



**California Department of Public Health
Center for Family Health
Maternal, Child and Adolescent Health**

**Black Infant Health Program
Request for Supplemental Information**

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PART I. PROGRAM

A. Overview

The California Department of Public Health (CDPH), Maternal, Child and Adolescent Health (MCAH) Division places a high priority on addressing poor birth outcomes that disproportionately impact the African-American community. CDPH/MCAH's Black Infant Health (BIH) program is intended to address the large and persistent disparities in maternal and infant health that affect the African-American community by focusing on a specific set of factors including chronic stress, social isolation, and limited access to services, which have been identified as likely contributors to these disparities.

The purpose of the California Black Infant Health program Request for Supplemental Information (BIH-RSI) is to obtain information from Local Health Jurisdictions (LHJs) with the highest number of African-American births and to give LHJs the opportunity to provide MCAH with critical information that addresses their capacity to implement the BIH Program. This information will assist MCAH in providing oversight, fidelity, standardization and accountability for the BIH Program.

B. Background

Across the United States, including California, African-American infants are twice as likely to die as white infants before reaching their first birthday¹. Therefore, reducing the disproportionate impact of infant mortality for African Americans is a major focus of California's infant mortality reduction efforts. Infant mortality is an important indicator of population health and the quality of health care, essential for monitoring the health and wellbeing of infants, children, and families. Reducing the risk of infant death requires a comprehensive, multi-faceted life-course approach that addresses both individual and social determinants of health². Therefore, infant mortality reduction strategies must focus not only on improving birth outcomes (e.g., preterm delivery), but on improving the health of the mother before, during and between pregnancy and on addressing social and environmental factors that impact health

With the passage of Senate Bill (SB) 165, Budget Act of 1989 (Alquist, Chapter 93, Statutes of 1988), California began to more aggressively address the challenge of improving the health of African-American women, infants, and children by promoting health and health care during the prenatal and postpartum periods, and providing services in a supportive and culturally competent manner. BIH was originally a pilot project in four sites; over time, the program was expanded to 17 local health jurisdictions where over 90 percent of all African-American births occurred in California. The primary focus of the original BIH program was to get participants into prenatal care.

In 2006, CDPH/MCAH commissioned the University of California, San Francisco (UCSF), Center for Social Disparities in Health to conduct an assessment of the BIH program. *The Black Infant Health Program: Comprehensive Assessment Report and Recommendations* found that there is no definitive scientific evidence related to

strategies to decrease racial disparities in birth outcomes and that solely receiving prenatal care will not close the gap. According to the assessment, improving the health of African-American mothers and infants and reducing Black: White disparities hinges on empowering women to create healthier lives for themselves and their children by strengthening life skills, building resilience, reducing/managing stress, and promoting healthy behaviors and relationships. The interventions identified in the assessment as having great promise were those that offered group-based prenatal care and emphasized social support and empowerment. Although results of studies linking social support to birth outcomes have been mixed, the assessment found strong evidence that health education, health promotion, social support and empowerment before, during, and after pregnancy contributed to improved maternal and infant health outcomes.

Based on these findings, the assessment recommended a *single core model* for the BIH program that addresses health promotion, social support, empowerment, and health education throughout a woman's pregnancy and that builds upon promising models, e.g. Centering Pregnancy⁴. The assessment concluded that standardizing interventions across sites would help the program's long-term sustainability by generating information about program impact that is both scientifically sound and compelling to policy-makers. Bringing program content in line with current scientific knowledge would also make the BIH program more effective in meeting its participants' needs and achieving program objectives. CDPH/MCAH developed and began implementing an intensive revised BIH program model in late 2010.

Currently the model for the BIH Program features 20 weekly group sessions held in culturally affirming environments. There are 10 sessions during pregnancy and 10 sessions postpartum – integrated with client-centered case management. The goals of both interventions are to reduce stress, promote social support, and empower women to set goals as they make healthy choices for themselves and their babies.

C. Funding Information

Funding Sources

The BIH Program is funded with Maternal and Child Health (MCH) Services Block Grant (Title V of the Social Security Act) and State General Funds (SGF) which was restored in 2014. LHJs must maximize their SGF dollars by matching funds under Title XIX. Per California Health and Safety Code, Division 106, Part 2, Chapter One, Article 1. Maternal, Child and Adolescent Health (123225 – 123255), subsection (g): *The department and counties shall maximize the use of federal funds available to implement this section, including using state or county funds to match funds claimable under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.).*

Funding Structure

Available Funding

Funding is contingent on future federal allocations from Title V of the Social Security Act and continuing support of SGF. CDPH/MCAH estimates that 15 LHJs in California will be selected to continue the BIH Program, although the exact number of funded programs will be determined by available federal and state funds.

Methodology

To ensure sufficient funding for implementation of the BIH Program, CDPH/MCAH has revised its LHJ funding allocation criteria. Counties with African-American births under 500 will not be considered for funding. However, if a currently funded BIH site meets the minimum threshold of African-American births, the LHJ site can partner with a non-eligible existing BIH site to form a consortium. No additional funds will be allocated to those LHJs deciding to form a consortium.

CDPH/MCAH uses birth records as the primary source of data to identify geographic areas that could support delivery of the group-based intervention to the target population throughout the year [\(See Appendix I\)](#). Birth records provide the most current and comprehensive data on the number of pregnancies among African-American women at the state and local level.

The funding tiers (See Table 1: Funding Tiers) outlines the total allocation with Title V and SGF and the total allocation with Title V, SGF and the estimated 30 percent minimum Title XIX matching funds each LHJ site is required to leverage. By maximizing the use of federal funds, LHJs will have sufficient funding to meet the minimum staffing requirements to implement the BIH Program with fidelity.

| Table 1: Funding Tiers | | | | |
|----------------------------------|--|---|--------------------------|--|
| Tier | Range of African-American Births/3-year average | Eligible LHJs | Title V & SGF | Title V, SGF and 30 percent Title XIX Match |
| 1 | 1583-1902 | San Francisco, Santa Clara, Orange | \$315,000 | \$450,000 |
| 2 | 2362-3782 | Contra Costa, Long Beach, Fresno, San Joaquin, Solano, Kern | \$385,000 | \$550,000 |
| 3 | 6001-7497 | San Diego, Alameda, Riverside | \$455,000 | \$650,000 |
| 4 | 8031-9183 | Sacramento, San Bernardino | \$595,000 | \$850,000 |
| 5 | 28995 | Los Angeles | \$700,000 | \$1,000,000 |
| Available LHJ Allocations | | | \$8,175,669 | \$9,375,669 |

D. Program Description

The goal of the BIH Program is to improve African-American infant and maternal health in California and to decrease Black: White health disparities for women and infants. The revised BIH Program ([See Appendix II](#)) is an intensive intervention that uses a group-based approach with complementary client-centered case management to help women develop life skills, learn strategies for reducing stress, and build social support in the context of a life-course perspective. BIH participants attend weekly group sessions (10 prenatal and 10 postpartum) designed to help them access their own strengths and set health promoting goals for themselves and their babies.

Key components of the BIH Program:

Participant Recruitment

Each site is responsible for developing a Recruitment Plan that targets African-American women as early as possible in their pregnancy. The primary recruitment strategy requires that sites build partnerships with community service providers and health care practitioners who can refer pregnant African-American women to BIH. Other methods of outreach designed to attract BIH participants include participation in community events (e.g., health fairs) and other activities that increase awareness of the BIH program among pregnant African-American women in their communities. When BIH staff receive a referral, staff must respond to the referral within 48 hours. Once initial contact is made Participants who are interested should complete the enrollment process outlined below and attend the first group session within 30 days.

Enrollment Process

Enrollment into BIH is conducted by a Mental Health Professional, ([See Appendix III - Staffing Requirements for Core BIH Program Staff](#)) who completes the initial prenatal assessment and in collaboration with the BIH Coordinator assigns the participant to a Family Health Advocate (FHA) for on-going case management. The enrollment process has three major components:

1. *Participant Orientation to BIH*: Orientation to the BIH program provides foundational information for the participant and should include an overview of the following program services:
 - Prenatal and postpartum group sessions that: (1) encourage social support; (2) provide opportunities for the participant to learn skills to care for herself and her child (e.g., stress reduction); and (3) empower the participant to develop skills, use her strengths and knowledge to problem-solve, pursue healthy behaviors, and achieve life goals.
 - Referrals to community and social service agencies.
 - Support with setting and achieving the goals of the participant's Life Plan.
2. *Consent to Participate*: By signing the BIH Consent Form, participants are officially enrolled and have agreed to fully participate in the BIH program. Enrolled women must consent to participate in the entire intervention (group and case management).
3. *Initial Prenatal Assessment*: This assessment gathers participant demographics, as well as baseline information on social support, self-esteem, self-efficacy, coping and mastery, and selected health behaviors (e.g., healthy eating) that are measured over time during the intervention.

Case Management

Case management is conducted by the FHA. The FHA is also responsible for on-going assessments, which provide a structured opportunity for participants to update the FHA and for the FHA to measure changes in the participant's level of social support and other program outcomes over time. Participants work with the FHA to develop a Life Plan. Life planning is the core of the case management intervention.

Life planning is a process that identifies a participant's desire for her future and clarifies goals and challenges, along with developing SMART (Specific, Measureable, Attainable, Realistic and Time-bound) tasks to move forward. It turns participants' hopes and dreams into a written plan for their future. The Life Plan focuses on goals in three broad areas: (1) health, (2) relationships, and (3) finances. The Life Plan is initiated in the first session following the assessment.

Each case management session starts with an assessment of the participant's

success in accomplishing each task identified in the Life Plan. Case management sessions conclude with the participant establishing one task she needs to address in order to accomplish her long-term goals. Successful goal setting is reinforced by group session activities and integrated into the Life planning process. Participants will bring their goals to the group sessions and the FHA will support goal attainment by ensuring participant goals are communicated to the group facilitator. This process is designed to ensure group session activities are consistent with the participant's Life Plan. An effective, seamless process requires a high degree of coordination and collaboration between FHAs and group facilitators.

The time intervals and frequency for case management are:

- Following enrollment and prior to the first prenatal group, the FHA should conduct bi-weekly case management sessions with the participant.
- FHA will hold one case management session between prenatal group sessions 4-6 and postpartum group sessions 14-16.
- Between the prenatal and postpartum group sessions, the FHA will hold a case management session once a month.
- Following the postpartum group sessions, the FHA will hold up to three additional case management sessions with the participant to complete the Life Plan.

Group Sessions

The BIH program is designed to increase social support among BIH participants through the group-based program component. Increasing social support is one of the primary BIH program outcomes. All BIH participants are required to attend and participate in group sessions. The group sessions are designed to provide participants with a culturally affirming environment that honors the unique history of African-American women in order to help participants develop life skills, learn strategies for reducing stress, and build social support.

Participants are expected to attend weekly group sessions (10 prenatal and 10 postpartum) designed to help them access their own strengths and set health-promoting goals for themselves and their babies. Group facilitators are required to use a standardized curriculum provided by CDPH/MCAH. The curriculum was developed based on other nationally recognized curricula (e.g. Effective Black Parenting) and was adapted for BIH. It focuses on health issues for pregnant women, health disparities for African-American women, and culturally relevant health information.

All group facilitators must be trained by CDPH/MCAH to conduct the curriculum with fidelity.

Case Closure

BIH case closure is a formal process between the participant and FHA. BIH participants' cases are expected to be closed within 60 days of the last postpartum group. The 60 days should be focused on finalizing the participant's Life Plan and transitioning the participant to any additional services. Although most participants are likely to complete the entire BIH program, a formal process should be completed for every participant when her case is closed, whether or not the participant completed the entire BIH program. Examples of reasons for case closures:

- Brief Case management without group participation
- Participants who transfer to another BIH site
- Request to exit the BIH program
- Lost-to-follow-up after several attempts to contact

E. Program Requirements*

1. Program

To ensure all enrolled women receive the entire intervention (group and case management), the following requirements must be met:

- Prenatal entry only – women must be pregnant and no more than 26 weeks gestational age.
- All participants who enroll in BIH must participate in group intervention within 30 days of initial contact. LHJs will develop a group schedule to ensure enrolled participants can start a group intervention by the third session.
- Enrolled women must consent to participate in the entire intervention (group and case management). If circumstances arise that prevent them from continuing in group sessions, they may receive 60 days of brief case management and will be closed out after 60 days.

2. Number of Women Recruited, Enrolled and Served

Based on current BIH data, it is anticipated that LHJs will need to recruit twice as many women as they enroll. Enrolled women are those who consent to participate in the entire BIH Program. Table 2 below shows the minimum and maximum number of women required to participate in the entire intervention. Number of women served is defined as participants who complete the entire intervention. The BIH Program is a group based intervention; however, MCAH recognizes that all women may not be able to continue to participate in the group intervention due to extenuating circumstances. Therefore, no more than 25% of those enrolled may receive 60 days of brief case management services.

| Table 2: Number of Women to be Served | | | |
|--|--|--------------|----------------|
| Tier (See Table 1) | Minimum # of prenatal group series | #women/group | # women served |
| 1 | 8 | 8 | 64 |
| | | 10 | 80 |
| | | 12 | 96 |
| 2 | 12 | 8 | 96 |
| | | 10 | 120 |
| | | 12 | 144 |
| 3 | 16 | 8 | 128 |
| | | 10 | 160 |
| | | 12 | 192 |
| 4 | 24 | 8 | 192 |
| | | 10 | 224 |
| | | 12 | 288 |
| 5 | 30 | 8 | 240 |
| | | 10 | 300 |
| | | 12 | 360 |

[Appendix IV](#) outlines a sample group schedule for Tier 1 sites that would meet program requirements ensuring that participants are able to start prenatal group sessions within 30 days after initial contact. This schedule can be adapted for the other tiers.

3. Staffing

CDPH/MCAH requires that each LHJ site fund the following positions outlined per tier in Table 3 below to ensure fidelity and standardization across all sites:

| Table 3: Staffing Requirements | Tier 1 | Tier 2 | Tier 3 | Tier 4 | Tier 5 |
|--------------------------------|---------|---------|---------|---------|---------|
| BIH Coordinator | 0.5 FTE |
| FHA/Group Facilitator | 2.0 FTE | 3.0 FTE | 4.0 FTE | 6.0 FTE | 8.0 FTE |
| Mental Health Professional | 0.5 FTE |
| Outreach Liaison | 1.0 FTE |
| Data Entry | 0.5 FTE |

Most sites should be able to leverage above the 30 percent Title XIX matching funds. These additional Title XIX funds shall be used to increase FTE(s) of required positions and/or used to fund a Public Health Nurse (PHN) position. While PHNs are not identified as a required position, CDPH strongly encourages the use of PHNs. CDPH/MCAH recommends that sites consider prioritizing staffing positions by tier as shown in Table 4 below.

| Table 4: Additional Staffing Considerations | Tier 1 | Tier 2 | Tier 3 | Tier 4 | Tier 5 |
|--|---------------|---------------|---------------|---------------|---------------|
| BIH Coordinator | 0.5 FTE |
| FHA/Group Facilitator | | | | | |
| Data Entry | | | | 0.5 FTE | 0.5 FTE |
| Mental Health | | | 0.5 FTE | 0.5 FTE | 0.5 FTE |
| Outreach Liaison | | | | | 0.5 FTE |
| Public Health Nurse | | 0.5 FTE | 0.5 FTE | 0.5 FTE | 0.5 FTE |

The positions noted in the above tables have specific duties associated with their titles. [See Appendix III - Staffing Requirements for Core BIH Program Staff](#) for additional information.

4. Reporting

- Quarterly Progress Reports – LHJ sites will submit a quarterly report that allows sites to monitor progress, plan, and correct any ongoing issues within the local BIH program.
- Annual Progress Report – LHJ sites will submit an annual report at the end of each fiscal year that will provide an overall assessment of their BIH program and SOW compliance.

5. Meetings/Trainings/Site Visits

- Sites shall attend all trainings, workshops and conferences as directed by MCAH.
- Sites shall participate in program discussions/meetings as determined by MCAH.

- MCAH may perform, at its discretion, formal and/or informal site visits in order to monitor compliance with Scope of Work activities.

6. Community Engagement Efforts:

- Create partnerships with community and referral agencies that support the goals of the BIH Program through advisory boards, formal and informal agreements.
- Describe how systems and/or frameworks within your LHJ are used to support collaboration of agencies and organizations across existing programs.

7. Evaluation

- Use of CDPH/MCAH data collection tools.
- Use of Efforts to Outcome (ETO) data collection system.
- Submission of accurate data on a timely basis.
- Abide by CDPH policy around data use.
- Adhere to program fidelity standards ([See Appendix V](#))

****For a Program Overview ([See Appendix VI](#)) Note: Policy and Procedures document will be provided when finalized.***

PART II. INSTRUCTIONS FOR COMPLETING THE REQUEST FOR SUPPLEMENTAL INFORMATION

Responses

Responding to questions in this BIH-RSI is necessary in order to receive funds under the California Black Infant Health program. Responses to this BIH-RSI must be submitted to CDPH/MCAH by the LHJ Maternal, Child and Adolescent Health Director.

Due Date

Responses to this BIH-RSI are due no later than **5:00 PM on Friday, March 13, 2015**. Information for each question must be submitted in the space provided within the Microsoft Word version of the BIH-RSI.

Technical Assistance

CDPH/MCAH will accept questions related to the RSI until Friday, February 20, 2015. Questions may include but are not limited to the services to be provided for the RSI and/or its accompanying materials, instructions, or requirements. Questions should be submitted to the BlackInfantHealth@cdph.ca.gov. All questions should include the name of the LHJ and the name of the individual submitting the question. Please submit a topic and reference the application page number or appendix number, if applicable, to the question. CDPH/MCAH will seek clarification of any inquiry received, and will answer only questions considered relevant to the RSI. At its discretion, CDPH/MCAH may consolidate and/or paraphrase similar or related inquiries.

CDPH/MCAH will host an hour long conference call to answer questions submitted by the due date. The conference call will be held on **Wednesday, March 4, 2015 at 10:00 AM**. The call-in number and passcode to access the conference call is below:

Call-in Number: 1-866-731-0441
Passcode: 7082901

Structure of the RSI

The contents of this BIH-RSI are organized into two parts, *PART A*, LHJ Level Information, *PART B*, *Budget*.

PART A

To be completed by LHJ, information provided in *PART A* should focus on how the LHJ intends to recruit/retain eligible participants, implementation of services and location of where services will be offered.

Note: Those partnering to form a consortium will complete PART A as well.

PART B

To be completed by lead LHJ, PART B will require LHJs to provide a budget based on their funding tier. Funds allocated from Title V and SGF are to be used for personnel and for State-mandated training and travel. Those deciding to form a consortium will not receive an increase in tiered funding.

The tiered funding amount includes an estimated 30 percent match of Title XIX funds. The applicant's response to the RSI must include a complete estimated budget for the 2015-16 Fiscal Year, using an Application Funding Agreement (AFA) budget template. Applicants can obtain a copy of the budget template by contacting the assigned contract manager. The contract manager can answer any questions about the budget and the budget template.

Please provide responses directly within the BIH-RSI document using the space provided for each question. Please use 12 point Arial font for responses. Save the file with the BIH RSI responses using the following convention: LHJ Lead Agency: *PART A*: "{LHJ Name} BIH RSI PART A>"; example: "Sacramento BIH RSI PART A".

If the LHJ is forming a consortium then use the following convention for the partnering LHJ: LHJ Lead Agency: Consortium: "{LHJ Name} {Partnering LHJ Name} BIH RSI>"; example: "Sacramento Yolo BIH RSI".

Submit your responses via Microsoft Word by attaching the files to an email and send to BlackInfantHealth@cdph.ca.gov no later than **5:00 PM on Friday, March 13, 2015**. You may submit responses to *PART A and Part B* by affixing multiple attachments to a single email. Please use the following as the "Subject" line of your email: "[SECURE] {LHJ Name} BIH RSI"; example: "[SECURE] Sacramento BIH RSI". Placement of "[SECURE]" in the subject line will encrypt the file in transport to CDPH/MCAH.

ENCLOSED MATERIALS AND LINKS TO ADDITIONAL INFORMATION

Appendices to this BIH-RSI will be posted on the CDPH/MCAH website. CDPH/MCAH has completed a geospatial hot-spot analysis of African-American women living in the 17 LHJs. ([See Appendix VII: Geospatial and Thematically Mapped Data](#))

RSI Review Process

MCAH staff will review the RSI PART A to ensure the LHJ responses provide pertinent information to assess the LHJ capacity to implement the BIH Program. For a description of this process, please see ([Appendix VIII](#)).

PART A: LOCAL HEALTH JURISDICTION INFORMATION

Instructions for PART A

Responding to questions in this California Black Infant Health Request for Supplemental Information (BIH-RSI) is necessary in order to receive funds under the Black Infant Health program. The purpose of this BIH-RSI is to obtain information from the Local Health Jurisdictions (LHJs) that have been identified as having the highest need based on the number of African-American births within a jurisdiction.

Please complete *PART A* for your LHJ only. Responses should not include operations, resources, services, and/or systems administered by agencies/organizations outside of your LHJ unless they are specific to meeting the needs of a particular program or population; in such instances, please clearly specify that the operations, resources, services, and/or systems are administered by agencies/organizations outside your LHJ.

If you are responding to this BIH-RSI as part of a consortium, please submit *PART A* and respond to your specific LHJ; please do not provide information on behalf of other partners in the consortia. Each partner LHJ should submit their own *PART A*.

General Information

Local Health Jurisdiction:

Name of Person Submitting RSI:

Title and Organization:

Address:

City/Town:

State:

Zip:

Email Address:

Phone:

If you do not wish to be considered for BIH funding during State Fiscal Year 2015/16 for the implementation of BIH services, please notify CDPH/MCAH by providing a statement with this information and submit it to BlackInfantHealth@cdph.ca.gov. LHJs no longer seeking funds do not need to respond to PART A or PART B of this BIH-RSI.

Questions

The following questions pertain to infrastructure, existing programs, resources, and services. In the space provided, please respond to each of the following questions:

- d) Enrolled women must consent to participate in the entire intervention (group and case management). If circumstances arise that prevent them from continuing in group sessions, they may receive 60 days of brief case management prior to case closure.
 - How will your site ensure that participants are informed of this BIH Program Policy?
3. What is your plan to ensure that your site will implement the BIH program in a standardized manner?
4. In Appendix VII you will find geospatial county maps. These maps show the density of African-American women who gave birth by Census Tract during 2010-2012. Based on these density maps, it is expected that LHJs will implement services in these high-density census tracts.
 - a. Please provide the location you anticipate conducting the group interventions and case management services.
 - b. If services are being conducted outside of the high-density areas, please provide a justification describing how you will access potential clients.
5. Please provide a plan for minimizing participant attrition rates in the BIH Program.
6. Please provide a rationale for each position listed on the budget. How will each position support the BIH Program?
7. Please identify strategies for enhancing administrative structures and staffing, including recruitment and hiring to develop high-quality ongoing training and supervision of program staff. Include staff and other capacity/infrastructure already existing for this Program.
8. Describe how systems and/or frameworks within your LHJ are used to support collaboration of agencies and organizations across existing programs.
9. If you are responding as part of a consortium, please provide an example of where and how you previously collaborated with your partner LHJs; and provide a description of your LHJs role in the proposed BIH consortia.

Thank you for responding to the Black Infant Health program Request for Supplemental Information.

Please be sure to save your responses as a Microsoft Word file using the following convention: "{LHJ Name} BIH RSI PART A"; example: "Sacramento BIH RSI PART A." Submit your responses via Microsoft Word by attaching the file to an email sent to BlackInfantHealth@cdph.ca.gov. You may submit responses to *PART A*, along with the budget from *PART B*, by affixing multiple attachments to a single email. Use the following as the "Subject" line of your email: "[SECURE] {LHJ Name} BIH-RSI;" example: "[SECURE] Sacramento BIH-RSI." Placement of "[SECURE]" in the subject line will encrypt the file in transport to CDPH/MCAH

References

1. California Center for Health Statistics. Table 1-4 Comparison of Vital Statistics Rates, California and United States, 1980-2002; NVSR (2008); California Birth and Death Statistical Master Files 2003-2005.
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3. California Center for Health Statistics. Birth Cohort Data 1960-2005. Birth Cohort Data unavailable for 1998.
4. Rising SS. Centering pregnancy. An interdisciplinary model of empowerment. J Nurse Midwifery. Jan-Feb 1998;43(1):46-54.