, 2023.
- Davis R, et al. [Moving from Understanding to Action on Health Equity: Social Determinants of Health Frameworks and THRIVE](#). Prevention Institute. 2015. Accessed September 27, 2023.
- Executives for Health Innovation. [Report: Incorporating Social Determinants of Health into Community Health Programs](#). 2023. Accessed September 27, 2023.
- National Health Center Training and Technical Assistance Partnership, Corporation for Supportive Housing, MHP Salud, and National Health Care for the Homeless Council. [Community Health Worker/Peer Workforce: Recruiting and Hiring for Social Determinants of Health Screening—Best Practices Guide and Findings from COVID-19 Pandemic](#). 2021. Accessed September 27, 2023.
- Population Reference Bureau. [Gender-Based Violence: Impediment to Reproductive Health](#). 2010. Accessed September 27, 2023.
- U.S. Health Resources & Services Administration [The HRSA Strategy to Address Intimate Partner Violence 2017–2020](#). Rockville, MD: U.S. Health Resources & Services Administration, Office of Women's Health. 2017. Accessed September 27, 2023.
- Washington State Department of Health, Health Education Resource Exchange. [Violence and Pregnancy: Screening, Resources, and Referrals—Provider Guide Washington State](#). 2012. Accessed September 27, 2023.

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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