Achieving Birth Equity through Systems Transformation
The Michigan Public Health Institute is a Michigan-based and nationally engaged, non-profit public health institute. We are a team of teams, process and content experts, dedicated to our vision of building a world where tomorrow is healthier than today! Our mission is to work with you to promote health and advance well-being for all. Our broad network of partners includes academia, government, community-based organizations, and healthcare providers. These connections empower all of us to develop solutions to a wide range of challenges.

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EXECUTIVE SUMMARY

Michigan Public Health Institute’s Achieving Birth Equity through Systems Transformation (ABEST) project was funded by the Michigan Health Endowment Fund. The impetus for the ABEST project is the fact that Black and Native American maternal and infant mortality rates are 2-3 times higher than the rates for White women and babies and there is a growing body of evidence that points to racism as the root cause of this inequity. The persistent and substantial disparities in infant and maternal mortality in the U.S. are a warning that the systems meant to prevent these devastating events require transformative change. These patterns have persisted for so long that progress is threatened by apathy and resignation. This project aimed to push against the status quo and build “productive outrage,” which we define as a sense of indignation that drives sustained change.
In order to achieve birth equity, we need systems change that goes deeper than changes to policies and practices or linking services and programs. We need change that shifts the conditions that are holding the problem in place. By focusing on root causes, especially the role of racism, and addressing relationships and power within systems, the project aimed to change the way we talk about and act on maternal and infant health. We recognized that this type of systems change is difficult, and many systems leaders don’t know how to lead it. To address this need, the project built capacity among state and local leaders to lead systems change and to shift mental models and narratives. The project partnered with two communities to develop specific, actionable strategies for transformative systems change to tackle the root causes of inequities in maternal and infant mortality.
This document tells the story of the ABEST project. We hope that it can serve as an example for others who are doing (or embarking upon) birth equity work in their communities and who share our deep commitment to disrupting inequities in birth outcomes.
Origin Story  Nationally, efforts to address inequities in maternal and infant health fall short because the actions to address inequities, for the most part, amount to tinkering around the edges of current systems and processes and a failure to adequately address the root causes. ABEST was designed to impart the skill to analyze what currently drives a particular system, to understand how those system drivers impact equity, and to actively transform them into processes that support equity.

Frameworks  Building capacity to initiate and lead anti-racism and systems change requires a translation of theory to practice. The concepts of root causes and systems transformation can seem abstract or intangible. Therefore, the ABEST project identified two frameworks to help operationalize these concepts: the Social-Ecological Model and FSG’s Six Conditions of Systems Change.

Getting Grounded  The first phase of the ABEST project was to get “the lay of the land” regarding current research on root causes and the degree to which infant and maternal mortality prevention practices intervene at this level. The project team conducted a literature review focused on research that has examined the impact of racism on birth outcomes for Black and Native women and infants and conducted an environmental scan focused on identifying examples of programs/initiatives addressing birth outcomes, as well as other community health programs targeting factors that impact birth outcomes (e.g., housing reform, economic opportunities).

Partner Engagement  Partnerships were key to the success of the ABEST project. The project was a joint effort between two Centers within the Michigan Public Health Institute, the Center for Healthy Communities and the Center for Health Equity Practice. External partners included Michigan Department of Health and Human Services, Vijaya Hogan, Health Resources in Action, and Bayard P. Love. Most importantly, the ABEST project partnered with two community coalitions and a group of 25 systems leaders from across Michigan. These partners all participated in the ABEST capacity-building process and the two community coalitions also developed specific, actionable strategies for transformative systems change to tackle the root causes of inequities in maternal and infant mortality in their communities.
Building Capacity for Birth Equity  At the core of the ABEST project was a recognition that many leaders are not trained to lead transformative systems change that tackles root causes. Therefore, a major focus of the project was to build this capacity among state and local leaders. Our approach to building capacity was not just focused on training, but on walking with our community partners through a process of learning/unlearning, application, and practice. This process had three major components:

- **Laying the Groundwork:** The capacity-building process started by orienting our community partners to the goals and objectives of the ABEST project, sharing the results of the literature review and environmental scan, and facilitating a visioning session with each community coalition.

- **Workshops:** The ABEST workshops were designed to build capacity to achieve birth equity by addressing root causes through systems change. The first workshop built understanding of root causes and applying a health equity framework to maternal and infant mortality. The second workshop linked root causes to systems by providing a framework for understanding racial inequity as structural in nature and expanding the conversation beyond specific sectors to an interconnected systems approach. The third workshop showed participants how to apply the concepts of root causes and structural racism to systems change strategies.

- **Roadmap Planning:** Derived from methods and tools of strategic planning, the ABEST Roadmap Planning process was designed to support our partner communities in visioning their ideal state, exploring concrete actions, prioritizing action, action planning, checking for alignment, and sustainability planning. The end product was a Roadmap for Systems Change to achieve birth equity for each community partner.

The two community coalitions and the group of systems leaders from across Michigan each went through the workshop series as separate cohorts. The two community partners then continued on to Roadmap planning. Each community went through the process separately so they could focus on the needs of their communities, and then we held a joint session as the final session for the project.
Evaluating ABEST It was important to the team to invest in a robust evaluation plan for the pilot year of ABEST. There were many audiences who were interested in understanding both the process indicators of successful project implementation (for example, the number of collaborative members who engaged in workshops and strategic planning) and outcomes of:

1. Collaborative growth and strengthening
2. Increased capacity for health equity work among community leaders
3. Increased capacity for systems work among community leaders

The ABEST team engaged in a process of inquiry and discovery as we developed the evaluation plan. Our first stop was to look for models and approaches from other researchers and community-based teams who were doing similar work. We focused on evaluation models from three content areas that aligned with ABEST’s goals and activities: systems change, health equity and root cause analysis, and collaborations.

As we were exploring different models and approaches to inform the evaluation, the team articulated the scope and units of analysis for this project. The ABEST project is focused on three units of analysis:

1. Systems Leaders as individuals—change in attitudes and knowledge through participation in workshops
2. Community Cross-sector collaboratives—change in membership, trust/cohesion, and strategic plans through member participation in workshops and strategic planning sessions
3. Systems Leaders’ home organizations/sectors—indirect change in efforts/resources for community collaboratives; main ask of state-wide group, but not directly supported by ABEST

While we hope that shifts in attitudes and knowledge among leaders will result in indirect effects within leaders’ home organizations, this is not an explicitly supported activity of the project. It may emerge as critical through community strategic plans and we ask for self-reported activities at the organizational level in the surveys to assess indirect impacts.
REFLECTIONS FROM ABEST COMMUNITY PARTNERS

We close the story of the ABEST project with reflections from our amazing community partners. We thank them for partnering with us on this journey and for bringing their hearts, minds, and authentic selves to the work. Though this particular project has ended, the work and the partnership has not. We look forward to continuing the journey.
INTRODUCTION

Michigan Public Health Institute’s Achieving Birth Equity through Systems Transformation (ABEST) project was funded by the Michigan Health Endowment Fund. The project aimed to disrupt racial inequities in maternal and infant mortality. The maternal and infant mortality rates for Black and Native American women and babies are 2-3 times that of white women and babies, and a growing body of evidence points to racism as a root cause. In order to achieve birth equity, we need systems change that goes deeper than changes to policies and practices or linking services and programs. We need change that shifts the conditions that are holding the problem in place.
OUR FOCUS

By focusing on root causes, including the role of racism, and addressing relationships and power within systems, the project aimed to change the way we talk about and act on maternal and infant health. We recognized that this type of systems change is difficult, and many systems leaders don’t know how to lead it. To address this need, the project built capacity among state and local leaders to lead systems change and to shift mental models and narratives. The project partnered with two communities to develop specific, actionable strategies for transformative systems change to tackle the root causes of inequities in maternal and infant mortality.

This document tells the story of the ABEST project. It begins with the origin story of ABEST and the frameworks that guided the project. It then details: the initial activities taken to ground the work in equity and systems change, the partnerships of ABEST, descriptions of the ABEST capacity-building workshops, an overview of the process used to develop specific actionable strategies for birth equity, and steps for building sustainability. In the appendices, we have included tools, resources, and references that were instrumental to the ABEST project. We hope that this document can serve as an example for others who are doing (or embarking upon) birth equity work in their communities and who share our deep commitment to disrupting inequities in birth outcomes.
PROJECT ORIGIN

... ADDRESS DISPARITIES

The impetus for the ABEST project is the fact that Black and Native American maternal and infant mortality rates are 2-3 times higher than the rates for White women and babies and there is a growing body of evidence that points to racism as the root cause of this inequity. The persistent and substantial disparities in infant and maternal mortality in the U.S. are a warning that the systems meant to prevent these devastating events require transformative change. These patterns have persisted for so long that progress is threatened by apathy and resignation. This project aimed to push against the status quo and build “productive outrage,” which we define as a sense of indignation that drives sustained change. Describing and discussing these persistent trends is no longer acceptable. The project recognized that reshaping the narrative will be required to shift conditions that are holding the problem in place and to ultimately reverse the patterns.

Nationally, efforts to address inequities in maternal and infant health fall short because the actions to address inequities, for the most part, amount to tinkering around the edges of current systems and processes and a failure to adequately address the root causes. Two examples of this “tinkering” include:

DEVELOPMENT OF NEW PROGRAM TO FILL IN THE GAPS LEFT BY EXISTING PROGRAMS. We continue to build a patchwork of new programs that challenge any system to maintain both the coherence and the connective tissue among them. The patchwork of programs challenges women to learn how to navigate effectively. And even with new evidence-based programs and interventions, there are implementation challenges that continue to affect outcomes. Some of these include challenges with patient uptake (“If we build it”, they still may not be able to come) and the inability of women to follow through on care plans because of limitations imposed by their jobs, family responsibilities, social hierarchies, and accessibility to resources.

INDIVIDUAL PROVIDER TRAINING. cultural competence, Implicit bias, etc.) Another way we have “tinkered” is by providing training to change the behaviors of individual providers. While this is of some benefit, it does not always result in the types of sustained changes that lock the organizational processes into a path toward attainment of equity. Individual rejection of trainings, provider turn-over, and other challenges to behavioral approaches impact the efficacy of this. Even intense racial equity training may not “take” when it is focused on behavior change of individuals without going the next step of fostering changes in the system that allows the behaviors that promote inequities.
Additionally, while there are some recent attempts to address social determinants that act as root causes, the largest root cause of inequities, racism, has persisted unabated in health and public health systems. At times, social determinants are used as a proxy root cause for racial differences, but addressing these social determinants in the absence of addressing racism can lead to deeper inequities. For example, addressing social determinants such as improving neighborhood green spaces, establishing walking trails, siting supermarkets and other community improvements can be a boon for revitalizing a neighborhood. However, when achieved outside of a racial equity framework, these actions can result in gentrification and displacement of historical residents of the community, deepening the health divide. Care must always be taken to ensure that the most egregious root cause that impacts all others is a main focal point for transformation.

Tinkering around the edges of a system that does not work and sidestepping racial inequity as a root cause are not productive, as evidenced by the lack of progress over the past decade in eliminating, or in some cases, lack of progress in even reducing disparities. The bottom line is that systems are perfectly designed to get exactly the outcomes they achieve. Systems fail Black and Brown mothers and babies and fail to address inequities because they are not set up to address the needs specific to these populations, nor are they set up to address the issue of racism.

So, while many maternal child health organizations have goals to address inequities, they do not have processes in place to address the two pathways—systems change and anti-racism-- that lead to equity.

The ABEST project sought to address this gap by building capacity among leaders to address racism as a root cause through systems change strategies. ABEST was designed to impart the skill to analyze what currently drives a particular system, to understand how those system drivers impact equity, and to actively transform them into processes that support equity. ABEST operates on the notion that there are specific capacities and tools that are needed by public health leaders to eliminate racism and create systems change. These include:

- A sense of “productive outrage” to spur public health leaders to invest in anti-racism and structural change actions
- Tools and capacity building to support transformative change
- Ensuring that the right people across sectors and community are involved in designing a change process
- Provision of space, resources and an environment for communities to develop a real plan for transformative change (Roadmap for Systems Change)
- Assistance in developing the capacity and skills to initiate and/or complete anti-racism and systems change
Building capacity to initiate and lead anti-racism and systems change requires a translation of theory to practice. The concepts of root causes and systems transformation can seem abstract or intangible. Therefore, the ABEST project identified two frameworks to help operationalize these concepts: the Social-Ecological Model and FSG’s Six Conditions of Systems Change.

The social-ecological model (Figure 1) was used as a framework for understanding root causes. The social-ecological model is a five-level model that takes into consideration complex interactions across the societal, community, institutional, interpersonal, and individual levels. When applied to a specific topic or issue, the social-ecological model can help show how different elements at each of these levels are related to the issue, and how those elements interact. The social-ecological model also helps to see how a single factor, such as racism, can play out differently at the various levels of the model.

The outermost band of the social-ecological model is the societal level, which includes factors such as social conditions, public policies, and social norms. Examples of racism at the societal level include federal policies contributing to mortgage lending discrimination and forced relocation of Tribes.

Moving inward, the second band of the model is the community level, which focuses on community and environmental factors. These include factors such as the physical environment, pollution, and public safety. The long-term impacts of racial residential segregation and the unequal distribution of resources and environmental risk factors in communities of color are an example of how racism operates at the community level.
The third band of the model is the *institutional level*, which includes social institutions and organizations such as healthcare systems, schools, police, employers, and community organizations. Racism at the institutional level can be experienced through workplace discrimination and discrimination in healthcare systems and other organizations.

The fourth band of the model is the *interpersonal level*, which focuses on relationships. These include relationships with family, neighbors, peers, and health care providers. Racism at the interpersonal level can be experienced through health care provider discrimination and interpersonal discrimination experienced with other individuals.

At the innermost level of the model is the *individual level*, which focuses on characteristics of individuals, such as health status, education, and income. It also includes individual beliefs, attitudes, and behaviors. The important thing to recognize about the individual level is that these characteristics of individuals are impacted by all the other levels. For example, racism at each level of the social-ecological model impacts health status for Black and Native American women and infants.

Within the field of maternal child health, and in many other areas of health, programs and interventions often occur at the individual level, focusing on things like health behaviors or treating disease.

The social-ecological model helps broaden the focus beyond the individual to see the importance of interpersonal interactions, institutional practices, community conditions, and laws and social norms. Taking the broader view, and examining how factors within each level interact, can help design actions that provide a more holistic and effective approach to improving health.
In a recent report by FSG\textsuperscript{2}, the authors provide a framework of Six Conditions of Systems Change (see Figure 2) that includes three types of change: 1) structural/explicit (policies, practices, resource flows), 2) relational/semi-explicit (relationships & connections, power dynamics), and 3) transformative/implicit (mental models). The premise of this framework is that all three levels and six conditions are necessary for transformative and sustainable systems change.

Structural changes are the most explicit. The three conditions within structural change are policies, practices, and resource flows. Policies include rules, regulations, and priorities that guide an entity’s actions. Practices are activities, procedures, guidelines, or informal habits of institutions, coalitions, networks, etc. Resource flows include money, people, knowledge, information, and other assets that are allocated and distributed. Because they are the most tangible, many systems-level interventions take place at this level.

Relational changes are semi-explicit. Within relational change there are two conditions: relationships & connections and power dynamics.

Figure 2. Six Conditions of Systems Change

Relationships include connections and communication among actors in a system. Of special importance is connections between those with differing histories, cultures, and perspectives. Power dynamics represent the distribution of decision-making power and/or authority, as well as formal and informal influence within entities. These changes can sometimes be seen and measured but may also show up in less obvious ways.

Transformative change is implicit. It refers to changes in mental models, the deeply held beliefs and assumptions that impact how we think, act, and talk. Because mental models are the least tangible, many systems-level interventions fail to operate at this level and don’t manage to create longer-lasting change beyond more explicit efforts. Changing mental models means fundamentally shifting how individuals operating within a system think about a problem or the best approaches to address it—and how these mental models are reflected in the system's structures.
LESSONS LEARNED

These two frameworks proved to be incredibly helpful in building structure and continuity for the ABEST project. They were used throughout the project to help build capacity around root causes and systems change, and to assist our community partners in deepening their thinking and action. An illustration of their centrality is that the frameworks appear throughout this document. Here is a brief summary of how they were used in different aspects of the project:

**Getting Grounded:**
- The social-ecological model was used as a structure for organizing the findings of our literature review.
- The six conditions were used as a structure for assessing systems change efforts in our environmental scan of promising practices.

**Engaging Partners:**
- The social-ecological model was used to create visions for birth equity with the ABEST community partners.

**Building Capacity:**
- The six conditions of systems change formed the basis of the systems change workshop.

**Developing Roadmaps:**
- A crosswalk of the social-ecological model and six conditions of systems change was used as a tool for identifying conditions that are holding the problem in place and brainstorming specific actions to promote birth equity.
- The six conditions of systems change formed the structure of action planning worksheets for developing Roadmap Plans for Systems Change to achieve birth equity.
The first phase of the ABEST project was to get “the lay of the land” regarding current research on root causes and the degree to which infant and maternal mortality prevention practices intervene at this level. The team recognized that getting grounded in these things could not only help inform the design and implementation of the project but could also serve as an excellent resource for our community partners.

The ABEST team decided that conducting a literature review and environmental scan would be the best approaches to ground the team in what is currently known about inequities in maternal and infant outcomes for Black and Native American communities, as well as current efforts to address disparities in birth outcomes. The literature review focused on research that has examined the impact of racism on birth outcomes for Black and Native women and infants. The environmental scan focused on identifying examples of programs/initiatives addressing birth outcomes, as well as other community health programs targeting factors that impact birth outcomes (e.g., housing reform, economic opportunities).
ABEST staff used a structured process to ensure a thorough literature review. Staff conducted a comprehensive search of peer-reviewed journals via the PubMed, Sociological Abstracts, and PsychInfo databases, as well as searches on Michigan State University’s Library site that searches articles, books, and journals from various databases. The literature review focused on articles within the last 10 years, but also included seminal works outside that range. In addition, organizational and government reports were located and downloaded utilizing Google searches of relevant search terms.

Early on in the process, the ABEST team discovered that there seemed to be two main themes in the research in relation to inequities in maternal and infant health outcomes for Black and Native women and infants. The first was Racism and Access to Quality Health Care. This theme traced the history of policies impacting racial geography and health insurance to their impact on differential access to quality health care and the resulting inequities in health status and birth outcomes. The second theme was Racism, Adverse Childhood Experiences, and Psychosocial Stress. This theme examined the impact of Adverse Childhood Experiences (ACEs) and psychosocial stress on maternal and infant health, and how factors at each level of the social-ecological model contribute to ACEs and stress. Identifying these two themes helped shape the ABEST team’s search strategy and structure for the literature review. The team focused on searching terms that related and added to these two main themes of the research.

In addition to organizing the findings of the literature review into two main themes, we also used the social-ecological model to structure the findings within each theme. We used this framework to help tell the story of how racism functions through each level of the social ecological model to create disparate birth outcomes for Black and Native families. It is our hope that the literature review will inspire readers to look for additional connections between the different levels of the social-ecological model and to discover more pathways by which racism serves as a root cause of birth inequities. We also hope the literature review can help readers identify areas to target if they are looking to push their maternal child health work more upstream to address root causes. An executive summary of the literature review is in Appendix A.
Along with the literature review, the ABEST team performed an in-depth environmental scan to identify and gather information on the current maternal child health programs serving Michigan and the U.S. The environmental scan was intended to provide examples and models to help project staff, consultants, pilot communities, and other stakeholders become grounded in related work that is already happening across Michigan and the country. Our goal was to find exemplar programs that were addressing birth outcomes and to assess what levels of systems change they were addressing, if any, using the FSG Six Conditions of Systems change framework (see Selecting Frameworks for the Project for more information about this framework). We focused primarily in Michigan, because that is where the ABEST project was implemented, but also looked for exemplars from across the U.S. We decided to look at efforts specific to maternal child health and efforts focused more broadly on community health if they addressed a sector that our literature review found strongly related to infant and maternal outcomes (e.g., housing reform, economic opportunities). Programs were identified through internet searches utilizing key terms related to maternal child health populations, maternal mortality, infant mortality, African American, Native American, and upstream sectors, as well as through targeted conversations with Michigan public health leaders.

Team members closely researched the identified programs and used two types of codes to categorize the major activities of initiatives identified in the environmental scan: FSG six conditions of systems change (structural, relational, and transformative change) and levels of the social-ecological model (individual, interpersonal, institutional, community, societal).
As foundational frameworks for the ABEST project, the team decided they would provide an excellent way to see where current supports to women, mothers, and infants is currently provided and how comprehensively those services impact systems change and root causes. We took a broad view of systems change to include as many examples of work impacting racial disparities in healthy birth outcomes as possible. Additional information about the services, target populations, health focus, and collaborating partners were documented to complete the picture of the environmental scan.

Programs were most likely to have structural program elements (policies, practices, and resource flows). This is consistent with FSG’s findings that this is the most intuitive level for most groups pursuing systems change. The second-most frequent program elements were relational (relationships & connections and power dynamics).

Finally, some programs were engaged in transformative systems change (mental models). Overall, we found that the social-ecological levels were well represented across the initiatives. We found more presence of transformative level activity than expected in this environmental scan. However, it was the least frequent type of systems change identified. This highlighted the need for more work focused on transformative change through shifting mental models, a key focus of the ABEST project. A copy of the Environmental Scan is in Appendix B.
LESSONS LEARNED

• Conducting a thorough literature review and environmental scan was a big undertaking, and the ABEST team found that having a team with diverse perspectives and backgrounds was a benefit to getting grounded in the root causes of inequities in maternal and infant health outcomes. Different team members brought different knowledge and perspectives on where and how to search for information, as well as interpretation of research findings.

• While the ABEST project intentionally focused on a literature review and environmental scan at the beginning of the project, learning happened throughout the project and was not a linear process. For example, the ABEST team started the literature review trying to be very precise in talking about specific cause and effect relationships between factors and outcomes but realized that approach was not telling the true story of the literature. The team realized that pulling back and focusing on the major themes that arose from the literature review and organizing the literature findings into the Social-Ecological Model provided a clearer picture of how racism functions as a root cause of birth inequities. This framework also allowed the ABEST team to clearly explain what we learned from the literature review to others and help them to apply the findings to their work.
PARTNER ENGAGEMENT

Partnerships were key to the success of the ABEST project. Within Michigan Public Health Institute, this project was a collaboration between the Center for Healthy Communities (CHC) and the Center for Health Equity Practice (CHEP). CHC uses a community-based participatory approach and works collaboratively with partners to transform systems and improve the health of communities through assessment, planning, evaluation, and continuous quality improvement. CHEP helps those who work in public health and related fields to understand health equity, social justice, and the social determinants of health so they can work together to reduce the likelihood that people are disadvantaged because of racism, classism, gender discrimination, and other forms of oppression.
Partnerships were key to the success of the ABEST project. Within Michigan Public Health Institute, this project was a collaboration between the Center for Healthy Communities (CHC) and the Center for Health Equity Practice (CHEP). CHC uses a community-based participatory approach and works collaboratively with partners to transform systems and improve the health of communities through assessment, planning, evaluation, and continuous quality improvement. CHEP helps those who work in public health and related fields to understand health equity, social justice, and the social determinants of health so they can work together to reduce the likelihood that people are disadvantaged because of racism, classism, gender discrimination, and other forms of oppression.

The project also had a number of external partners. The ABEST project aligned with the goals of the Michigan Department of Health and Human Services’ Mother Infant Health & Equity Improvement Plan, and the advisory group for that plan also served as an advisory group for ABEST.

Vijaya Hogan served as a consultant for the project. Dr. Hogan is a nationally known perinatal epidemiologist. In her career, she has worked at the community, state, and federal levels, in public and private sectors, in academia, and has worked both domestically and globally. She conducted research and authored several papers relating to understanding and addressing health inequities in perinatal outcomes.

Health Resources in Action (HRiA) co-designed and facilitated the workshop on leading systems change. HRiA is a public health institute with a mission to help people live healthier lives and create healthy communities through prevention, health promotion, policy, and research. With a strong health equity lens, HRiA has earned a national reputation as a public health leader by identifying approaches that address the social, economic, political, and systemic determinants of health.

Bayard P. Love, from the Racial Equity Institute, led the workshop on the Groundwater Approach. Bayard “Bay” Love is an organizer, trainer, and management consultant whose work is dedicated to ending structural racism by building successful campaigns, strong organizations, and empowered leaders.
ENGAGING PARTNERS

Most importantly, the ABEST project partnered with two community coalitions and a group of 25 systems leaders from across Michigan. These partners all participated in the ABEST capacity-building process and the two community coalitions also developed specific, actionable strategies for transformative systems change to tackle the root causes of inequities in maternal and infant mortality in their communities. The two community partners were the Inter-Tribal Council of Michigan (ITCM) Asabike Coalition and the Berrien County Raising Up Healthy Babies Taskforce.

Asabike is the community coalition for the ITCM home visiting network. It is a coalition comprised of community members, public health, nursing, counseling, and health education professionals from multiple tribal agencies across the state. In the native language of the Anishinaabe people, asabike is a word that refers to someone who weaves, creates, and gathers. In a contemporary context, asabike can also refer to people who come together for a similar purpose to create something meaningful for the people.

The RUHB is a coalition made up of partner organizations and community members from across the Berrien County community with the mission of reducing infant mortality in Berrien County. Over the past few years, the coalition has experienced many changes in membership and staffing and has since renewed its commitment to addressing infant mortality in the County and more specifically to reducing disparities in mortality between White and Black babies in the County.
The ABEST project designed a multi-step process to identify and select community partners for the project. The team began by identifying selection criteria based on the goals of the project:

- Readiness to address the root causes of birth inequity, particularly racism.
- Focus on addressing inequities for African Americans and/or Native Americans, because these are the two groups who experience the greatest inequity in birth outcomes.
- Potential for buy-in and active involvement of both community and systems leaders.
- Prior experience with (or willingness to engage in) cross-sector collaboration.
- Leadership team members that authentically represent the community being served.
- Commitment to implement and sustain efforts long-term.

The project team determined that we needed to work with community partners who were ready to address root causes and had the infrastructure in place to carry out the work. Because the ABEST project was piloting a new approach within a two-year project period, the project timeline simply did not afford time to work with partners who needed significant coalition building or who had not already begun to explore and address racial inequities.

The ABEST team distributed a call for community partners, which explained the purpose of the project, an overview of the capacity-building activities of ABEST, the selection criteria, selection process, and benefits of participating. Interested communities were instructed to submit a letter of interest. The ABEST team held an informational session prior to the submission date to provide more information and answer questions.
ENGAGING PARTNERS

. . . SELECTING COMMUNITY PARTNERS & SYSTEMS LEADERS

Four community coalitions from across Michigan submitted letters of interest. The ABEST team and our consultant, Vijaya Hogan, conducted interviews with all four communities. The interviews gathered more information about their community, the membership of their coalition, past experience with equity work, how they thought the ABEST project could help them expand their work to address racial inequities, and whether they had the infrastructure in place to support participation. After the interviews, the ABEST project team and Dr. Hogan used a review rubric to score each potential community partner on how well they fit with the stated goals of ABEST and the selection criteria (see Appendix C). Each community was reviewed by three people. The team then met to review scores and make final decisions on who to invite to be community partners for the project.

The project team distributed an invitation for the ABEST leadership training opportunity that explained the purpose of the project, an overview of the capacity-building workshops, and benefits of participating. The invitation included a link to a brief web application. The application asked participants about their organization and job title, and asked a series of questions about the level of influence they had in their organization. The questions were built around the six conditions of systems change (e.g., influence on rules, regulations, and priorities that guide the entity’s own and other’s actions). Responses were on a 4-point scale and ranged from “I have no influence” to “I have primary decision-making power for my organization.” When selecting the 25 leaders who would participate in the workshops, the team used three selection criteria:

• The level of influence reported, aiming to include leaders with organizational power.
• Organizational sector (e.g., health care, public health, transportation), aiming for a cross-sector group of leaders.
• Geographic location, ensuring leaders were in communities with sizeable populations of Black and/or Native families.
LESSONS LEARNED

- Every one of the partnerships in the ABEST project was essential for success. The varied partners brought different perspectives that all shaped the project.

- The alignment between the project goals, community partner selection criteria, interview questions, and review rubric helped streamline a complex process and helped the team select communities who became authentic partners in reaching the goals of ABEST.

- The group of systems leaders was made up of mostly health care and public health professionals. The project had aimed for more representation from other sectors that influence social determinants of health. In hindsight, the team needed to do more work to target these sectors with the invitation and explain why they should attend a series of workshops on birth equity.
At the core of the ABEST project was a recognition that many leaders are not trained to lead transformative systems change that tackles root causes. Therefore, a major focus of the project was to build this capacity among state and local leaders. Our approach to building capacity was not just focused on training, but on walking with our community partners through a process of learning/unlearning, application, and practice. This process had three major components: groundwork, workshops, and Roadmap planning. The two community partners went through the process separately so they each could focus on the needs of their communities, and then we held a joint session as the final session for the project.
BUILDING CAPACITY

. . . LAYING THE GROUNDWORK

The capacity-building process started by orienting our community partners to the goals and objectives of the ABEST project and facilitating a visioning session with each partner group. This was accomplished at kick-off meetings soon after the two community partners were selected. Each partner community was supported through a series of activities designed to prepare the group for the planned milestones in the project. Given the sensitive and complex nature of the work being done and the fact that this was new work, building consensus in what the group expected of each other in the work felt critical. Common group agreements were shared for inspiration and each partner community was able to select/add their own expectations for how they would work together. There was also time and organized activity built in to let the group members speak to their questions that needed to be answered, things they were excited about, suggestions for the work, and worries that were important to address as the work began. Lastly, the kick-off meetings ended with a roster check – taking inventory of the individuals currently showing up to do the work, thinking through who else needed to be added, and creating a plan for engaging all partners in a meaningful way. These kick-off meetings were held in late 2019. The kick-off with Berrien was in person. The kick-off for ITC was supposed to be conducted in two parts, one held in-person in the lower peninsula, and one held in-person in the upper peninsula. The upper peninsula meeting was cancelled due to weather and rescheduled to be virtual.

The visioning session at the kick-off meeting asked each partner community to examine the current state of their communities, their ideal state for the future, and highlight the strengths of the community that can be engaged for targeted change.
Using focused conversations and graphic facilitation, each partner community designed a vision of what things were currently like in their communities, where there are strengths to note and leverage, and what the groups believed their communities would look like/be like if efforts in their ABEST work are successful. This step was purposely designed to happen before participants engaged in the workshops so they could carry a succinct goal with them through the process to engage their critical thinking, bring real life examples into the concepts, and keep their learnings focused. The social-ecological model was used as a structure for the visioning. When describing the current and future states, partners were asked to visualize their community and think about what people were doing (individual), what interactions were happening (interpersonal), what was happening within organizations (institutional), what was happening within the community (community), and what was happening beyond the community (societal).

In addition to the groundwork accomplished at the community kick-off meetings, we also shared the results of the literature review and environmental scan with each community group during virtual sessions. During these sessions, the ABEST team presented our learnings from the literature review and environmental scan and invited our community partners to reflect on how well the findings applied to their communities. Both community groups saw a number of parallels between their communities and the findings of the literature review and environmental scan.
WHERE ARE WE NOW?

OUR VISION FOR THE FUTURE
LESSONS LEARNED

• The visions for birth equity were an integral part of the ABEST project journey for our community partners. They provided a tool for bringing people together around shared goals and communicating those goals to others. They provided a helpful check-in along the way for applying the learnings from the workshops and they were a central element of developing specific, actionable strategies for birth equity.

• Sharing the results of the literature review and environmental scan with our partners helped to create a shared understanding about birth equity. The ABEST team was able to share what we had learned, and we were able to learn from our partners about what birth equity/inequity looked like in their communities.
ABEST WORKSHOPS

through systems change. The workshop guided participants through a learning experience where each workshop built upon the previous one. The first workshop built understanding of root causes through shared vocabulary, understanding social identities and how they intersect with health, discussing root causes and levels of oppression, considering power as it relates to oppression and change, and applying a health equity framework to maternal and infant mortality. The second workshop linked root causes to systems by providing a framework for understanding racial inequity as structural in nature and expanding the conversation beyond specific sectors to an interconnected systems approach. The workshop provided tools for using stories and data to present this framework. The third workshop showed participants how to apply the concepts of root causes and structural racism to systems change strategies. The workshop covered the six conditions of systems change, analyzing power within systems, identifying windows of opportunity for change, and coalition building.

The two community partners and the group of systems leaders from across Michigan participated in the three workshops. For the two community partners, this workshop series was followed by four months of facilitated planning to put all of the content into action by developing a Roadmap for Systems Change that included a vision and goals, planning for how to overcome potential challenges and barriers, identifying specific plans for action, and building sustainability.
The ABEST team began developing the workshop content by identifying goals, objectives, and core competencies. Together with two of our partners, Health Resources in Action and Bay Love, we created a curriculum map that was a crosswalk of the core competencies and the objectives. For each core competency, we identified the objective(s) that contributed to that competency and identified which workshop(s) would address that combination of objective/competency. We then used those objectives and competencies to form the basis of each workshop’s content. Each workshop facilitator took responsibility for designing their workshop and we checked in monthly to ensure the workshops aligned, built upon one another, and felt like a seamless progression to participants.

The ABEST workshops were planned to be in person, but the COVID-19 pandemic forced us to do them virtually. The workshops were originally planned to begin in March 2020 but were postponed until October 2020. The workshop facilitators used a variety of techniques to make the workshops more interactive, such as break out rooms, annotations in Zoom, and Google slides that everyone could access. We also split up the workshops to be no more than four consecutive hours, rather than the full days that were planned for in-person.

The Health Equity Workshop was facilitated by MPHI’s Center for Health Equity Practice. The goal of the workshop was to introduce participants to health equity and systems change core concepts using the FSG framework and Social-Ecological Model as a foundation to support the learning objectives of the overall series and the development of critical competencies needed to engage an equity lens and transform systems. Using a combination of didactic and interactive activities, participants were invited to integrate personal experience, link learning to their everyday work, and engage in dialogue that allowed for them to explore new ideas and critically reflect on their relevance to real-world challenges and scenarios.
The workshop was presented over the course of 4 scaffolded 4-hour sessions that introduced participants to several tools to carry forward into subsequent workshops. All workshop activities were designed to build upon one another and prepare participants for a culminating activity where they integrated all concepts and tools into the roadmap planning that would take place at the conclusion of the workshop series. The following table outlines the learning objectives built into each session:

Throughout the workshop, the facilitators uplifted the importance of engaging an equity lens as the through line for all systems change activities, noting that systems cannot truly be transformed if root causes are not addressed across all conditions. Sessions began by focusing on health equity core concepts and the FSG framework. While the full FSG framework was discussed, particular focus was given to mental models. To begin session one, participants were introduced to the concept of a mental model and guided through a facilitated mapping activity to capture their own mental models regarding maternal and infant health outcomes. The activity allowed participants to do the following:

- Capture their knowledge about a complex social problem (e.g., maternal mortality) to increase their decision-making power
- Think through possible outcomes of decisions, policies, or to predict system-level changes
- Represent and share their ideas about maternal and infant health and help them understand assumptions, commonalities, and differences
- Capture the collective wisdom of the group and improve collaborative problem-solving
- Create a baseline from which the group could reflect as they move through the workshop series and iterate as they learn new content and skills that center a health equity framework
- Identify mental models that hold the issue in place and support intentional shifts to new ways of conceptualizing long-standing issues

After completing the baseline mental model mapping, it was clear that many of the participants did not integrate root causes into their conceptualization of maternal and infant health outcomes. Using this, the facilitation team was able to introduce participants to a health equity frame to support a shift that explicitly connected these outcomes to various forms of oppression such as racism, classism, and gender discrimination.
To support participant’s understanding of health equity core concepts, the facilitation team defined foundational terms as the following:

“Health equity can be viewed as both process – removing economic and social obstacles to health such as poverty and discrimination and an outcome – everyone has a fair and just opportunity to be healthy.” -Braveman, Arkin, Orleans, Proctor, & Plough

“Health inequity is differences in population health status and mortality rates that are systemic, patterned, unjust, and actionable, as opposed to random or caused by those who become ill.” –Whitehead

These definitions were critical to framing subsequent workshop activities. The focus on both process and outcome supported a shift to orienting maternal and infant outcomes to their root causes and explicitly linked disparities to a social justice frame, highlighting both their systemic and actionable nature – key components of a health equity lens. By sharing these definitions, the facilitation team was able to contrast a root cause approach to that of current public health practice that typically focuses downstream on individual level behavior and highlight a prevailing mental model within the context of their work. To further explicate the meaning of root causes, the facilitators discussed racism, gender discrimination, and classism (among other forms of oppression) and their connection to entrenched maternal and infant disparities.
To help participants think more deeply about how root causes manifest at various levels (i.e., personal, interpersonal, institutional, cultural, and structural), a framework for analyzing oppression was shared with the group. This framework supported participants’ ability to discern experiences of oppression in everyday scenarios and identify opportunities for disruption and change. The combination of the root cause and oppression frameworks supported a shift in participants mental models, where they began linking experiences of racism, for example, to inequitable maternal and infant health outcomes.
Once participants were primed to link root causes to maternal and infant health outcomes, the facilitation team brought them through a more structured root cause analysis, where they were introduced to a tool that took them through a stepwise process, focused their thinking upstream, and integrated historical context into their understanding of contemporary outcomes.

To support the integration of the concepts into their planning, the four-day series concluded with a facilitated crosswalk activity that overlaid the FSG framework and the Social-Ecological Model and served as the foundation for brainstorming shifts in systems conditions that explicitly addressed root causes.
LESSONS LEARNED

• It is common in systems change spaces to discuss strategies to address systemic issues but fail to integrate equity as a through line for all systems change activities. To support systemic transformation, it is critical to address root causes and focus mental model work directly on worldviews, ideologies, and various forms of oppression that serve as the blueprint and architecture of systems, as a means for advancing sustainable, meaningful, and just change.

• Historical context is a critical part of equity and systems change work. Participants need deeper engagement and support around linking historical events to contemporary experiences. Specifically, understanding how race is a social construct and worldview and how racializing (i.e., a prevailing mental model) populations both ideologically and through practice, policies, and structures, is fundamental to transforming the way issues and solutions are conceptualized.

• Advancing equity must happen at all levels to truly shift systems. It is critical for those engaged in this work to reflect both on their own embodied experience and the experience of those most impacted by inequitable conditions. Thinking critically about who they are in this work and connecting it to the larger vision of the project is fundamental to supporting the collaborative process and building power within the groups.

• Connecting root causes to strategies and action planning is complex and at times overwhelming for participants, so providing clear strategies and robust opportunities to practice are critical to sustaining the work.
Typical Narrative Thread | Counternarrative | Implication
--- | --- | ---
Racial inequity is evidence that the healthcare system (or any other system – education, housing, etc.) is “broken” and needs to be fixed. | Racial inequity in the healthcare system (or any other system) is a result of a system that is working as it was designed, because all systems were designed intentionally or unintentionally to maintain better outcomes and competitive advantage for white people compared to all other racial groups. | Robust interventions and effective leadership must look at how all systems were and are intentionally designed to maintain better outcomes and provide competitive advantage for white people.
Racial inequity is caused by lack of access or inequity in socioeconomic status, so we need to correct for that inequity to address racial inequity. | Systems in the U.S. are so heavily racialized that differences in access and socioeconomic status are a result of racial inequity, not the cause of it. | Trying to solve for access or socioeconomic status and access without addressing the underlying systems of racial advantage may exacerbate the problem. Effective leadership should do both simultaneously, and always keep in mind that achieving socioeconomic access does not close gaps for people of color.
Racial inequity is largely caused by differences in behavior and culture across racial groups. | Racial inequity is caused by systems even when people of different races (patients, students, business owners, etc.) live with exactly the same culture, behavior, and even biology. | Effective change must focus on changing the way systems treat people. This does not preclude the utility of behavioral or cultural interventions but must be a primary area of focus.

The Groundwater Workshop was facilitated by Bay Love from the Racial Equity Institute. Consistent with the goals of ABEST to reshape the narratives and ultimately shift conditions that maintain inequity, the Groundwater Approach workshop was designed to spur a fundamental shift in people’s thinking about the nature of the problem at hand. The Groundwater workshop was developed prior to ABEST and was tailored to the needs of the ABEST community partners and systems leaders.

Based on years of collective experience community organizing and leading in institutions, the workshop took head on key narrative threads that typically guide U.S. thinking about health disparities. These are types of assumptions that the workshop developers believe undergird thinking about health inequities in the U.S., and some of the counternarratives that they believe to be more accurate:
The following expert from “The Groundwater Approach: Building a Practical Understanding of Structural Racism” provides an overview of the metaphor employed to help illustrate these shifts in thinking.5

“Our metaphor is aligned with many who trace racial inequity to “structural racism,” “structural racialization,” or a “race-based caste system,” but these are complex terms that can be hard to grasp. We hope the “Groundwater” metaphor helps makes the complex accessible and practical. It’s based on a simple tale of dying fish that goes like this:

If you have a lake in front of your house and one fish is floating belly-up dead, it makes sense to analyze the fish. What is wrong with it? Imagine the fish is one student failing in the education system. We’d ask: Did it study hard enough? Is it getting the support it needs at home? But if you come out to that same lake and half the fish are floating belly-up dead, what should you do? This time you’ve got to analyze the lake. Imagine the lake is the education system and half the students are failing. This time we’d ask: Might the system itself be causing such consistent, unacceptable outcomes for students? If so, how?

Now... picture five lakes around your house, and in each and every lake half the fish are floating belly-up dead! What is it time to do? We say it’s time to analyze the groundwater. How did the water in all these lakes end up with the same contamination? On the surface the lakes don’t appear to be connected, but it’s possible — even likely — that they are. In fact, over 95% of the freshwater on the planet is not above ground where we can see it; it is below the surface in the groundwater. This time we can imagine half the kids in a given region are failing in the education system, half the kids suffer from ill health, half are performing poorly in the criminal justice system, half are struggling in and out of the child welfare system, and it’s often the same kids in each system! By using a “groundwater” approach, one might begin to ask these questions: Why are educators creating the same racial inequity as doctors, police officers, and child welfare workers? How might our systems be connected? Most importantly, how do we use our position(s) in one system to impact a structural racial arrangement that might be deeper than any single system? To “fix fish” or clean up one lake at a time simply won’t work — all we’d do is put “fixed” fish back into toxic water or filter a lake that is quickly re-contaminated by the toxic groundwater.”
The groundwater metaphor is designed to help practitioners at all levels internalize the reality that we live in a racially structured society, and that is what causes racial inequity. The metaphor is based on three observations: racial inequity looks the same across systems; socioeconomic difference does not explain the racial inequity; and inequities are caused by systems, regardless of people’s culture or behavior. Embracing these truths forces leaders to confront the reality that all our systems, institutions, and outcomes emanate from the racial hierarchy on which the United States was built. In other words, we have a “groundwater” problem, and we need “groundwater” solutions.

The four-hour Groundwater workshop was situated between the health equity workshop and the systems change workshop in order to draw the connection between the two. The health equity workshop helped participants understand root causes of oppression and start to identify how those root causes show up in systems. The Groundwater workshop built upon this learning by deepening participants’ understanding of how systems cause inequity. This prepared participants to then consider how to change systems to address inequity in the systems change workshop.
LESSONS LEARNED

• Narrative change requires consistent repetition and practice, even among leaders engaged in racial equity work. We encourage leaders to continue to revisit this kind of material and watch for how “fish” and “lake” narratives pop up and draw our attention away from critical “groundwater” interventions.

• Part of what allows narrative change to take root is people applying the thinking to their own work and experience. We found it helpful to work with groups, examine the framework as a framework, and to do the collective work of asking and wrestling with questions like “does this apply here?” “how does this apply here?” “what other narratives exist in our community that are related to these key narratives?”

• More attention should be paid to changing thinking of systems leaders. Health behavior work, in particular, often focuses us on the task of changing the thinking and action of people who have the least institutional power (e.g. patients, communities, people with worse health outcomes). Experience from ABEST and other work has demonstrated that leaders in institutional positions of power are just as likely and often more likely to operate with mental models that locate the problem at the level of the fish or the lake. This, we suspect, is in part because of implicit institutional pressure to look “externally,” instead of examining the processes and practices of the institutions themselves.
WORKSHOPS

. . . SYSTEMS CHANGE WORKSHOP

The systems change workshop was facilitated by Brittany Chen and Kathleen McCabe from Health Resources in Action (HRiA), a Boston-based non-profit public health social change organization that envisions a world where all people attain and experience optimal health and well-being.

Health equity demands racial equity and HRiA affirms Racial Equity Institute’s observations that racial inequity looks the same across systems; socioeconomic difference does not explain racial inequity; and, inequities are caused by systems, regardless of people’s culture and behavior. Therefore, HRiA explicitly (though not exclusively) leads with race in its work, bringing a public health approach to advance racial equity. This means HRiA works across sectors (e.g., healthcare, philanthropy, education, housing, etc.) to look broadly at what influences health; works upstream, recognizing that to sustainably tackle the root causes of health inequities, we need to examine and address the policies, systems, and environmental conditions that created and continue to perpetuate them; and pursues health equity for all by specifically identifying and working alongside the most systemically disadvantaged populations most affected by health inequities. In partnership with MPHI, HRiA approached the ABEST systems change training development informed by these core assumptions and approaches.

HRiA’s approach to the development of the systems change workshops emphasized the integration of head and heart. This is a recognition that understanding inequities at an intellectual level — synthesizing and understanding data, studying history, and examining practices and policies — is important, but incomplete on its own. Deep equity work also requires emotional investment, or the “heart” work. HRiA integrates opportunities to reflect upon and share personal feelings, identities, trauma, and resiliency to ensure one’s whole self in invested in advancing racial equity.

Another core priority emphasized in the development of the systems change workshop series was the recognition of the role of power in maintaining systems that perpetuate inequities. The workshops were designed to prompt participants to reflect on their own power within systems, and where there are opportunities to build power to advance equity.

Finally, HRiA works to ensure relevance of the local context and history in its trainings by lifting the collective wisdom of participants and offering ample time for community building to ensure momentum after a workshop ends.
To advance the goals of ABEST, uphold the approaches described above, and communicate core content about systems change, HRiA built upon and adapted existing systems change workshop material specifically for the ABEST participants. The trainers hoped that the structure and content of the training would:

- Encourage participants to build and strengthen relationships with each other.
- Create a brave and safe space where participants would reflect and engage with the material and each other in honest and vulnerable ways.
- Provide tools and activities that participants could carry with them as they planned and implemented their work.
- Prepare participants to translate conceptual frameworks into concrete action as they moved into the planning phase of their work together.

The 8-hour, two-part systems change workshop series intentionally built upon the Health Equity and Groundwater trainings that preceded it. Using An Ecosystem of Justice: A Poem Story by Elissa Sloane Perry, HRiA prompted participants to reflect on how equity and systems change are connected and how – done without intention and synergy – can be either ineffective, harmful, or both.

To facilitate the connection between head and heart, HRiA also introduced a life map exercise which prompted participants to explore pivotal moments and people in their own lives that shaped their understanding of their identity, race, and their own power.

Finally, HRiA aimed to build facility with FSG’s six conditions of systems change, offering a modified illustration (Figure below) to communicate the depth of work required to upend the systems that have been designed for white advantage.
Through the iceberg metaphor, HRiA posited that mental models are not only implicit and below the surface, but massive and deeply ingrained in our ways of being. Participants practiced making the implicit explicit, with the understanding that we need to know where we are to figure out how to transform the root causes of health inequities. The metaphor allowed participants to reflect upon the interconnectedness of the six conditions of the framework, and how the work of systems change grounded in deep equity requires constant movement across levels and between conditions. Participants used this modified framework to make explicit the dimensions of systems change required to advance birth equity in Michigan.

The training series was successful because it was built intentionally to allow for breadth and depth in exploring foundational concepts and brought together systems leaders with local experts to build community and identify ways to move forward together to advance birth equity.
LESSONS LEARNED

- Centering the lived experiences and shared expertise of the participants made the workshop more meaningful for participants.
- The openness of the facilitators to share their own stories created brave spaces for people to reflect, share, and plan together.
- Providing concrete tools, technical assistance, and frameworks allowed participants to translate concepts into practice.
Derived from methods and tools of strategic planning, the ABEST Roadmap Planning process was designed to support our partner communities in plotting an intentional path of action to address racist systems impacting Black and Indigenous birthing people and babies in their communities. Based on Technology of Participation (ToP) methods, we supported the two community partners through a process that included visioning their ideal state, exploring concrete actions, prioritizing action, action planning, and checking for alignment. The end product was a Roadmap for Systems Change to achieve birth equity for each community partner.

An Overview of the Roadmap Planning Process. The Roadmap Planning sessions were conducted through a series of 3-4 hour facilitated sessions led by Jennifer Torres and Angela Precht from Michigan Public Health Institute. The facilitators were flexible in the number of sessions, adapting to what was most supportive for the group. One group completed seven sessions and the other completed four sessions. Although the structured Roadmap planning sessions did not occur until after the systems change workshops, the Roadmap Planning process really began at the kick-off meetings when our community partners created their visions for birth equity. To help participants think ahead to Roadmap Planning and to help them document their ideas along the way, participants were given a journal with prompts and blank space to keep notes, organize their learnings, and carry ideas back to Roadmap Planning.

Exploring Concrete Actions. Once partner communities completed the series of workshops, groups used information from the workshops, understanding of the community, and individual perspectives to brainstorm concrete actions that could address barriers and make progress toward the partner communities’ ideal state/vision for the future. Partner communities used structured brainstorming to create a broad and deep list of specific actions to consider for the work ahead, eventually grouping similar activities that were connected into clusters of activities. Each group started this activity by brainstorming answers to the question “What existing elements are reinforcing the current conditions of birth inequities in your community?” After exploring these conditions, participants were asked “What actions and strategies could you and your organization take to lead systems changes that address birth inequities in your community?” This order of action allowed for participants to be focusing on the root causes of inequities and consider meaningful and comprehensive solutions.
At this point in the process, each group took pause to ensure that their initial actions were working toward comprehensive systems change and deep equity. One tool used in this process was a crosswalk that allowed for potential actions to be placed within each level of systems change and each layer in the social-ecological framework. This activity protected the action moving forward from focusing on only one layer (i.e. individual actions) and assured that actions were spanning all critical levels of meaningful systems change. This crosswalk is included in Appendix D.

In another check for depth, groups cross-checked brainstormed actions with components from the R4P framework. With this framework in hand, small groups were encouraged to consider if their draft actions:

- Repair the damage of the past;
- Change the structures (Restructure);
- Identify and undo racism (Remove);
- Protect from current conditions (Remediate);
- Provide services/policies/practices that are culturally and economically feasible.

From here, groups were able to add other ideas that addressed missing levels of systems change, critical layers in the social-ecological model, and components from R4P that drive the work into deep and comprehensive systems change.
WORKSHOPS

PRIORITIZING STRATEGIES. Once each partner community had a robust list of potential actions that felt meaningful and deep, they were asked to select priority strategies that work toward comprehensive systems change. Tools such as prioritization matrices and polling/voting on priority areas assisted in collective decision making. Once a cluster of strategies were selected, each partner community cross-checked the actions against the social-ecological framework and levels of systems change to assure that the selected strategies are cross cutting and aligned for meaningful systems change.

ACTION PLANNING. Once initial strategies were selected, each partner community used small group work to begin designing in-depth action plans for their strategies at the transformative, relational, and structural levels. Each small group used an action planning template (available in Appendix E) that supported the design of specific and actionable steps that would make meaningful progress in their level of change. Small groups were asked to articulate the goals of the work at their level and begin planning the discrete steps that would need to be taken to reach the goal/s. When combined, these small group ‘action plans’ became the partner communities’ Roadmap Plan draft.

Small groups regularly shared their drafts and progress with the larger group, collecting feedback, suggestions for improvement, and looking across all action plans for alignment, duplication, and the presence of deep systems/equity work. Each group used a unique processes to maintain alignment and strategic deep systems work, which included:

- Once draft sections of the Roadmap Plan were created, one group benefitted from the creation of a short-term vision. They asked “What is at the heart of these actions we are planning? What do we hope will happen if we do these things?” This didn’t need to be a perfectly polished statement, but having a shorter-term goal allowed the group to have a clear and strategic plan forward.
WORKSHOPS

... ROADMAP PLANNING

- In different stages of action planning, each group took the time to review all action plans together. The following questions were supportive of a comprehensive review and relevant adjustments across the full Plan:
  - Are all areas working together toward the short-term vision? (if applicable)
  - Where is the deep equity? Systems change?
  - Are the goals aligned and working together, in the same direction? How could our strategy be tightened across the levels?

- Reviewing the mental model shifts being targeted through their Roadmap Plans and probing for any additional policies, practices, resource flows, relationships and connections, and power dynamics that are keeping those mental models in place. Groups then adjusted strategies to better align and deepen the work.

Eventually, each group was able to streamline the separate action plans for each level of systems change to fit together as one cohesive Roadmap Plan draft. Once drafts were solidified, both partner communities came together for a joint session to share their Roadmap Plans, ask questions, and learn from each other. This connection afforded the groups the ability to adjust their Roadmaps based on collective wisdom and build additional momentum and resources together to support their paths forward.
Roadmap for Systems Change – Berrien County Raising Up Healthy Babies Taskforce. The Roadmap for Systems Change in Berrien County is guided by a vision of building authentic connections that break down division and build community power to achieve progress toward birth equity. The Raising Up Healthy Babies Taskforce (RUHB) determined that the work of building connections and community power for birth equity needs to start by transforming the way that perinatal care is provided to Black Indigenous and People of Color (BIPOC). Inspired by the core principles of Birth Detroit, the roadmap focuses on affirming that BIPOC are “leaders in our own care.” The roadmap addresses all six conditions of systems change, from shifting mental models to transforming institutional policies and practice. It also takes an approach to change that works simultaneously at the level of the community (e.g., building collective voice and patient advocacy) and institutions (e.g., changing provider behavior and hospital practice).

The RUHB roadmap for birth equity has four objectives:

- Complete an inclusive development process to design a strategy to affirm that BIPOC birthing individuals/families are leaders in their own care.
- Conduct a campaign by and for BIPOC birthing individuals/families that aims to affirm that they are leaders in their own care.
- Conduct a campaign targeted at perinatal providers that aims to affirm that BIPOC birthing individuals/families are leaders in their own care.
- Work with healthcare institutions to change their policies and practices to treat BIPOC birthing individuals/families as leaders in their own care.

Activities within these objectives include development of key messages, storytelling, implementing campaigns with community members and providers, creating opportunities for connection between patients and providers, providing birth equity tools and training to providers, and working with healthcare organizations to examine and improve their current policies and practices to recognize and treat BIPOC birthing individuals/families as leaders in their own care.
Roadmap for Systems Change – Inter-Tribal Council of Michigan Asabike Coalition. The Roadmap for Systems Change developed by the Asabike Coalition is guided by a vision of systems change that supports whole-person birth experiences that hold tradition and culture at the center. The roadmap addresses all six conditions of systems change, from shifting mental models to transforming institutional policies and practice. It also takes an approach to change that works simultaneously at the level of the community (e.g., elevate the role of BIPOC birth workers and home visitors, support families in advocating for their rights) and institutions (e.g., changing hospital policies and procedures).

The Asabike Coalition roadmap for birth equity has three objectives:

- Develop a toolkit for creating systems change around birth equity that targets multiple audiences from Tribal leaders to healthcare providers to families.

- Devise equitable policies and procedures that incorporate an understanding of the differences between Indigenous and Western worldviews, to produce an elevated framework for health care providers and policy makers that includes knowledge of Indigenous cultural practices and belief systems, that is easy to incorporate into existing systems to ultimately establish an elevated standard of care.

- Support access and create more equitable options within existing systems that center the whole person and family, including culture and tradition, in the perinatal experience.

The work will be guided by an advisory group composed of self-identifying Indigenous birthing people, traditional knowledge holders, community members, and other allies. Activities to achieve these objectives include gathering information from Indigenous birthing people about their experiences navigating healthcare systems, examining existing policies and practices to identify points of integration of Indigenous ideologies, developing a toolkit for multiple audiences that can be used to drive systems change, and piloting the toolkit and change process with hospital system partners. While the toolkit contents will focus on Indigenous worldviews, culture, and traditions, the system changes targeted by the toolkit will make space for all cultures and traditions to be centered in perinatal care.
LESSONS LEARNED

• This is not a linear process. A strong focus on the overarching goal can keep the process and energies focused.

• To keep the work poised for meaningful systems change, groups doing this work are encouraged to be nimble in their planning and frequently ‘zoom in/zoom out’. While typical strategic planning can create separate silos of action that can successfully function on their own, focused systems change requires action at all levels of systems change to be working in concert with each other. This might look like constant toggling between the drafting of specific action plans for certain levels of change/objectives, then comparing progress across all planning to check for alignment and adjust action and direction toward strategic systems change.

• This is a challenging process for established groups familiar with the topics and process. This would be especially hard for a newly established group.

• There isn’t a ‘one size fits all’ approach. Different groups will need different paths, tools, and steps.

• Whenever you are forging new paths, you must be ready to innovate. This process will look and feel different from any other planning process.

• Highly structured, neutral facilitation can be an asset to this process. Facilitators need both deep content and process knowledge and experience.

• There can be a natural inclination for groups to focus on actions that work around the core roots of systemic racism but do not address them directly or comprehensively – what is referred to in the introduction of this document as tinkering around the edges. Using tools like R4P and the levels of systems change/social-ecological crosswalk can support Roadmap Plans that are deep, direct, and effective in addressing and dismantling racist systems. This is a continual process of checking for deep and structural work, and one that both of the community partners are continuing to do.

• There was great value in being able to connect the partner communities in a joint session once Roadmap Plans were drafted. This may have been confusing earlier in the process, but served as a critical connector of future resources, supports, and leverage in the work.
Once partner communities had thorough Roadmap Plan drafts in place, they participated in planning sessions related to sustainability of their efforts. The goal of this session was to help each community prepare for ancillary supports needed to build and maintain momentum in their efforts.

Sustainability discussion and activities focused on specific components of sustainability based on the Program Sustainability Assessment Tool (PSAT). The group focused initial conversations and actions related to sustainability on Funding Stability, Communication, Partnerships, and Organizational Capacity/Administrative Functions. Each participant received a copy of a Sustainability Workbook that included more detailed information about each component, space for notes from the conversations and activities, and follow-up action steps to consider for each component.
WORKSHOPS

... CRITICAL COMPONENTS OF ROADMAP PLAN SUSTAINABILITY

FUNDING STABILITY. Through focus on this component, partner communities were encouraged to prepare for the eventual building of a stable and diverse funding base. The groups discussed successful funding structures experienced in other work to glean and apply lessons learned to the sustainability of their Roadmap Plans. They also revisited their Roadmap Plans to highlight proposed actions that would require funding and identify what type/level of costs they estimate needing. Each group populated a table that listed actions in their plan that would likely require funding and identified a cost type (salaries and wages, equipment, travel, materials and supplies, other) along with a cost estimate. This activity aimed to position the groups to have estimates of costs needed to sustain the work and have a starting point for budgets as funding opportunities are identified and pursued.

COMMUNICATION. To consider communication, partner communities explored steps to assure that people know what they are doing, why it is important, and how they can support the work. The group discussed successful models of communicating in other initiatives they have participated in and explored how lessons learned could be applied in the context of their Roadmap Plans. To build concrete resources in this space, each group worked on their Roadmap Plan “elevator speech” – a brief description of what the group is, what the group does, and how others can support the efforts. To do this, each partner community worked on the answers to the following questions to inform their description: Who are you (answer as your team, not as an individual)? What is your big picture purpose or goal? How do you plan to get to your goal? What can others do to support your work? Once these questions were answered, responses were combined into one longer description and edited for flow, accuracy, and clarity.
WORKSHOPS

... CRITICAL COMPONENTS OF ROADMAP PLAN SUSTAINABILITY

**PARTNERSHIPS.** Successful and sustainable initiatives benefit from strategic and comprehensive partnerships. Partners are essential providers/connectors to resources, expertise, support, and advocacy for work, especially that which spans multiple dimensions of complex systems. Partner communities first considered examples of high functioning and supportive partnerships experienced in other work to apply understanding and lessons learned to their Roadmap Plans. Additionally, each group made a list of partners who aren’t engaged yet. To think comprehensively, they used the following focus questions: Who will be affected by your work? Who will have influence over your process and outcome? Who will have an interest in the success of your work? After identifying potential partnership, groups indicated if each partner needed to be engaged immediately or at a later point. The purpose behind each of these activities was to encourage each partner community to keep their eye to critical engagement of missing partners to continue to build support and momentum for their Roadmap Plans.

**ORGANIZATIONAL CAPACITY.** To boost organizational capacity, partner communities were encouraged to plan for and strengthen the functions of the team and administrative oversight. Given that segments of each Roadmap Plan were planned by small groups and will likely be carried out by individuals across many different organizations, attention and strategy to the functions of the full team are critical for long term success of each Roadmap Plan. Discussion started with the exploration of successful teams that participants have been a part of to find templates, styles, and functions that could be applied to support high functioning Roadmap Plans. As a first steps activity to support organizational capacity, partner communities were invited to discuss the following questions: Who will coordinate the continued needs and progress of the Roadmap? Should each objective area have a lead/leaders to share the work and keep momentum going? Who might that be for each? What meeting needs does the group have? Will small groups keep meeting? Should the larger group come together? What would that look like? What kind of decision-making process does the group want to follow (i.e full group consensus when any decisions are made, small groups have autonomy to make decisions about their strategies, group leaders have final decision making, etc.). While the conversations around these questions were just beginning, each partner community added dimension to the critical infrastructure that will ultimately carry out their Roadmap Plan.
LESSONS LEARNED

• To strategize group time and energy, a group may consider prioritizing certain components of sustainability planning to address first. While all components are worthy of eventual attention by the group, it is important to focus on the content and status of Roadmap Plans and address aspects of sustainability that are most relevant to the first steps in implementing Roadmap Plans.

• Sustainability planning benefits from an ‘all hands on deck’ approach. The energy and supports needed to implement and sustain Roadmap Plans likely exceeds the efforts required in the planning phase. Engaging a variety of vested partners brings additional perspectives, resources, and energy to the work. Time, energy, and attention of partners will be critical to successful implementation of the Roadmap Plans and sustainability planning creates another important opportunity for meaningful engagement.

• Skipping sustainability planning can leave Roadmap Plans unprepared for implementation and long-term success. Taking the time to consider and plan for the ancillary supports required for sustained success is worthy of valuable group time and attention.
EVALUATING ABEST

EVALUATING ABEST. It was important to the team to invest in a robust evaluation plan for the pilot year of ABEST. There were many audiences who were interested in understanding both the process indicators of successful project implementation (for example, the number of collaborative members who engaged in workshops and strategic planning) and outcomes of:

1. Collaborative growth and strengthening
2. Increased capacity for health equity work among community leaders
3. Increased capacity for systems work among community leaders

DEVELOPING THE PLAN. The ABEST team engaged in a process of inquiry and discovery as we developed the evaluation plan.

MODELS. Our first stop was to look for models and approaches from other researchers and community-based teams who were doing similar work. We focused on evaluation models from three content areas that aligned with ABEST’s goals and activities: systems change, health equity and root cause analysis, and collaborations.

SYSTEMS CHANGE. Since systems change is the long-term goal and core framework of ABEST, we began by learning more about approaches to evaluating systems change efforts. Given the increased interest in systems change work, there are a number of helpful resources and guides on how to conceptualize, facilitate, and evaluate it. Some themes that emerged across the resources we found most helpful included:

• The field is still somewhat emergent
• There is no single “best practice” to evaluating systems change
• Systems change in inherently non-linear and complex—any approach needs to be flexible enough to capture this
PARTICIPATORY APPROACH. The ABEST project took an intentional participatory approach to developing the evaluation plan. Engaging in a power-sharing and co-constructed evaluation process takes more time than an evaluator-driven approach. It also asks more of our partners in terms of time and thought partnership. We are grateful to the leaders from our two pilot communities for engaging with the evaluation team and helping articulate important aspects of the evaluation. We held several calls where we discussed what the important questions were for the local communities. Community partners were also critical in reviewing and shaping the case studies we used to offer a contextualized way to understand participants’ mental models about the experiences of birthing Black and Native American women.

SCOPE & UNITS OF ANALYSIS. As we were exploring different models and approaches to inform the evaluation, the team articulated the scope and units of analysis for this project. The ABEST project is focused on three units of analysis:

1. **Systems Leaders as individuals**—change in attitudes and knowledge through participation in workshops

2. **Community Cross-sector collaboratives**—change in membership, trust/ cohesion, and strategic plans through member participation in workshops and strategic planning sessions

3. **Systems Leaders’ home organizations/sectors**—indirect change in efforts/ resources for community collaboratives; main ask of state-wide group, but not directly supported by ABEST

While we hope that shifts in attitudes and knowledge among leaders will result in indirect effects within leaders’ home organizations, this is not an explicitly supported activity of the project. It may emerge as critical through community strategic plans and we ask for self-reported activities at the organizational level in the surveys to assess indirect impacts.
EVALUATING ABEST

EVALUATION PLAN AND CORE DATA ELEMENTS

EVALUATION QUESTIONS. These are the questions the ABEST staff & community partners think are important about understanding the work:

How has participation in ABEST impacted the growth and/or strengthening of a community cross-sector collaboration focused on reducing racial disparities in infant and maternal birth outcomes?

1. Do the policies and practices within each community collaborative encourage diverse participation?
2. Do collaborative members have the ability to make changes within and outside of their organization (even at the state level if possible)?
3. Has there been improvement on partner trust and cohesion?

How has participation in ABEST increased community collaboratives’ capacity for health equity work?

1. How often are “upstream” root causes cited as reasons/solutions for inequitable birth outcomes?
2. Is there an increase in awareness and knowledge of community historical context around racial inequities and systemic disinvestment in communities?
3. Does the collaborative’s work within the system that we currently have acknowledge the impacts of historical racism?
4. Has ABEST facilitated a shift in how the collaborative talks about equity?

How has participation in ABEST increased community collaboratives’ capacity for systems work?

1. Do participants have a better understanding of how to change systems and why some types of systems changes will be more lasting than others?
2. Do collaboratives engage in more conversations around how to impact the system?
3. Do ABEST participants grow in awareness & understanding of the ways that the system is not working? Is there greater awareness about what happens in the systems that hurt or fail people and what their part in it is?
4. Who is taking ownership of different activities and is there representation from all voices in ownership of the work?
DATA SOURCES. Evaluators took advantage of data sources produced in the context of ABEST programming and workshops in an effort to minimize additional data collection burden on participants. Additional data collection elements were needed to address some of the evaluation questions (pre-post ABEST evaluation survey) and address satisfaction and action steps after each of the three major workshops to understand immediate responses to these major programming elements (post-workshop evaluations).

ABEST staff used an observational coding scheme to code for patterns and trends during the core ABEST workshops. Two observers coded each workshop session, providing observations and evidence for three major categories:

- **Observations about the collaborative:** including growth or strengthening, partner trust and cohesion, ownership of work, and representation from all voices
- **Observations about content and capacity:** including novelty of content, challenges and opportunities around content, growth and transfer of knowledge over workshop series, and opportunities for quality improvement
- **Areas for action:** Notes about specific aspects of birth equity or specific areas for systems change that are discussed during the meeting

ABEST EVALUATION SURVEY. The pre-post survey was organized into three main components. The pre-survey was sent before the first Health Equity workshop. The post surveys were sent about six months after the pre-survey.

- **Case studies:** Four case studies featured stories of women during pregnancy, birth, and/or post-partum. The case studies were informed by real women’s stories and reviewed by community partners for accuracy. Two featured Black women and two featured Native American women. Participants were asked to read the case studies, brought alive in the electronic survey with photographs, and respond to four open-ended thought prompts.

- **Causes of health inequities:** Three open-ended items asked about the causes of health inequities. Questions asked about historical factors, persistency of racial inequities, and top factors that could end racial disparities.
• Capacity building for systems work: The final items focused on capacity building to address racial inequities in birth outcomes at a system’s level. Questions were framed at three levels that align with the different units of analysis identified for this work.

  • Personal growth items included those on comfort with health equity concepts and comfort discussing these issues with others

  • Organizational growth items included estimates of how much participants’ home organizations do around racial equity and the impact of their organization on Black and/or Native American families in their community

  • Collaborative growth items included an item about frequency of cross-organization collaboration and items from the Wilder Collaboration Factors Survey

POST-WORKSHOP EVALUATIONS. After each workshop series, participants were sent a link to a brief survey that asked about most and least useful parts, novelty of content, action items from the workshop, and ratings of facilitation. Participants who offered action items were asked about them in the post-evaluation survey to see if progress was made.
EVALUATING ABEST

... FINDINGS

A total of 67 participants attended the ABEST workshop series during at least one of the workshop sessions. Twenty-five were members of the System Leaders’ cohort, twenty-four from Raising Up Healthy Babies Task Force of Berrien County cohort, and eighteen from Inter-Tribal Council of Michigan Asabike Coalition cohort. Of these 67 attendees 42(63%) participants completed the pre-workshop survey, compared to 9(13%) participants completing the follow-up. Because the number of participants was low at follow-up compared to baseline, the focus of the evaluation analysis shifted from a linear comparison of changes for individuals from time one to time two (pre-workshop to post-workshop), to a stepwise comparison across each community collaborative. The observational notes and qualitative responses to case studies are key to providing the evolution of participants’ thoughts during the ABEST workshop series, thus allowing us to focus on evaluation capacity building for systems work components of the surveys.

There were three key themes that emerged from the data that were in the form of transformational and relational changes: 1. Growth in comfort and content knowledge – personal growth. Before the workshop, participants were asked to rate their comfort level with talking about racism as a root cause of health inequities with others in their collaborative, workplace, and community. Participants used a 10-point scale for self-ratings, that ranged from very uncomfortable to very comfortable. Participants’ responses revealed wide variability with their comfort levels (Range = 1 to 10; Average Range = 7.35-8.29). Because participants varied so greatly in their degree of comfort before the workshop, there was a lot of room for growth in this area as participants went through the workshop sessions. From the observations of the workshop sessions, participants began to develop a shared vocabulary and started to engage more when talking about racism as a root cause of birth inequities. 2. Changes in perceptions – organizational growth. Increases in comfort also suggests strengthening in trust with other collaborative and community members. Before the workshop, participants were asked to rate their level of agreement with the statements “People involved in our collaboration trust one another” and “The level of commitment among the collaboration participants is high.” The options were on a 5-point scale, ranging from strongly disagree to strongly agree.
EVALUATING ABEST

... FINDINGS

There was a wide range of variability with participants’ feelings of trust and cohesion with other collaborative members (Range = 1 to 5; Mean = 3.69) and perceptions of collaborative members commitment to birth equity (Range = 2 to 5; Mean = 3.54). Throughout the workshop series, we observed the degree of trust and commitment evolve in a positive direction, and the dominant voices at the beginning of the workshop series began to step back and allow others to speak more. **3.- Identified areas of action – collaborative growth.** As each collaborative went through the workshop series, there were very targeted discussions around moving from a “downstream” approach to addressing birth inequities to an “upstream” approach. From the observational notes, collaborative members began to identify and think through who should be involved from their community to facilitate changes in policies and procedures that promote birth inequities without the prompting of the facilitation teams. Discussions primarily focused on engaging with organizational leaders, such as representatives from local hospitals, and community members who are invested in birth equity. Discussions around who should be included to promote birth equity during the workshops were different from those named during the pre-workshop survey. Before the workshop, participants read case studies and were asked what needs to change to better support mother and baby and who has the power to make the changes. Participants tended to name policies and procedures needed to change to better support baby and mom. They also tended to name law makers and policy makers as the changemakers, while rarely mentioning the impact of including community members. Participants viewed engagement at this level as a challenge to successful engagement or change and did not know how to remove this barrier.

Many of these thematic changes can also be attributed to the diverse group of participants attending the workshops. We had representatives from various professional and service sectors, including local food systems, criminal justice, housing, transportation, health care, public health, and local government officials. This range of community affiliations contributed to the richness of the dialogue that took place during the workshop sessions, which in turn created a space for increasing capacity to do systems work through personal growth, organizational growth, and collaborative growth.
LESSONS LEARNED

• PARTICIPANT TRACKING
  • There were challenges with good attendance records in the virtual context because not everyone’s Zoom account membership aligned with their organizational email account we had on file.
  • Keeping track of new partners was difficult. When some community partners were not able to attend specific workshops, they sent representatives in their place, which in turn led to the absence of a baseline data capture for these individuals

• SURVEY PARTICIPATION
  • Rates were relatively low due to the time burden and commitment of our data collection efforts. Taking the time to send out surveys with an iterative dissemination plan will increase engagement and survey response rates in the future.
REFLECTIONS

. . . FROM ABEST COMMUNITY PARTNERS

We close the story of the ABEST project with reflections from our amazing community partners. We thank them for partnering with us on this journey and for bringing their hearts, minds, and authentic selves to the work. Though this particular project has ended, the work and the partnership has not. We look forward to continuing the journey.
REFLECTIONS

. . . FROM INTER-TRIBAL COUNCIL OF MICHIGAN

BARRIERS

• It can be hard to bring everyone to the table that needs to be there. Engaging certain stakeholders and getting commitment to the work is sometimes not easy. It can be challenging to engage stakeholders that also represent or serve different levels of the social ecological model.

• There are different levels and types of supports for this work depending on where you live and what the history is of the land you are on.

• For community members who are most affected by inequity, work and advocacy in this area can be both painful and at the same time empowering. Acknowledging history means revisiting trauma. Oftentimes that history is in the not so distant past.

LESSONS LEARNED

• While the problem(s) seem really big and make it seem like solutions are going to be really hard to attain, there are things we can do in the short term that are meaningful, impactful, and important to keep moving equity forward.

• It is important to focus on building relationships with 1) individuals and organizations already doing the work we hope to accomplish so we can learn from them; 2) existing and potential partner/collaborating individuals and organizations that share similar visions or motivation to promote and work together to achieve our goals and outcomes; and 3) new key stakeholders to help strategize and pilot the work and support outcomes.

• Training in this area is important for people that experience inequities. It helps us in healing, in sharing our stories and experiences, and in mobilizing our actions to create change. Training is also important for those who serve as allies to people who are working toward equity and systems change. It helps them to help others in a way that creates change, disrupts inequities, and supports the healing of the People.

• The answers to these issues are out there. They’ve been out there all along. People have been saying these things for decades. People these days are just listening differently now. And that is a good thing.
• ABEST has provided a framework for systems change addressing birth inequities that the leadership of the Raising Up Healthy Babies Taskforce has craved for years.

• BIPOC families experience inequities throughout their whole lifespan, and pregnancy and the postpartum period amplify these disparities due to systems that are *not* broken, but intentionally set up to best serve non-BIPOC families.

• It is an honor and privilege to collaborate with community partners.

• ABEST will continue this meaningful work to improve maternal and infant health outcomes.

• Thank you to ABEST for a platform to put passion into action!
Achieving Birth Equity through Systems Transformation
Racism and Inequity in Birth Outcomes for Black and Native American Families: A Review of the Literature

A product of the Achieving Birth Equity through Systems Transformation (ABEST) project
Michigan Public Health Institute
Environmental Scan of Infant and Maternal Mortality Efforts

A Product of the Achieving Birth Equity through Systems Transformation (ABEST) project

Michigan Public Health Institute
ABEST Community Partners Score Sheet

1. Give the application a score of 1-5 points in each of the areas listed.
   - 1=Not at all
   - 2=A little
   - 3=Somewhat
   - 4=To a considerable degree
   - 5=Very much so

2. Provide comments under strengths, weaknesses and recommendations.

<table>
<thead>
<tr>
<th>Reviewer Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicant Organization</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Readiness</th>
<th>Value</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does the collaborative have a commitment to addressing root causes of inequity?</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>2. Has the collaborative considered structural or systems changes needed in their community to support maternal child health?</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>3. Are members of the collaborative familiar with the concept of health equity?</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td><strong>Total readiness score (add up 1-3)</strong></td>
<td><strong>15</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Target Community</th>
<th>Value</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Does the collaborative focus their work on African American and/or Native American families?</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>5. Does the collaborative focus their work on both maternal and infant health?</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td><strong>Total target community score (add up 4 &amp; 5)</strong></td>
<td><strong>10</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Leadership Involvement</th>
<th>Value</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Does the collaborative already have active involvement of systems leaders?</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>7. Does the collaborative already have active involvement of community leaders?</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>8. Has the collaborative identified additional systems or community leaders they would like to engage?</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td><strong>Total leadership involvement score (add up 6-8)</strong></td>
<td><strong>15</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cross-Sector Collaboration</th>
<th>Value</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Does the collaborative have involvement from a broad array of community sectors (i.e., beyond just public health and health care)?</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>10. Is it likely that ABEST will reach the full collaborative, either through consistent participation of multiple members or through members taking content back to the full collaborative?</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>11. Has the collaborative identified additional community sectors they would like to engage?</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td><strong>Total cross-sector score (add up 9 &amp; 10)</strong></td>
<td><strong>15</strong></td>
<td></td>
</tr>
</tbody>
</table>
ABEST (Achieving Birth Equity through Systems Transformation) Project - Community Conditions and Concrete Actions Crosswalk

The following tables are a tool to help brainstorm:

- Conditions that are Reinforcing the current problem you are trying to improve in your community
- Actions and Strategies that could be taken by this group to lead systems change that addresses the conditions creating the problem you are trying to improve in your community

The rows represent the Six Conditions of Systems Change:

- Policies: government, institutional, and organizational rules, regulations, and priorities that guide the group doing the work’s own and others’ actions
- Practices: Espoused activities of institutions, coalitions, networks, and other entities; Also, within the group doing the work, the procedures, guidelines, or informal shared habits that comprise their work
- Resource Flows: How money, people, knowledge, information, and other assets such as infrastructure are allocated and distributed
- Relationships & Connections: Quality of connections and communication occurring among actors in the system, especially among those with differing histories and viewpoints
- Power Dynamics: The distribution of decision-making power, authority, and both formal and informal influence among individuals and organizations
- Mental Models: Habits of thought—deeply held beliefs and assumptions and taken-for-granted ways of operating that influence how we think, what we do, and how we talk

The columns represent the levels of the Social Ecological Model:

- Societal (e.g., social conditions, public policies, social norms)
- Community (e.g., physical environment, pollution, public safety)
- Institutional (e.g., healthcare systems, schools, police, employers, community organizations)
- Interpersonal (e.g., relationships with family, neighbors, peers, health care providers)
- Individual (e.g., health status, education, income; individual beliefs, attitudes, behaviors)

Instructions:
1. Begin with the first table that focuses on conditions reinforcing the current problem you are trying to improve in your community.
2. In the first row, brainstorm policies that create/reinforce the problem in your community. Think about policies at different levels of the Social-Ecological Model (e.g., societal/federal policies, local community policies). You can put as many ideas as you want in each cell. You may not have content in each cell and that is ok (e.g., policies are by definition at the institutional level and higher).
3. Continue on through each row.
4. Move to the second table which focuses on actions and strategies.
5. Consider the elements you listed in the first table. What actions and strategies could you take to address those elements? Record them in the appropriate cell. An action may end up in a cell other than its corresponding reinforcing condition. For example, changes in institutional policies and practices could address conditions at the individual and interpersonal levels (e.g., standardized hospital procedures to mitigate personal provider bias).

Examples related to the issue of birth inequities have been provided in italics to help spur ideas.

For questions about the ABEST project or about this template, contact Jennifer Torres (jtorres@mphi.org).
ABEST Action Planning Handout

Strategic Priority: Systems Change at the **STRUCTURAL** Change level

2. Assign a notetaker in your group to take notes and document initial plans.
3. Use the worksheets below to get started on initial plans.

**Table 1**

<table>
<thead>
<tr>
<th>1. Actions suggested within the Structural Level (taken directly from the brainstorm of concrete actions on the Community Conditions and Concrete Actions Crosswalk):</th>
</tr>
</thead>
</table>
| 2. What is the broad goal of the work that includes the actions listed above?  
*What are we working towards? What do we want to accomplish with the actions above?*
| 3. What needs to be done to make meaningful progress towards the goal in the next 2 years? |

For questions about the ABEST (Achieving Birth Equity through Systems Transformation) project or about this template, contact Jennifer Torres (jtorres@mphi.org).