2022-2023

FIRST 5 SACRAMENTO

Reduction of African American Child Deaths

Annual Report FY 2022-23

FIRST 5 SACRAMENTO

ASR

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Introduction

BACKGROUND AND GOALS

The RAACD Strategic Plan outlines strategies to address the top four causes of disproportionate African American child deaths.

In 2011, the Sacramento County Child Death Review Team (CDRT) released a 20-Year Report which revealed that African American children were dying at twice the rate (102 per 100,000) of any other ethnic group.[i] In response to these alarming findings, the Sacramento County Board of Supervisors created the Blue Ribbon Commission on Disproportionate African American Child Deaths. In 2013, the Blue Ribbon Commission released a report with a set of specific goals to be achieved by 2020.[ii] The goals included an overall reduction in African American child deaths, and specific reductions for four leading preventable causes of disproportionate African American child deaths, including:

- Infant Perinatal Conditions
- Infant Sleep-Related (ISR)
- Child Abuse / Neglect (CAN)
- Third-Party Homicide

The Blue Ribbon Commission Goals Included:

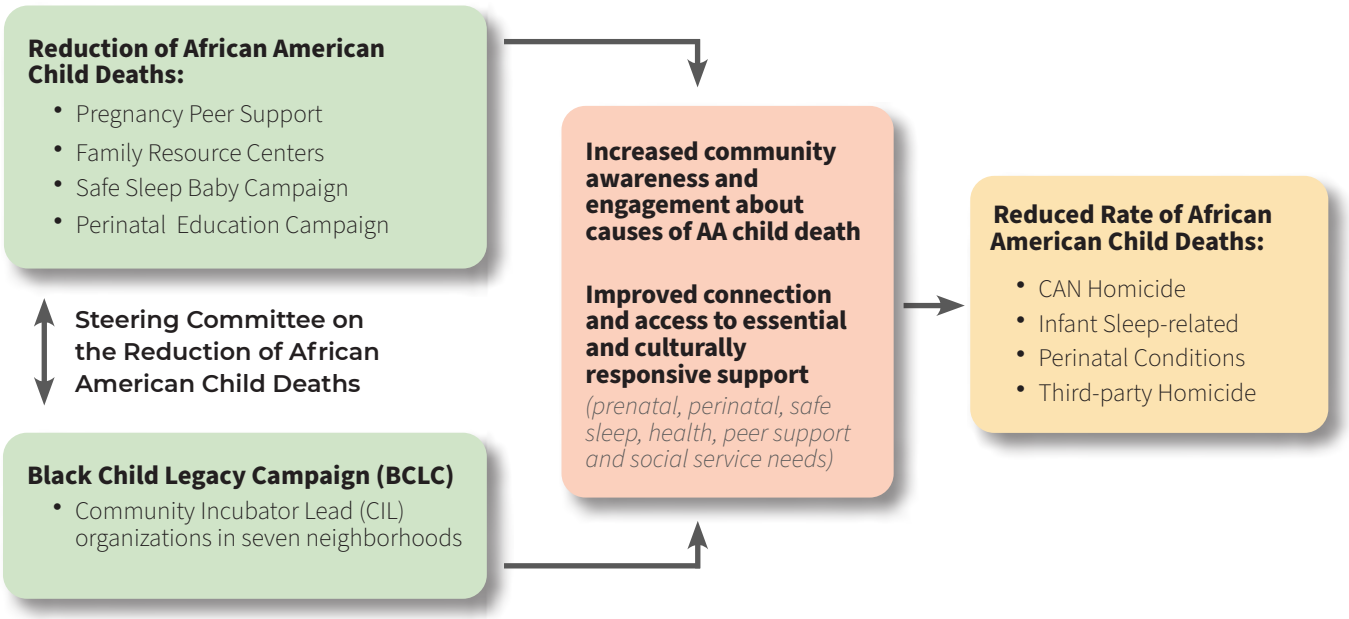
- Reduce the African American child death rate by **10-20%**
- Decrease the African American infant death rate due to infant perinatal conditions by at least **23%**
- Decrease the African American infant death rate due to infant safe sleep issues by at least **33%**
- Decrease the African American child death rate due to abuse and neglect by at least **25%**
- Decrease the African American child death rate due to third-party homicide by at least **48%**

The Blue Ribbon Commission report also called for the establishment of the Steering Committee on Reduction of African American Child Deaths (RAACD). Convened by the Sierra Health Foundation, the RAACD Steering Committee released a Strategic Plan[iii] and Implementation Plan[iv] iin 2015. RAACD plans outlined strategies to address the top four causes of disproportionate African American child deaths Using a Collective Impact model harnessing the power of multiple county and community stakeholders and funding sources. Over time, these plans evolved into two interdependent components:

- **The Black Child Legacy Campaign (BCLC):** Led by the Sierra Health Foundation, Community Incubator Lead (CIL) organizations are located in each of the targeted neighborhoods and lead prevention and intervention efforts to reduce disproportionate African American child deaths.
- **Reduction of African American Child Deaths (RAACD):** Led by First 5 Sacramento, this strategy complements and contributes to BCLC. First 5 programs focus on preventing deaths due to Perinatal Conditions, Child Abuse and Neglect, and Infant Sleep-Related causes, including a *Pregnancy Peer Support Program*, *Family Resource Centers*, the *Infant Safe Sleep Campaign*, and a *Public Perinatal Education Campaign*.

The graphic below presents a strategic framework for how Sacramento County is coordinating efforts to reduce African American child deaths.

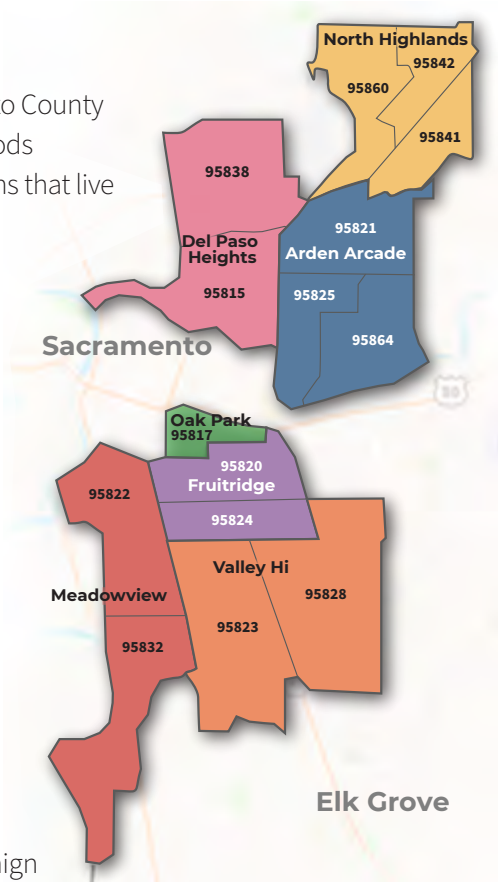
Figure 1 — Sacramento County's Strategic Framework to Reduce African American Child Death



Note: There are many other programs and projects that are also working to decrease the rate of African American child deaths. The current report focuses on perinatal, infant, and child (ages 0-5) deaths among African Americans and does not include deaths of all children ages 0-17.

To meet the Blue Ribbon Commission goals, efforts have focused on the Sacramento County neighborhoods with the highest rates of child death. Not only do these neighborhoods experience high proportions of child death, almost two-thirds of all African Americans that live in Sacramento County reside in these neighborhoods. These communities include:

- Arden Arcade
- Fruitridge/Stockton Boulevard
- Meadowview
- Valley Hi
- North Sacramento/ Del Paso Heights
- North Highlands
- Oak Park



FIRST 5 STRATEGIES TO REDUCE AFRICAN AMERICAN INFANT AND CHILD DEATHS

To address the preventable causes of infant death and 0-5 child death – First 5 Sacramento partnered with various community organizations to launch and implement four programs:

- Pregnancy Peer Support Program
- Family Resource Centers
- Safe Sleep Baby Education Campaign
- Public Perinatal Education Campaign

This report includes the ongoing evaluation of First 5 Sacramento's efforts, including FY 2022-23 outcomes for each strategy and recommendations about areas to strengthen.

PROGRESS TOWARD BLUE RIBBON COMMISSION GOALS

The Blue Ribbon Commission (BRC) identified 2020 as the year by which its initial goals should be met and if applicable, to reconvene and create a new set of goals. Available countywide data now surpass this benchmark year (data current as of 2021). However, rates continue to be measured by the 2020 goals pending updated goals to be determined by County partners. The 2020 data period identified key successes toward the BRC goals, with countywide progress exceeding three of the four mortality reduction goals (among ages 0-5). Since that time, the rate of perinatal deaths among African Americans decreased another 21%, with countywide progress meeting the BRC goals. On the other hand, infant sleep related and CAN deaths each increased since 2018-2020, highlighting alarming new challenges in the RAACD focal areas. In particular, African American infants were four times as likely suffer ISR or CAN deaths compared with all other races in 2019-2021 and remain twice as likely to die compared with all other races overall.

It is important to note that some BRC goals do not align exactly with the focus of this report. BRC goals were developed with the entire Sacramento County infant, child, and young adult population (ages 0-17) in mind, whereas the RAACD Initiative, funded by First 5 Sacramento, provides services to families with children ages prenatal through age five. The figure below outlines the 2020 Blue Ribbon Commission goals, the goal status as of the 2020 benchmark, and the percent change for each goal area as of 2019-2021 (compared with the 2012-2014 baseline, based on 0-5 data). This information should be used when revisiting goals and fine tuning where funding should be focused to continue to promote positive change.

Figure 2 — Progress toward Blue Ribbon Commission Goals to Reduce African American Child Deaths (ages 0-5)

2020 BRC Goal:	2020 BRC Goal Status 2012-2014 to 2018-2020	As of Most Recent Data (2019-2021)…	
		% Change 2012-2014 to 2019-2021	Disparity Gap 2012-2014 to 2019-2021
10% to **20%** reduction of African American **child deaths**	Goal Exceeded* **30% Reduction**	**25% Reduction** (ages 0-5)	**35% Reduction** (ages 0-5)
At least **23%** reduction of *infant deaths due to* ***perinatal conditions*** (ages < 1 month)	Goal Unmet **4% Reduction**	**24%** Reduction (ages 0-1)	**31% Reduction** (ages 0-1)
At least **33%** reduction of ***Infant sleep related*** (ISR) deaths (ages 0-1)	Goal Exceeded **54% Reduction**	**37%** Reduction (ages 0-1)	**43% Reduction** (ages 0-1)
At least **25%** reduction of **child abuse and neglect (CAN)** deaths	Goal Exceeded* **85% Reduction**	**52%** Reduction (ages 0-5)	**60% Reduction** (ages 0-5)
At least **48%** reduction of **third-party homicides**	Not funded or reported by First 5 Sacramento – see BCLC report		

* Not intended to be a direct comparison to the BRC goals as these were intended to reflect change among all children ages 0-17. Values presented here are limited to rates for children ages 0-5.

Pregnancy Peer Support Program

*For the fourth consecutive year, there were **zero newborn deaths** among infants born to BMU participants.*

88%** of infants were born full term and had a **healthy birth weight.

The Pregnancy Peer Support Program is implemented by Her Health First's Black Mothers United (BMU) program. BMU provides a community-based network of support to empower Black mothers during their pregnancies and the transition into motherhood through culturally relevant outreach, education, and individualized support.

The BMU program includes weekly check-ins with **pregnancy coaches, doula care, lactation support, health resources, and social/ educational gatherings**. The program is open to pregnant women prior to their 30th week of pregnancy who reside in Sacramento County and self-identify as African American.

Pregnancy coaches are African American women from within the community who are trained to provide education, offer information about medical and social service options, and help mothers in preparation for the birth of their child. Coaches provide individualized support through regular check-ins during pregnancy and up to 12 weeks postpartum, as well as recurring peer support events such as Mommy Mingles, lactation support groups, mindfulness-based Sister Circles, and The Last Nine birth story-sharing sessions. In addition to RAACD funding, grant funds from CalMHSA between FY 2020-21 and FY 2022-23 enabled Her Health First to provide additional doula and lactation services for BMU clients.

PROFILE OF CLIENTS

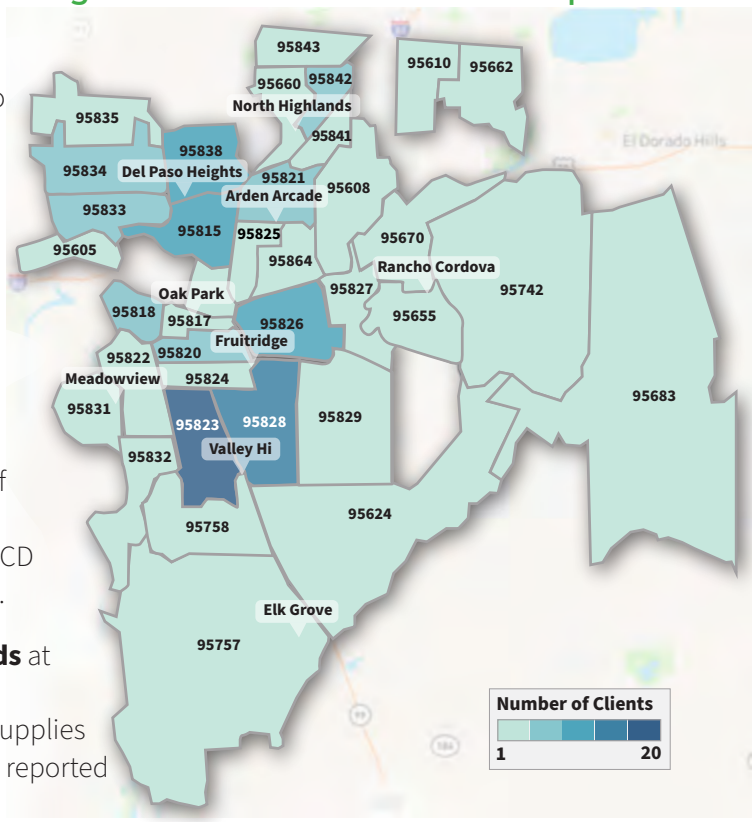
From July 1, 2022, to June 30, 2023, BMU served 149 pregnant African American women – including 17 who entered the program for a subsequent pregnancy (indicating they were previously served by BMU).

Among those served (including those who entered during the previous FY), 39% found out about the program through BMU outreach efforts, 18% were returning clients, and 17% were referred by a friend, family, or neighbor.[1]

The largest proportion of participants lived in the Valley Hi neighborhood (see map), and more than half (59%, 87/147) lived in one of the seven RAACD focus neighborhoods. The proportion of participants in RAACD zip codes decreased compared with FY 2021-22 (66%).

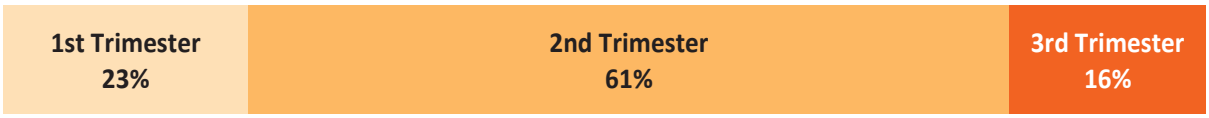
BMU clients reported an average of 2.3 **pressing needs** at intake. Mothers most commonly reported a need for pregnancy information and support (74%) and baby supplies (66%). Additionally, more than one in five participants reported housing as a pressing need (22%).

Figure 3 — Location of BMU Participants Served



Clients who enter the program earlier have more time to receive pregnancy education and necessary referrals, including support connecting to prenatal care earlier (as needed). As seen below, the majority of participants (61%) entered during their second trimester of pregnancy, while nearly one-quarter (23%) enrolled in their first trimester. The proportion who entered during their first trimester increased slightly compared with FY 2020-21 (21%) or FY 2021-22 (20%), indicating that **BMU has been reaching clients earlier in their pregnancies**.

Figure 4 — Number of Mothers Served, by Trimester of Entry



Source: Health Assessment Intake. N=148.

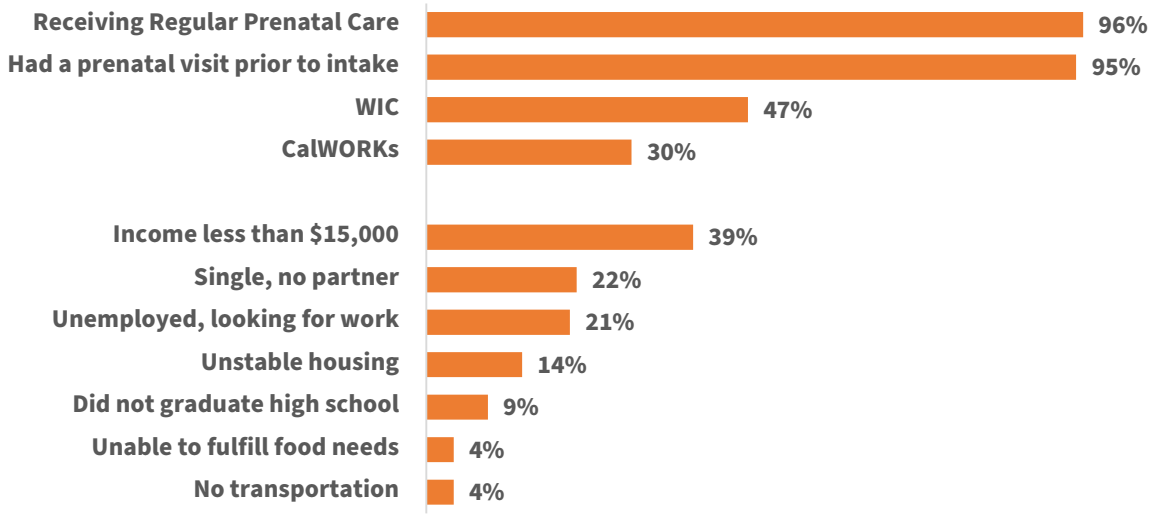
[1] Represents most common responses. Not intended to equal 100% as participants can select more than one response.

One aim of the Pregnancy Peer Support program is to provide resources, referrals, and education support to increase protective factors and reduce risks to the health and well-being of participants and their babies. Oftentimes, BMU serves pregnant African American women with substantial needs that may be most at-risk of adverse pregnancy outcomes.

Participants' **protective factors** include utilization of WIC, CalWORKs, and the timely initiation and use of prenatal care. At intake, nearly all participants reported they were receiving regular prenatal care (96%) and have had a prenatal visit (95%). About half (47%) were enrolled in WIC at intake and 30% were on CalWORKs. WIC and CalWORKs are considered protective factors to support low-income participants, however not all BMU participants qualify or need this support.

In terms of other **socioeconomic characteristics**, more than one-third (39%) of participants served in FY 2022-23 reported a family income less than $15,000, one in five (21%) were unemployed and looking for work, and 14% were experiencing unstable housing[2] (see additional characteristics below).

Figure 5 — Participants' Protective Factors and Socioeconomic Characteristics at Intake



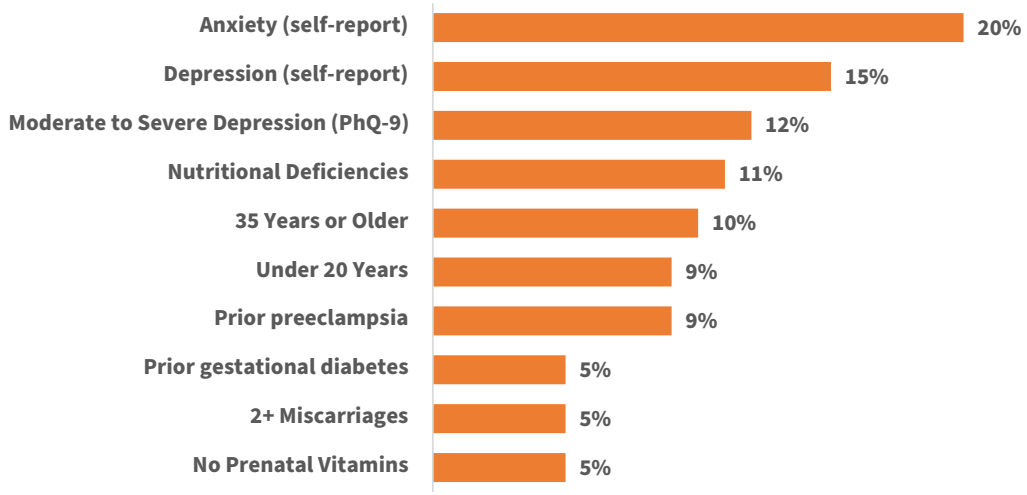
Source: Health Assessment Intake (N = 148) and Family Information Form (N = 119).

[2] Interestingly, more participants reported housing as a pressing need (22%) than those who were experiencing unstable housing (14%), which indicate the range of needs associated with housing circumstances may extend beyond housing stability.

***29%** of BMU clients were experiencing **anxiety** and/or **depression** at intake*

Consistent with prior years, anxiety was the most common self-reported **health risk** (20%), followed by self-reported depression (15%), and moderate to severe depression according to the PhQ-9 assessment (12%). When combined, 29% of clients entered the BMU program with anxiety or depression.[3] About one in ten participants self-reported nutritional deficiencies (11%) or were 35 or older (10%). Compared with clients served in FY 2021-22, the proportion of participants reporting anxiety and/or depression at intake decreased (40% to 31%). Fewer participants reported nutritional deficiencies (16% to 11%) or had another child under one year of age (9% to 3%).[4]

Figure 6 — Most Common Health Factors Reported at Intake



Source: Health Assessment Intake (N = 148) and PhQ-9 Assessment (N = 146), though response rates may vary for each variable. Chart includes most common health factors reported and does not represent all characteristics measured.

More than half of the participants served in FY 2022-23 reported at least one socioeconomic (59%) risk or health (58%) risk. When combined, more than three quarters (78% unduplicated) BMU clients had one or more health and/or socioeconomic risk factor at intake (see below for detailed breakdown). Additionally, 30% of participants served in FY 2022-23 had one or more pre-existing medical condition (e.g., asthma, high blood pressure, diabetes, obesity).[5]

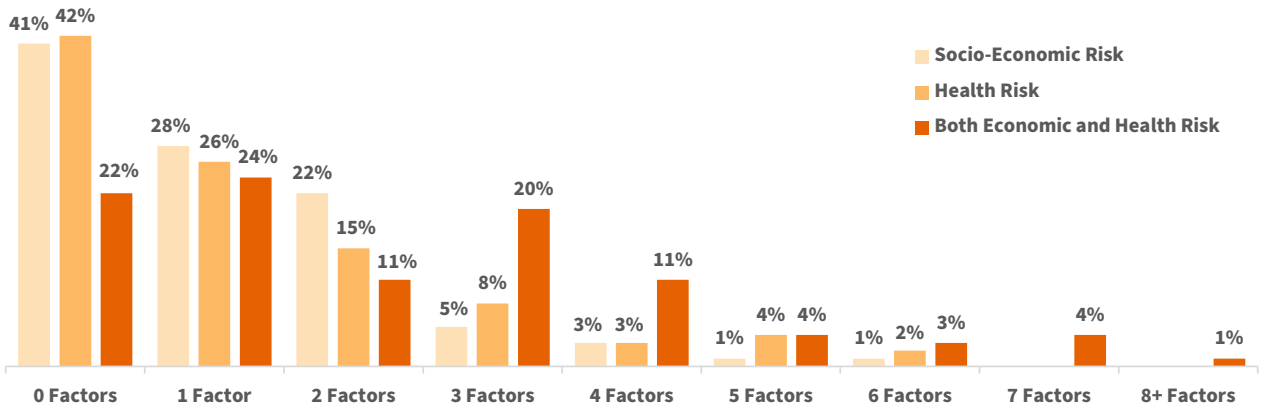
***78%** of BMU clients had at least one **health and/or socioeconomic risk** factor at intake.*

[3] Unduplicated count of self-reported anxiety, self-reported depression, and/or moderate to severe PhQ9 depression scores. Does not intend to represent the sum of these categories described independently.

[4] Multiple births spaced closely together can increase adverse outcomes for mothers and babies, including low birth weight and premature birth. https://www.mayoclinic.org/healthy-lifestyle/getting-pregnant/in-depth/family-planning/art-20044072

[5] Reported pre-existing medical conditions (e.g., autoimmune diseases, kidney disease, obesity, diabetes, high blood pressure) are not included in the reported counts of socioeconomic and health risk factors.

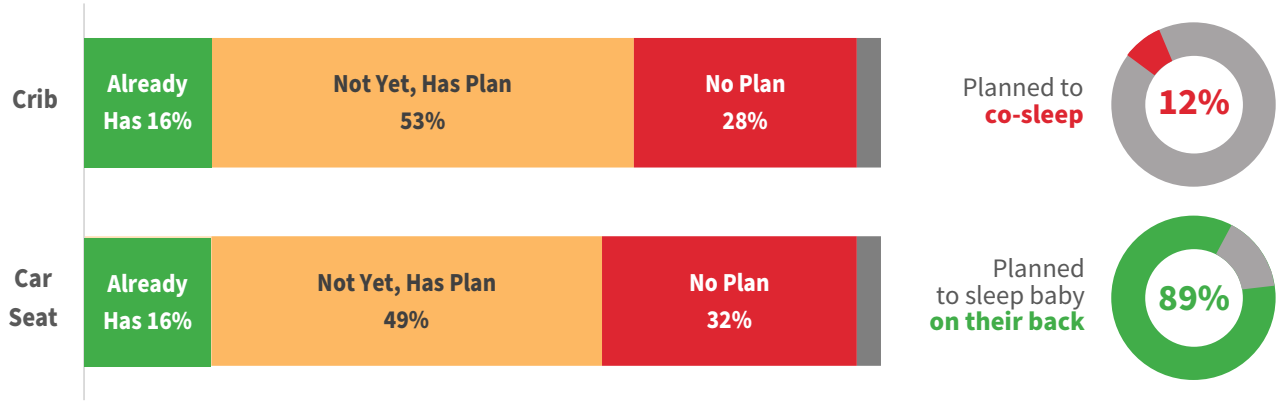
Figure 7 — Percentage of Clients Experiencing Socioeconomic or Health Risks, by Number and Type



Source: Health Assessment Intake (N = 148), Family Information Form (N = 119), and PhQ-9 Assessment (N = 146).

BMU pregnancy coaches also assess **infant safety preparedness** and provide support as needed. At intake, most participants did not yet have a crib (81%) or car seat (81%). Nearly one-third of participants reported they did not yet have a plan for a car seat (32%) and 28% did not yet have a plan for a crib. Additionally, about nine out of 10 (89%) participants planned to sleep babies on their back, while 12% of participants planned to co-sleep with their child at the time of intake. The proportion of mothers intending to co-sleep increased slightly compared with FY 2021-22 (9%) yet remained lower than FY 2020-21 (20%).[6]

Figure 8 — Plans for Infant Sleeping and Safety Reported at Intake



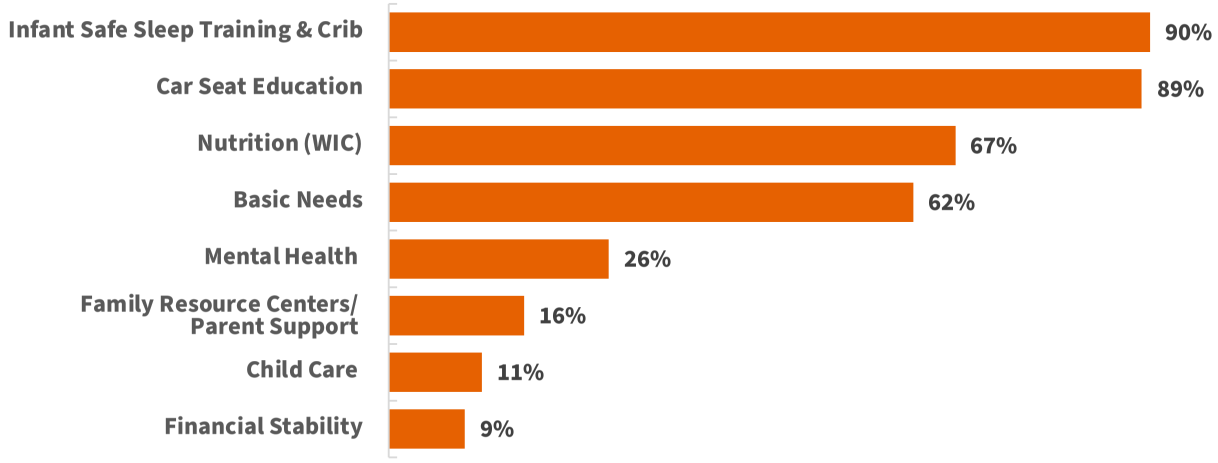
Source: Health Assessment Intake. N = 148

[6] Comparisons to behaviors following program support discussed in the "Changes in Risk and Protective Factors" section.

REFERRALS

BMU pregnancy coaches provide individualized support and referrals to services to reduce barriers and improve outcomes for both mother and her child(ren). Most participants received a referral for infant safe sleep training (90%) and car seat education (89%). Additionally, two-thirds (67%) received referrals for nutrition support (i.e., WIC), and 62% received a referral to basic needs support services. The most common referrals provided were consistent with FY 2021-22.

Figure 9 — Most Common Referrals Provided to BMU Clients



Source: BMU Service Referral Log. N = 142. Percentages reflect number of referrals provided out of all participants with a referrallog minus participants that did not receive a referral because they were already receiving services. Chart includes most common referrals and does not represent all referrals provided.

Because referrals and follow-ups are ongoing, the next section explores the **closed-loop referral status** for 88 clients who received at least one referral and exited the program in FY 2022-23.[7] Following a referral, pregnancy coaches connect the client to the referral site and follow-up with clients to identify if they were able to *receive services* from the provider.

For instance, 95% (81/88) of exited clients were referred for infant safe sleep training during their time in the BMU program. A HHF pregnancy coach provided Zoom and hybrid Safe Sleep Baby trainings or referred clients to other agencies, as needed. Among those who connected with a provider, 57% (21/37) received safe sleep training. In most instances, **at least half of all clients that contacted providers were able to receive services**. The launch of the First 5 Referral Portal in FY 2023-24 will strengthen families' direct connection to providers to further increase services received.

[7] As indicated by completion of an Exit Form during FY 2022-23 and at least one referral noted on the Service Referral Form completed during FY 2021-22 or FY 2022-23. Includes participants who exited for reasons other than program completion (e.g., lost contact or dropped out). As a result, closed loop data may not be complete for all participants.

Figure 10 — Type of Referrals Provided and Service Connections *among* Exited Program Participants

Referral Type	Referrals Provided		Referral Contacted		Received Services		Already Receiving
	#	%	#	%	#	%	#
Infant Safe Sleep Training and Crib	81	95%	37	46%	21	57%	3
Car Seat Education	81	95%	32	40%	19	59%	3
Nutrition (WIC)	45	76%	21	47%	15	71%	29
Basic Needs	54	69%	31	57%	17	55%	10
Mental Health	20	24%	12	60%	6	50%	4
Family Resource Centers/Parent Support	15	17%	9	60%	5	56%	2
Child Care	12	14%	8	67%	4	50%	0
Financial Stability	8	9%	5	63%	3	60%	2
Health (Insurance, Medical/Dental Home)	4	5%	1	25%	1	100%	3
Help Me Grow	4	5%	1	25%	1	100%	0
Breastfeeding (WIC)	3	4%	2	67%	0	0%	7
School Readiness	2	2%	1	50%	1	100%	0
Domestic Violence	2	2%	1	50%	1	100%	0
Previous High-Risk Pregnancy	2	2%	1	50%	0	0%	2
Alcohol, Tobacco, Drug	1	1%	0	0%	NA	NA	1
Home Visiting Program	1	1%	0	0%	NA	NA	0

Source: BMU Service Referral Log (N = 88). Because referrals are ongoing, service connections are assessed only for clients who have both a referral form and an exit form, therefore counts will not match referrals described above. *Referrals Provided* percentage denominator is exited clients minus clients who were already receiving services (no referral provided) which will vary from total for each item. *Referral Contacted* percentage denominator is total number of referrals provided. *Received Services* denominator is total number who contacted referral.

CHANGES IN RISK AND PROTECTIVE FACTORS

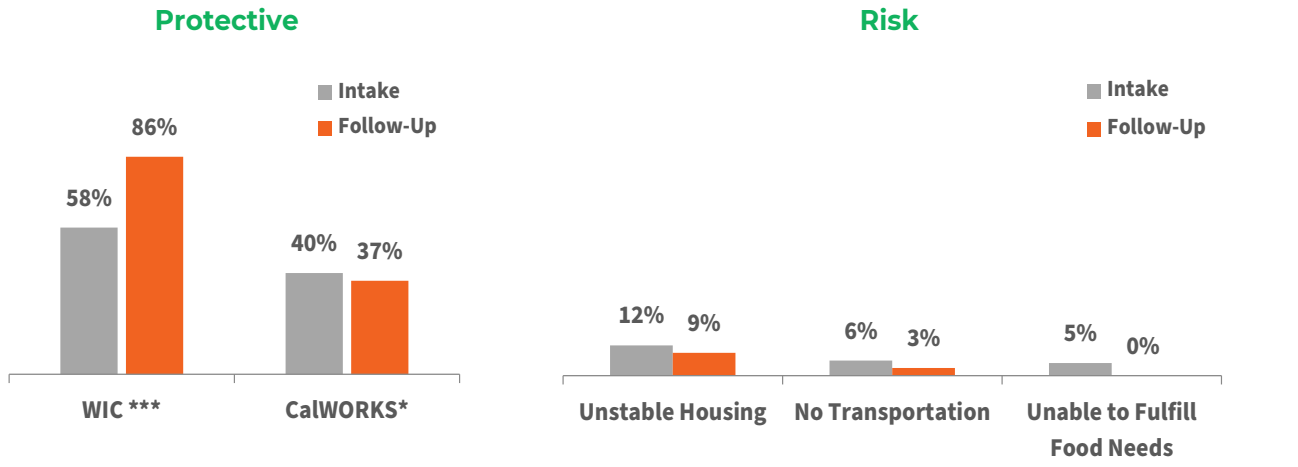
BMU Pregnancy Coaches provide a postpartum visit to check-in with participants, including a reassessment of mother's self-reported health, safety, and socioeconomic conditions. The following section explores changes in risk and/or protective factors between intake and the post-delivery follow-up (n = 65).[8] Overall, participants' enrollment in WIC as a **socioeconomic protective factor** significantly increased. At intake, 58% of the mothers who delivered were enrolled in WIC, while 86% were enrolled in WIC post-delivery. The proportion of clients receiving CalWORKs financial support remained relatively similar between intake (40%) and follow-up (37%).

"The support is great and I felt heard and understood during this birth and pregnancy."

– BMU Client

Participants' access to basic needs also improved, with decreases in the proportion experiencing **socioeconomic risk factors**. At follow-up, fewer participants had unstable housing (9%) or transportation needs (3%), and all participants were able to fulfill food needs. While changes were not statistically significant, reductions in risk factors continue to highlight the value of peer support on participants' connections to essential services for their families' stability and basic needs.

Figure 11 — Change in Reported Socioeconomic Factors from Intake to Follow-up Assessment



Source: Health Assessment Intake and Follow-up. Matched sets; N = 65. Ns for each item vary based on response rate to item in pre- and post-assessment. Statistically significant change (indicated on column names) reported as $p < .5$, ** $p < .01$, *** $p < .001$.

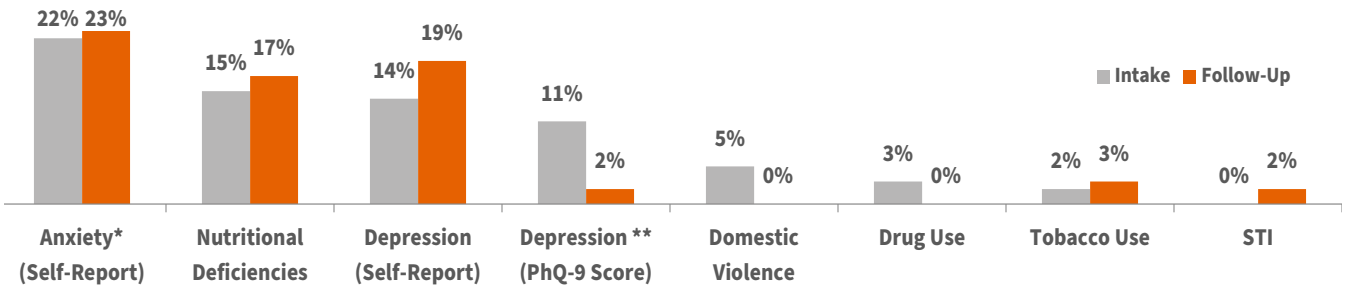
As for **health factors**, participants with both intake and follow-up assessments were most likely to report anxiety (22%), nutritional deficiencies (15%), and self-reported depression (14%). Additionally, about one in 10 (11%) had moderate to severe depression (according to PhQ-9 scores). At follow-up, moderate to severe PhQ-9 depression scores decreased significantly (2%).

[8] This section is limited to participants who completed a health assessment at intake, delivered, and completed a post-delivery health assessment, although ns may vary per question due to missing item data.

The proportion of mothers reporting anxiety, nutritional deficiencies, and self-reported depression increased slightly, although changes were not statistically significant. These changes may be due, in part, to increased access to health monitoring services and/or added post-birth stressors. A large portion of group level increases are due to new reports, rather than ongoing experiences. For instance, five of the 11 participants with nutritional deficiencies at follow-up also reported nutritional deficiencies at intake (a 50% decrease among the 10 participants reporting deficiencies at intake). The remaining six participants reporting nutritional deficiencies at follow-up (55%) were new reports, which may highlight increased awareness of nutritional needs through program support and connection to health services. Similarly, 14 participants self-reported anxiety at intake. At follow-up, only five of the same individuals also reported anxiety, while the remaining two-thirds (10/15 participants) were new reports.

Further, at follow-up, 12 participants self-reported depression compared with nine participants at intake. However, only four of the 12 reported depression at intake *and* follow up, while the remaining eight were new reports. Additionally, self-reported depression at intake and follow-up is distinct from the PhQ-9 assessment which uses an index of depressive symptoms to measure the severity of depression. Both measures are important to explore a participant's perceived experience of depression as well as the severity of these experiences), and the different directions at the group-level may be worth further consideration.

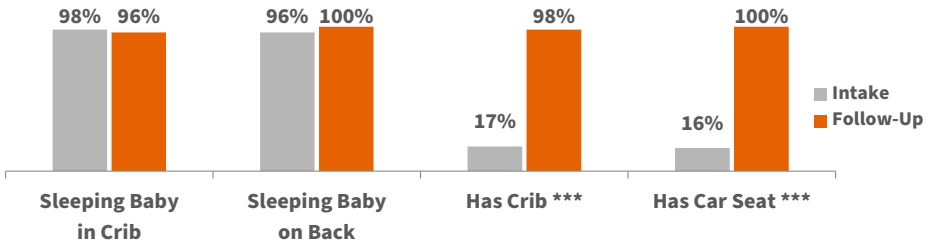
Figure 12 — Change in Reported Health Factors from Intake to Follow-up Assessment



Source: Health Assessment Intake and Follow-up Matched Sets (N = 65) and PhQ-9 Assessment Matched sets (N = 64). Statistically significant change (indicated on column names) reported as * $p < .05$, ** $p < .01$, *** $p < .001$.

Mothers showed positive improvements in their **preparedness for infant safety**. At intake, 16% had a car seat and 17% had a crib for their baby, which increased to 100% and 98% (respectively) by the post-delivery follow-up. Additionally, 100% of participants reported they slept their baby on their back, while there was a slight decrease in participants exclusively sleeping their baby in a crib.

Figure 13 — Change in Reported Infant Safety Practices from Intake to Post-Delivery Follow-Up



*At follow-up, **100%** of participants were* **sleeping babies on their back.**

Source: Health Assessment Intake and Follow-Up Matched sets; N = 65. Statistically significant change (indicated on column names) reported as * $p < .05$, ** $p < .01$, *** $p < .001$.

BIRTH OUTCOMES

There were 67 infants born to mothers served in FY 2022-23,[9] including 63 singletons and two sets of twins (four infants). Twelve of the 65 deliveries (18%) were C-Sections and 12 babies initially stayed in the NICU. For the fourth consecutive fiscal year, there were **zero newborn infant deaths** reported as of the mothers' postpartum follow-ups. There were also no stillborn births in FY 2022-23.

Of the 67 infants, 91% (61/67) were born at a healthy birth weight, 94% (63/67) were born full term, and combined, **88% (59/67) had an overall healthy birth (healthy birth weight *and* full term)**. On the other hand, six infants were born low birth weight or preterm (9%), while only two infants (3%) were born low birth weight and preterm. The proportion born preterm decreased compared with FY 2021-22 (11%, 8/71), while the proportion of infants born with low birth weight stayed about the same (10%, 7/71).

Similarly, BMU participants who received doula services during their time in the program had promising birth outcomes. Out of 27 mothers who received doula support during FY 2022-23, 14 delivered during the fiscal year. Among these 14 infants, only one was born preterm and low birth weight. The table below describes birth outcomes for infants. Further, a list of family socioeconomic and health characteristics is detailed in Appendix 1 for each birth with at least one adverse outcome.

Figure 14 — Birth and Perinatal Outcomes of Pregnancy Peer Support Clients

	All Infants (N = 67)		Twins (N=4)		Singletons (N=63)		Served by Doula (N = 14)	
Live Births	**67**	**100%**	4	100%	63	100%	14	100%
Favorable Outcomes								
Healthy birth weight	**61**	**91%**	4	100%	57	90%	12	86%
Full term birth	**63**	**94%**	4	100%	59	94%	13	93%
Healthy birth weight *and* full term	**59**	**88%**	4	100%	55	87%	12	86%
Unfavorable Outcome								
Low birth weight *(< 5 lb, 8 oz)*	**6**	**9%**	0	0%	6	10%	2	14%
Preterm birth *(< 37 weeks)*	**4**	**6%**	0	0%	4	6%	1	7%
Low birth weight *and* preterm	**2**	**3%**	0	0%	2	3%	1	7%
Newborn death	**0**	**0%**	0	0%	0	0%	0	0%
Stillborn	**0**	**0%**	0	0%	0	0%	0	0%

Source: Birth Outcomes – Baby and Post-Delivery Health Assessment. Served by Doula section refers to infants born to mothers who received any doula service, some of which may have been prenatal services only, not a doula-supported birth. Infants born to mothers served by doula are also represented in the total births.

[9] Also includes mothers who joined in FY 2021-22 who received services and delivered in FY 2022-23.

Longitudinal Outcomes of BMU Participants

A total of 76 infants were born in 2020 to mothers who received BMU service during the 2020 calendar year. Among these infants, there were **zero infant deaths** in the first year of life, compared to a rate of 10.7 per 1,000 African American births in 2020, countywide (see Appendix 3).

While COVID-19 may have affected the number of births and mothers served during the 2020 calendar year, zero infant deaths amidst the height of the global pandemic is particularly notable.

Note: data presented here includes countywide death rates for 2020 although countywide data are current as of 2021 in order to ensure 12-month outcomes for all infants born to mothers served. For instance, the 12-month observation period for an infant born in December 2020 would go through December 2021, meanwhile 2021 births would not yet have complete data available.

The figure below represents the prevalence of various protective and risk factors compared with the different profiles of birth outcomes: *Healthy births* (neither low birth weight, nor preterm), *One unhealthy birth outcome* (low birth weight or preterm), and *Both unhealthy birth outcomes* (low birth weight *and* preterm).[10] Among those with healthy births, nearly all were receiving regular prenatal care, were taking prenatal vitamins, and four out of five (83%) had initiated early prenatal care (first trimester). Nearly one-third reported one or more pre-existing medical conditions (32%) and high stress levels at intake (31%), and one in five self-reported anxiety at intake (22%) or were unemployed and looking for work (20%). Due to the small number of births with one or both unhealthy birth outcome, comparisons between groups are not described here. Full details are available in the figure below.

Figure 15 — Birth Outcomes and Health and Socioeconomic Factors Identified at Intake

Pregnancy Risk and Protective Factors from Intake	Healthy Births (N = 59)		Either LBW *or* Preterm (N = 6)		Both LBW *and* Preterm (N = 2)	
Protective Factors	**n**	**%**	**n**	**%**	**n**	**%**
Receiving Regular Prenatal Care	57	97%	6	100%	2	100%
Taking Prenatal Vitamins	57	97%	6	100%	1	50%
Prenatal visit in first trimester	49	83%	5	83%	1	50%
Enrolled in WIC	30	51%	4	67%	2	100%
Receiving CalWORKs	24	41%	2	33%	1	50%

[10] Interpret comparisons between groups with caution due to large difference in group size.

Pregnancy Risk and Protective Factors from Intake	Healthy Births (N = 59)		Either LBW *or* Preterm (N = 6)		Both LBW *and* Preterm (N = 2)	
Health Risks	**n**	**%**	**n**	**%**	**n**	**%**
One or more pre-existing medical condition†	19	32%	0	0%	2	100%
High Stress Level (quite a bit or very)	18	31%	2	33%	2	100%
Anxiety (Self-Report)	13	22%	1	17%	0	0%
Nutritional Deficiencies	9	15%	0	0%	1	50%
Prior Preeclampsia	8	14%	1	17%	0	0%
Depression (Self-Report)	7	12%	1	17%	1	50%
35 years or older	6	10%	0	0%	1	50%
Under 20 years old	5	8%	1	17%	0	0%
Moderate to Severe Depression (PhQ-9)	4	7%	2	33%	1	50%
Prior Gestational Diabetes	4	7%	1	17%	0	0%
2+ Prior Miscarriages	3	5%	1	17%	1	50%
Domestic Violence	2	3%	0	0%	1	50%
Has child under a year old	2	3%	1	17%	0	0%
Prior Preterm Birth(s)	2	3%	0	0%	0	0%
Prior Low Birth Weight Delivery	1	2%	1	17%	0	0%
Obesity	1	2%	0	0%	0	0%
Alcohol Use	1	2%	0	0%	0	0%
Tobacco Use	1	2%	0	0%	0	0%
Drug Use	0	0%	1	17%	1	50%
Prior Stillbirth(s)	0	0%	0	0%	0	0%
STI	0	0%	0	0%	0	0%
Socioeconomic Risks	**n**	**%**	**n**	**%**	**n**	**%**
Single, Unpartnered	16	27%	1	17%	0	0%
Unemployed, Looking for Work	12	20%	1	17%	1	50%
Unstable Housing	8	14%	0	0%	1	50%
Did Not Graduate High School	6	10%	1	17%	1	50%
No Transportation	3	5%	0	0%	1	50%
Unable to Fulfill Food Needs	3	5%	0	0%	1	50%
Program Factors	**M**	**SD**	**M**	**SD**	**M**	**SD**
Gestational Weeks at BMU Intake	18.7	7.6	15.2	6.9	23.0	7.1
Gestational Weeks at First Prenatal Visit [11]	8.8	3.5	7.0	3.5	10.0	5.7
Number of BMU Weekly Check-Ins	18.2	11.3	21.3	10.4	14.5	14.9

Source: Health Assessments (intake and post-delivery), Pregnancy Outcomes Form, and Service Records (N = 67)

† Pre-existing medical conditions include AIDS/HIV+, asthma, autoimmune disease, cancer, diabetes (Type I/II), high blood pressure, gastrointestinal diseases, kidney disease/UTI, obesity, polycystic ovary syndrome, thyroid disease, or other health condition.

[11] Results should be interpreted with caution – out of the 66 participants reporting having had a prenatal visit, 11 (16%) did not report the number of gestational weeks at which the appointment occurred.

"I didn't think/believe I was capable of being a good mom, but after attending a few groups and hearing other moms ultimately say it's going to be okay, ***I felt more comfortable and confident*** *about mommyhood. I felt good.* ***I knew I could do it*** *and everything was going to be ok."* – BMU Client

FACTORS ASSOCIATED WITH ADVERSE BIRTH OUTCOMES

Next, a series of statistical analyses were conducted to further understand factors associated with **healthy birth outcomes**. Three cohorts of BMU clients (FY 2020-21 through FY 2022-23) were combined to increase statistical power.[12] It is important to note that these analyses identify statistical relationships among characteristics, but do not imply causation. It is likely that other unmeasured factors contribute to the relationship between the characteristics described here.

This section explores the impact of various risk factors on three major outcomes:

- A binary outcome of whether the birth was **healthy** (neither LBW nor preterm) (yes/no).
- A numerical, continuous outcome of all reported **birth weights**.
- A numerical, continuous outcome of all reported **gestational ages**.

ASR entered correlated variables into a regression model to determine how each characteristic independently predicted birth outcomes in the larger model.[13] Regressions can discern if a variable can independently predict an outcome variable, over and above the influence of any other covariates. *Variables that were not marginally or significantly correlated with birth outcomes were not included in regression models since they did not have a statistical relationship or impact on one another.*[14]

The first regression explored factors independently predicting the dichotomous measure of whether the birth had both healthy outcomes (yes/no). A higher number of **check-ins with a BMU pregnancy coach**,[15] earlier initiation of **first prenatal visit**, fewer **pressing needs** at intake, and not having a **child under one year of age** each independently predicted having a healthy birth.

Having a higher number of ***BMU check-ins*** *significantly predicted the likelihood of a healthy birth as well as a higher gestational age.*

Secondly, results of a linear regression on the continuous birth weight variable highlighted that having two or more **prior miscarriages** and having a **prior low birth weight** birth each independently predicted having a lower birth weight.

Lastly, a linear regression was conducted on the continuous outcome of gestational age. Results displayed that having a higher number of **weekly BMU check-ins** and not having **gestational diabetes** in a prior pregnancy each independently predicted having a higher gestational age.

[12] Combined data sets resulted in a total sample size of 223 live births. Includes duplicate records when clients re-entered BMU for subsequent births and/or had multiple gestations (twins).

[13] Includes variables marginally and significantly correlated ($p < .10$).

[14] See Appendix 2 for additional analytical details, including outcomes of bivariate correlations for inclusion in regression models, as well as the statistical outcomes of the three multivariate regression models.

[15] Marginally significant at $p < .051$.

The table below displays the factors that were found to independently predict birth outcomes.

Figure 16 — Factors that Independently Predict Birth Outcomes[16]

Risk/Protective Factors at Intake	Healthy Birth *(Dichotomous; Y/N)*	Birth Weight *(Continuous)*	Gestational Age *(Continuous)*
	N = 220	*N = 223*	*N = 220*
Number of BMU Check-Ins	*M*		●
Prior Gestational Diabetes			●
First Prenatal Visit in 1st or 2nd Trimester vs. 3rd	●		
2+ Prior Miscarriages		*M*	
Number of Pressing Needs at Intake	●		
Prior Low Birth Weight Birth		*M*	
Has a Child Under One Year of Age	●		

Source: Health Assessment Form, Pregnancy Outcomes Form, and Exit Form. A green dot represents statistical significance of at least $p < .05$. M represents marginal significance at $p < .10$.

Overall, multiple risk factors correlated with having a healthy birth outcome. Importantly, the number of BMU check-ins independently predicted two of the three outcomes (healthy birth outcome and gestational age) with at least marginal significance ($p < .10$).

It is important to note that regression model outcomes exclude the unmeasurable structural level characteristics that may impact birth outcomes (e.g., adverse childhood experiences; the long-term toll of racism and/or socioeconomic conditions on the mother's health). Regardless, these results may provide guidance for program focus and improvements.

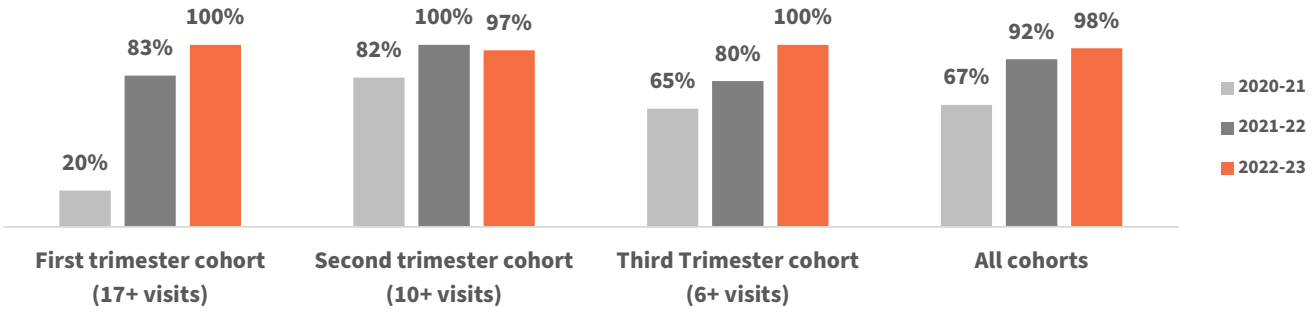
[16] Each regression model included variables correlated with the corresponding outcome. See Appendix 2 for full analysis details.

LEVEL OF PROGRAM COMPLETION

Program completion is defined as completing the minimum prenatal service requirements based on the trimester of entry[17] and a postpartum visit with the BMU pregnancy coach. Partial completion is defined as completing one but not both requirements. Participants who exited without completing either requirement are categorized as not completing the program.

Retention of program participants may be a challenge, particularly among those with several pressing needs. Additionally, residual effects of the COVID pandemic continue to pose challenges for families served by BMU. Despite this, **98%** of the 49 mothers who delivered and exited the program during FY 2022-23 **completed the minimum number of prenatal visits with a BMU coach** based on their trimester of entry.[18] The proportion of participants who delivered and exited who completed the minimum prenatal dosage has increased compared with FY 2020-21 (67%) and FY 2021-22 (92%).

Figure 17 — Prenatal Service Dosage Completion among Participants who Delivered during Fiscal Year, by Trimester Cohort of Entry



Source: Exit Form. Excludes clients who delivered but did not have a completed exit form, as the dosage status is unknown. N = 49

Another essential component of the Pregnancy Peer Support model is the **postpartum support provided by coaches**. These visits typically occur within 30 days of delivery and offer an opportunity for coaches to learn about the delivery, check in on mom and baby's well-being, complete postpartum paperwork, and provide any additional referrals needed. All participants (100%, 49/49) who delivered and exited during FY 2022-23 met with their pregnancy coach for at least one postpartum visit.

> *"This was my second go around with [my pregnancy coach] and she provided a lot of support to me."* – **BMU Client**

[17] Minimum prenatal service requirements are specified for each trimester at entry as women who enter the program earlier in their pregnancy have more time between program entry and anticipated delivery. The minimum service requirement for women entering during their first trimester is 17 prenatal visits; second trimester entries should complete ten or more prenatal visits; and third trimester entries should have six or more prenatal visits.

[18] N = 48/49. Includes participants who may have joined the program in the prior FY if delivered and exited during FY 2022-23. Excludes participants who exited during FY 2022-23 but delivered in FY 2021-22.

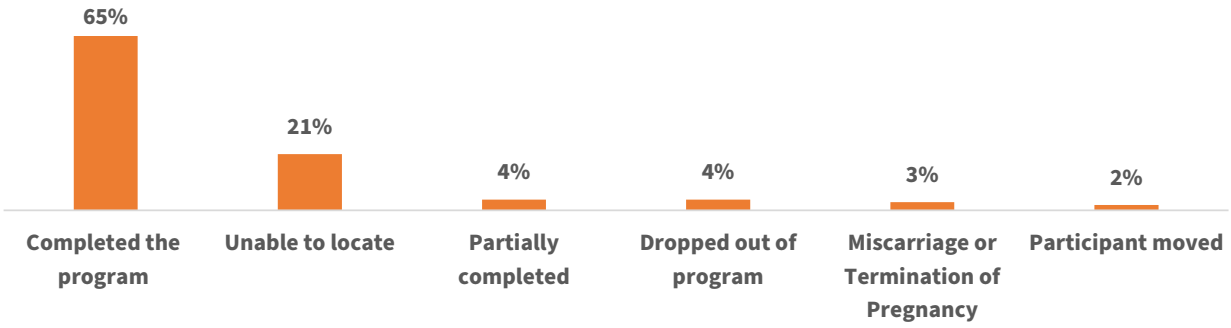
At follow-up, 90% of infants born in FY 2022-23 had attended a well-baby visit with a pediatrician – an increase from 80% in FY 2021-22. The proportion of babies exclusively breastfed in the hospital (79%, 53/67) also increased compared with FY 2021-22 (68%) and exceeds the state and Sacramento County averages for African Americans.[v] Similarly, nearly three-quarters of infants born in FY 2022-23 (72%, 48/67) were exclusively receiving breast milk at follow-up, a substantial increase compared with FY 2021-22 (51%, 36/71). Overall, **nearly four out of five infants born to mothers served in FY 2022-23 (78%) were receiving breastmilk**, exclusively or in combination with formula, at follow-up. This highlights the effectiveness of the program's focus on lactation focus via "Titty Talks" support groups, the Lactation Support Specialist, and pregnancy coaches.

> *"Support matters and [my pregnancy coach] was my ROCK."* **– BMU Client**

Among *all participants who exited* the BMU program in FY 2022-23 (regardless of exit reason),[19] nearly two-thirds (65%, 64/98) completed both the minimum number of prenatal visits and a postnatal visit with their coach. An additional 4% exited after completing one of the two requirements.[20] One in five (21%) exits were participants who were unable to be located. The remaining exited participants either dropped out (4%), miscarried or terminated the pregnancy (3%), or moved outside of the service area (2%) prior to program completion. The proportion of participants who were unable to be located/lost contact nearly doubled compared with FY 2021-22 (11%, 11/96).

In FY 2022-23, two veteran BMU coaches transitioned out of HHF, which may have contributed to increased instances of lost contact as some clients find it challenging to connect with a new coach midway through their pregnancy. BMU plans to implement a new strengths-based approach to screen and match clients in FY 2023-24 to increase retention. Additionally, mostly virtual interactions among BMU staff have increased challenges for new coaches to gain detailed insights and best practices for navigating client relationships. Leadership continues to implement strategies to increase opportunities for staff engagement (e.g., one-on-one check-ins, discussing successes/challenges) as they onboard and train new coaches.

Figure 18 — Status at Program Exit



Source: BMU Exit Form. N = 98.

[19] May include participants who did not receive services during FY 2022-23 as some individuals exited due to lost contact or drop out between fiscal years.

[20] Three out of four completed the minimum prenatal visits but did not complete a postpartum visit with pregnancy coach.

CLIENT SUCCESS STORY: BLACK MOTHERS UNITED

Viviane (fictional name) was 29 years old and four months pregnant with her first child when she saw a BMU outreach table set up at her local Walmart. Since she did not have much family support in the area, she was excited to get involved with BMU for needed support and supplies. Viviane enrolled in the BMU program and received pregnancy coaching and lactation support services. She also attended BMU's Mommy Mingle pregnancy support group and received referrals for nutrition/breastfeeding, basic needs, safe sleep education, and car seat education.

Viviane explained to her pregnancy coach that that her finances had taken a hit and she was stressed about getting the things she needed for her baby before she delivered. Her pregnancy coach discussed with her how stress can sometimes cause preterm labor and gave her advice on how to alleviate her stress. Her pregnancy coach was also able to help reduce Viviane's stress by connecting her with the resources that she needed and gave her some baby essentials (such as a car seat, diapers, wipes).

Viviane was diagnosed with pre-eclampsia and felt that her pregnancy coach helped reassure her and provided support to manage this added stress. Viviane delivered early at 29 weeks via an emergency C-section due to the pre-eclampsia, and her baby had to spend about six weeks in the NICU. During this time, her pregnancy coach and lactation consultant encouraged her to continue pumping breast milk and explained the benefits of breastfeeding. Viviane felt that her ability to provide breast milk was helping to give her baby strength. Viviane continued to receive postpartum support from her Pregnancy Coach, as needed until she exited the program at four months postpartum.

> *"**BMU helped me through my difficult pregnancy** … [and] was there to provide anything that I needed to prepare for my daughter coming early. … I do not have much family out here and with BMU, it was my back up support like family. BMU has **made me proud to be an African American mother.**"* – "Viviane," BMU Participant

OPPORTUNITIES FOR IMPROVEMENT

The BMU program continues to show promising results for participants served, particularly in comparison to countywide rates of adverse birth outcomes and recurring rapport and community-building (e.g., the proportion of participants who learned of the program through BMU outreach and the proportion participating for subsequent pregnancies). Her Health First continues to seek sustainable funding activities to enhance and expand Doula and Lactation support services to further support positive birth and breastfeeding outcomes. To take the program even further, the BMU program could consider the following:

01 Improve client **retention** by utilizing a strengths-based approach for screening and matching clients with coaches that will best meet their personality and pregnancy needs and seek additional ways to obtain and include client feedback in program plans.

02 Increase **outreach, enrollment, and program access**. Strategies may include:

a. More concrete referral pipelines with OB/Gyn and medical providers in Sacramento.
b. Reaffirming established partnerships and utilizing fresh approaches to engage untapped potential referral partners and revitalize BMU's presence in the Sacramento community.
c. Identify gaps or additional outreach strategies needed to reach areas or populations which may not currently be accessing the program as easily as others.

03 Provide **training and development opportunities** to assist coaches in establishing trusted relationships that enable high frequency of weekly check-ins to promote positive birth outcomes. This includes utilizing a variety of typical and more innovative methods (call/text, video chat, direct messaging, in-person, events, and support groups).

04 Strengthen relationships between BMU coaches and medical providers to ensure that clients with previous adverse birth outcomes, prior miscarriages, and high-risk pregnancies receive **collaborated assistance** with navigating medical services, doctor appointments, and managing care.

05 In partnership with First 5 and external evaluator, Applied Survey Research, expand efforts to measure and promote an understanding of **structural racism** as the root cause of adverse racial disparities impacting African American mothers and babies.

06 Increase support from coaches to "close the loop" on **referrals** by utilizing First 5's new Referral Portal to directly/immediately connect clients to community resources, building relationships with organizations to support "warm handoffs," and further empowering participants to follow up on referrals provided.

Family Resource Centers

Birth & Beyond supports a strengths-based approach, with the goal of decreasing child abuse and neglect through prevention and early intervention.

First 5 Sacramento provides funding for Birth & Beyond Family Resource Centers (FRCs)[21] with the goal of decreasing child abuse and neglect through prevention and early intervention. FRCs offer a wide range of services, including social-emotional learning and supports, crisis intervention, group parenting education workshops, and home visiting. FRCs are strategically located in neighborhoods characterized by high birth rates, low income, and above average referrals to the child welfare system for child abuse and neglect. The locations of the FRCs tend to coincide with neighborhoods identified by the Blue Ribbon Commission as the focal areas for the RAACD initiative.

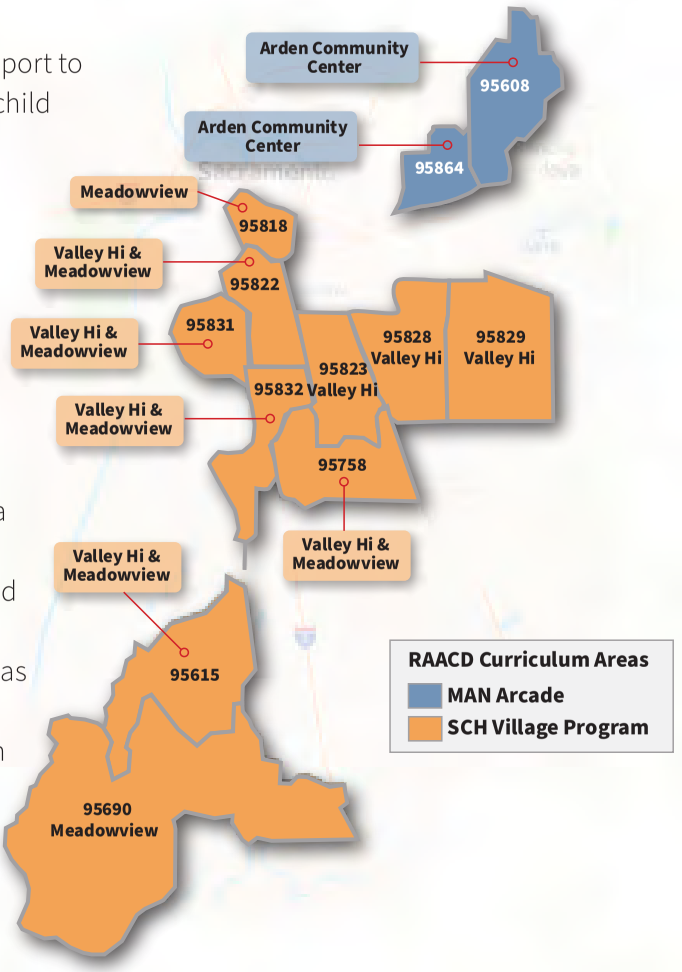
In FY 2013-14, the Commission funded more equitable prevention and early intervention services for African American families, which led to the expansion of Family Resource Centers in the Arden Arcade and Meadowview/Valley Hi communities.

Beginning in FY 2021-22, First 5 began intentionally tracking these services as part of the larger RAACD initiative to offer a comprehensive look at services targeted by this funding.

[21] FRCs are implemented by seven community-based organizations that aim to prepare staff with the skills and competencies to serve families through home visiting, parenting education workshops, crisis intervention, and social-emotional learning and supports in nine Sacramento County neighborhoods.

While all nine Birth & Beyond FRCs provide crucial support to Sacramento families with the intention of decreasing child abuse and neglect, **the following sections describe efforts from the two FRCs that received RAACD-funding**, Mutual Assistance Network Arcade Community Center (MAN Arcade)'s Stronger Families Stronger Generations (SFSG) program, and the Sacramento Children's Home Village Program (serving Valley Hi and Meadowview.)[22]

In total, **370 adults and 203 children** participated in RAACD-funded activities at these locations, including a total of 507 home visits and 215 parenting education workshops. While the majority of participants identified within the Black/African American or multiracial focus populations, a small portion of participants identified as some other race/ethnicity (6%)[23] as no one is turned away from participation in RAACD parenting education classes and light touch activities.



[22] Information about all nine FRCs can be found in the Birth & Beyond Annual Report.

[23] May be a slight underestimation as some multiracial participants may not be Black/African American but a more detailed breakdown of racial/ethnic composition of multiracial families are not available.

RAACD-funded services are reaching a high need, high risk population. Among those receiving RAACD-funded services, 333 caregivers (90%) completed a Family Information Form (FIF) at intake. Nearly two-thirds (64%) had accessed food/nutrition services in the six months prior to intake, and more than half (54%) reported a family income of $25,000 or less (see figure below).

Figure 19 — RAACD Funded Participants Family Information at Intake (Caregivers)

	FY 2022-23
# Caregivers Served with Recent Family Information Form (Unduplicated)	**333 (90%)**
Support Services Used in Six Months Prior to Intake	
Food/Nutrition (e.g., WIC, CalFresh, Food Bank)	64%
FRC Services	21%
Parenting Education/Support	14%
Home Visits	11%
Perceptions of Support and Hope: % (n) who agree or strongly agree (at intake)[24]	
I know of safe places for my child to play that are outside of my home	81%
I involve my child in day-to-day tasks for our family	75%
I have people in my life who provide me with support when I need it	71%
I am able to handle the stresses of day-to-day parenting	70%
I know what to expect at each stage of my child's development	68%
I know which program to contact when I need help with basic needs	62%
I am able to take a break and do something enjoyable at least once a week	62%
I know which program to contact when I need advice on raising my child	60%
I attend events in my community with my child	50%
I find myself in stressful situations at least once a week	41%
In the past two weeks I have felt down, depressed, or hopeless	26%
Family Income[25]	
Less than $15,000	39%
$15,000 - $25,000	15%
$25,001 - $50,000	10%
$50,001 - $75,000	4%
$75,001 or more	1%
Don't Know/Prefer not to Say	31%

Source: Birth & Beyond Family Information Form – Caregiver and Family Information Form - Parent (recent FIFs among those who received RAACD-funded services during FY 2022-23). N = 333 although ns may vary by question due to missing data/non-response. Percentages include participants who have valid responses, by question.

[24] Percentages are out of those who have responses to each question.

[25] Percentages include participants with valid income data only (N = 323).

Family Information Forms were also available for 184 (90%) children engaging in RAACD-funded activities during FY 2022-23. Responses showed that **most children were current on their well-child visits and had a strong support network**. For instance, 88% had a well-child visit with a pediatrician in the last 12 months. two-thirds had a hearing (67%) screening, and 63% had a recent vision screening. Most children (94%) had at least two non-parent adults in their lives who take a genuine interest in them, and most families had one-on-one play time with the child (84%), shared meals together (81%), told stories or sang songs (78%), and talked together (76%) between five and seven days a week.

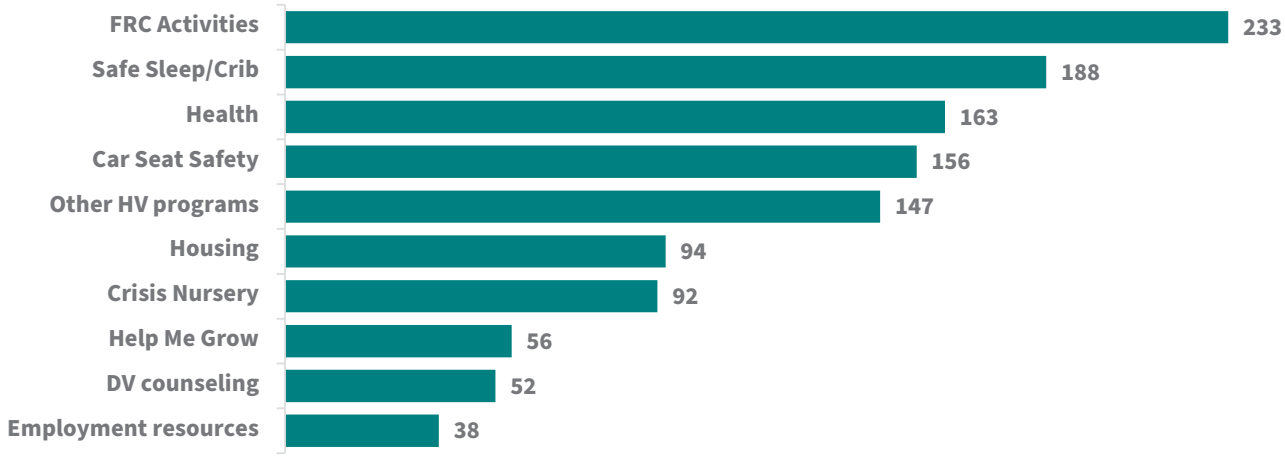
Figure 20 — RAACD-Funded FRC Participants Family Information at Intake (Children)

	FY 2022-23
# Children Served with Recent Family Information Form (Unduplicated)	**184 (90%)**
Health Services and Supports Used in Six Months Prior to Intake	
Has had a well-child health check-up in the past 12 months	88%
Has had a hearing screening in the past year	67%
Has had a vision screening in the past year	63%
Has had a developmental screening in the past year	42%
Has seen a dentist in the past six months	36%
Family Activities and Social Support (as of intake)	
Child has at least two non-parent adults who take a genuine interest in them	94%
Played one-on-one with child *(5-7 days per week)*	84%
Sat and shared a meal together *(5-7 days per week)*	81%
Told stories or sang songs together *(5-7 days per week)*	78%
Talked with child about things that happened during the day *(5-7 days per week)*	76%
Practiced the same bedtime routine *(5-7 days per week)*	73%
Read together at home for 10+ minutes *(5-7 days per week)*	49%

Source: Birth & Beyond Family Information Form – Child (recent FIFs among those who received RAACD-funded services during FY 2022-23). N = 184 although Ns may vary by question due to missing data/non-response. Percentages include participants who have valid responses, by question.

Additionally, families engaging in RAACD-funded activities and curriculum are connected to additional services at FRCs and other community-based support systems based on their specific needs. Participants most often received referrals for other FRC activities/services, safe sleep training/crib, health services, and car seat safety resources.

Figure 21 — Top Referrals Provided to Participants in RAACD-funded Services

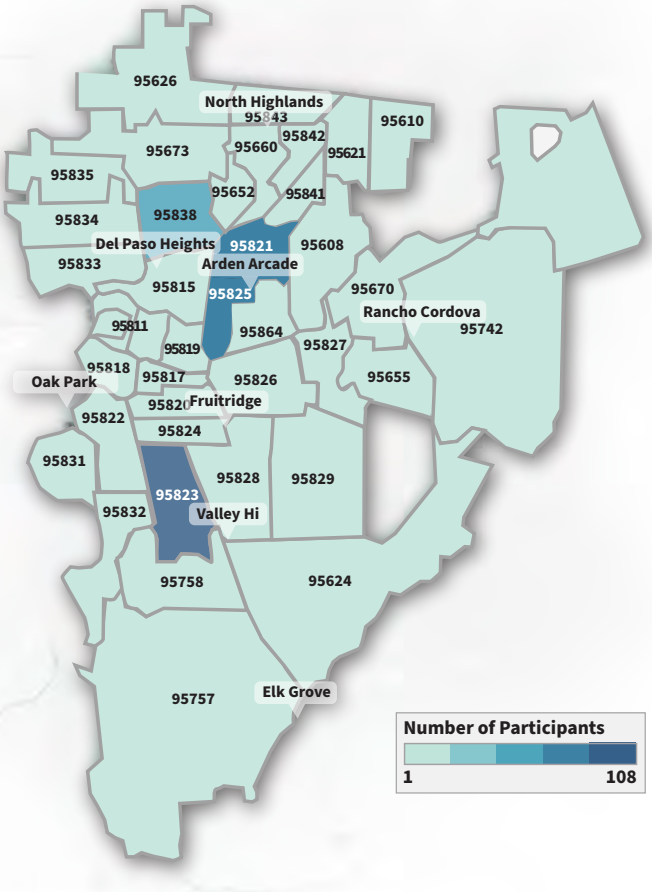


Source: Service Records, Persimmony. Counts are duplicated as participants may receive more than one referral of each type.

Figure 22 — Location of FRC Participants Served by RAACD Curriculum and/or Activities

The map shows the number of clients engaged in RAACD-funded FRC activities at MAN Arcade and SCH Village Program in FY 2022-23, by zip code. Participants primarily resided in Valley Hi (95823) and Arden Arcade (95821) zip codes, likely due to the proximity to the two FRCs. However, participants had addresses across Sacramento County.

Source: Service Records. N = 558. Map excludes participants who did not have an address on file.



PARENTING EDUCATION

Parent education workshops serve as the primary prevention strategy to reduce risk for child abuse and neglect and enhance parenting skills by building parent efficacy, empathy, and increasing knowledge of child development and safety. Parenting education includes group-based workshops conducted virtually and in-person, using evidence-based curricula specifically designed to be culturally responsive for Black/African American families. The MAN Arcade and SCH Village Program utilized the Effective Black Parenting Program (EBPP) as well as the Make Parenting A Pleasure (MPAP) curricula.[26]

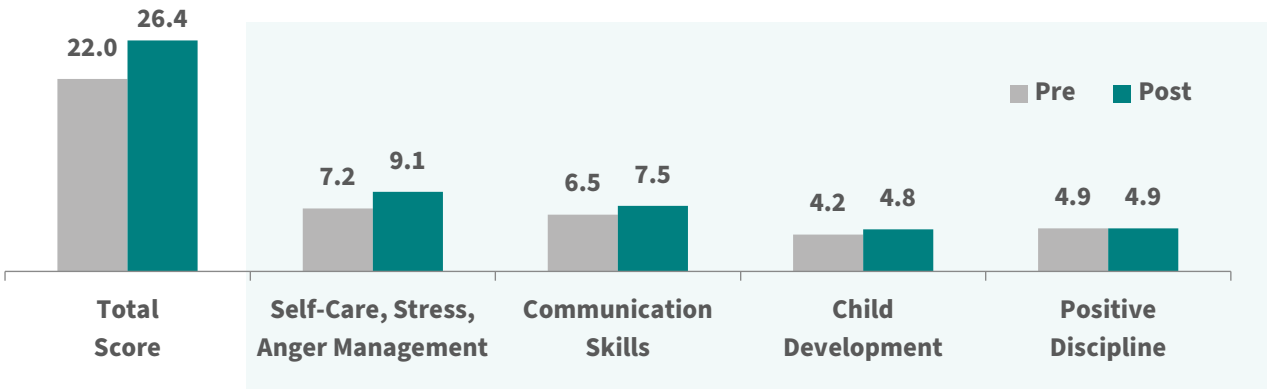
Families who were court-mandated to attend parenting education classes elected to engage in the MPAP curriculum as EBPP was not yet court approved as of FY 2022-23

Make Parenting A Pleasure (MPAP)

Make Parenting A Pleasure (MPAP) is a court-approved, research- and evidence-based parenting curriculum targeting highly stressed families to improve the protective factors, increase knowledge of parenting skills, and reduce the risk of child abuse and neglect. MPAP is group-based and discussion-focused and typically consists of 13 modules. This curriculum measures key topics including self-care, stress and anger management, understanding child development, communication skills, and positive discipline.

In FY 2022-23, 11 unduplicated parents/caregivers participated in a total of 126 MPAP classes at MAN Arcade. The number of MPAP participants decreased by about half (-48%) compared with FY 2021-22. Eleven participants completed both a pre-test and a post-test upon course completion.[27] **Ten out of 11 participants improved their scores in at least one domain**. Among the total group, self-care, stress, and anger management had the largest average increase, followed by improved communication skills.

Figure 23 — Average Scores for Make Parenting A Pleasure Curriculum, Pre and Post Tests

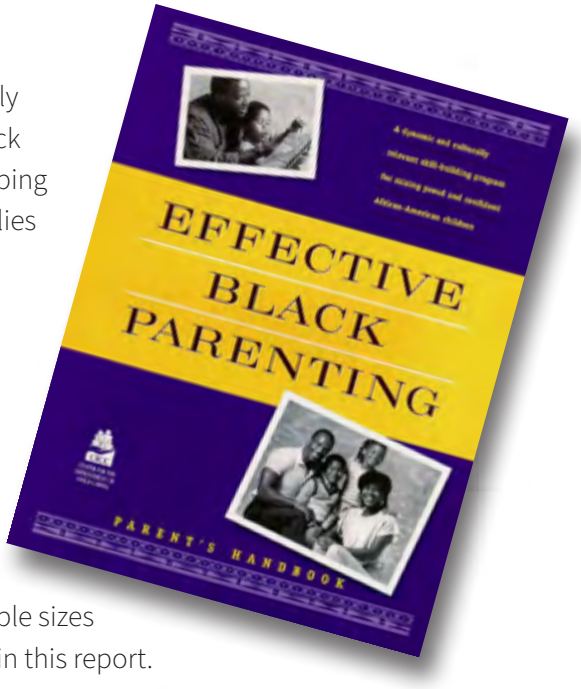


Source: MPAP Pre and Post Test Scores. N = 11. Scores for each domain range from 1 = High Risk to 10 = Low Risk. Total score represents the average of participant's totals including all four domains. Due to small sample sizes, significance levels not calculated.

[26] As of FY 2022-23, the EBPP curriculum was not yet approved for families attending parenting classes to meet court-mandated requirements. MPAP served as a supplement to meet the needs of these families. MPAP was used at MAN Arcade this FY.

[27] Includes duplicates – two individuals completed the course multiple times within the fiscal year, while two individuals did not have a pre- and post-test completed.

Effective Black Parenting Program (EBPP)



The Effective Black Parenting Program (EBPP) is a group-based, culturally sensitive, and culturally specific training program designed to serve Black and African American families. The goals of the program include developing parenting skills, promoting family pride and cohesion, and helping families cope with the negative effects of racism. Skills taught include setting family rules, using positive reinforcement as a reward for respectful and desirable child behavior, and using corrective consequences to address undesirable and disrespectful childhood behavior. EBPP provides activities for families to practice the skills learned in the session as well as information on drug use, single parenting, and child abuse.[vi]

Implementation of the EBPP curriculum continued into 2022-23. During the fiscal year, **six participants engaged in a total of 79 (duplicated) EBPP parenting education sessions**. Due to small sample sizes and ongoing implementation efforts, outcomes data are not presented in this report.

HOME VISITING

RAACD-funded FRCs provided families with home visiting based in the participant-centered Effective Black Parenting Program (EBPP) curriculum.[28] The addition of the EBPP home visiting curriculum has been highly regarded by participants and staff as a curriculum that is culturally responsive to the needs and experiences of Black families. Parents have shared with staff that the curriculum gives good guidance for fostering strong, healthy self-esteem, and pride in Blackness.

*EBPP home visiting has helped families foster strong, **healthy self-esteem**, and **pride in Blackness**. Home visitors have also built **deep connections with families** beyond the curriculum.*

In FY 2022-23, SCH Village Program and MAN Arcade home visitors provided a total of 872 home visits to 114 African American or multiracial parents. Additionally, staff completed 48 new intakes into the EBPP curriculum during the fiscal year.[29] Program staff worked with families to identify immediate needs (using the Family Development Matrix),[30] develop family-led goal plans, provide referrals/support to access services, and identify participants' protective factors. Throughout the fiscal year, home visitors developed deep connections with enrolled families which has enabled them to provide more well-rounded support beyond the curriculum materials. For instance, home visitors have been able to accompany parents to school meetings, court dates, assist with housing needs, and help provide necessary transportation.

During FY 2022-23, the MAN SFSG Program measures program impact and family progress using the 40-question EBPP pre- and post-test as well as the Protective Factors Survey -2 (PFS-2),[31] while participants of the SCH Village Program completed the EBPP assessment as well as the Family Development Matrix (FDM). Due to ongoing implementation and outreach, limited assessment data are available for FY 2022-23. However, the following information offers preliminary highlights based on available data.

Eighteen participants completed a pre- and post-EBPP assessment. Nine participants (50%) had a net improvement in their responses to questions related to parenting behaviors.[32] Scores ranged between 1 "Strongly Disagree" to 4 "Strongly Agree." On average, the group had the largest improvements in the statements "As long as children follow family rules, it is not necessary to give them reasons why they should follow the rules," (desired decrease), "Sometimes it is necessary to change the child's environment to keep them from breaking the rules" (desired increase), and "Praise works best when it is used often" (desired increase).

[28] In FY 2021-22, willing families using the Nurturing Parenting Program (NPP) curriculum were transitioned to a modified Parents as Teachers (PAT) curriculum to a more culturally responsive version for Black/African American families. However, various staffing, training, and documentation challenges led MAN Arcade to decide that the PAT model was not the ideal curriculum for the program in practice. As of the end of FY 2021-22, MAN was transitioning from the PAT curriculum to EBPP as the RAACD-funded home visiting model.

[29] Count of EBPP HV Case Records. Includes duplicate individuals who may reenter program at different points in time, and not intended to represent the total number of individuals who received RAACD-funded home visits during the fiscal year.

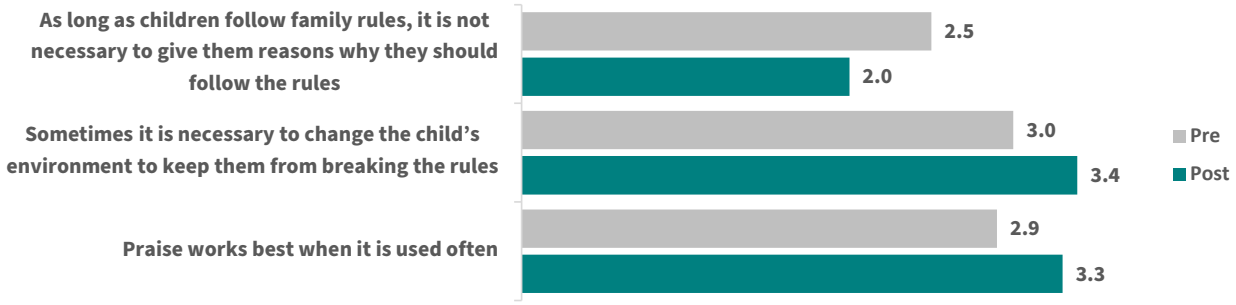
[30] FDM was implemented for Crisis Intervention Services and RAACD home visiting in late FY 2021-22 and was utilized in until the creator terminated the site and partners' utilization of the tool on June 30, 2023. As a result, limited follow-up data are available as staff began to transition case management families to a new assessment tool and goal planning procedure.

[31] In FY 2022-23 individual responses to the PFS-2 pre- and post-tests were not entered into the online database.

[32] Note the EBPP assessment does not have established domains or groupings of measures. For the purpose of this preliminary exploration of impact, only the 13 questions rated on a scale of Strongly Disagree to Strongly Agree are included here. This excludes the 25 true-false or yes-no questions on the assessment.

The two measures with the largest change were related to “family rules.” The EBPP curriculum’s focus on rule setting in "Modern Black Self-Discipline" includes focuses on the value of positive discipline, "appeal[ing] to their minds, not their behinds" (EBPP Curriculum Session 5). As the curriculum describes, "In Traditional Black Discipline, rules were often used to make children afraid of their parents." On the other hand, in Modern Black Self-Discipline, "rules are intended to make children feel safe and secure rather than fearful."

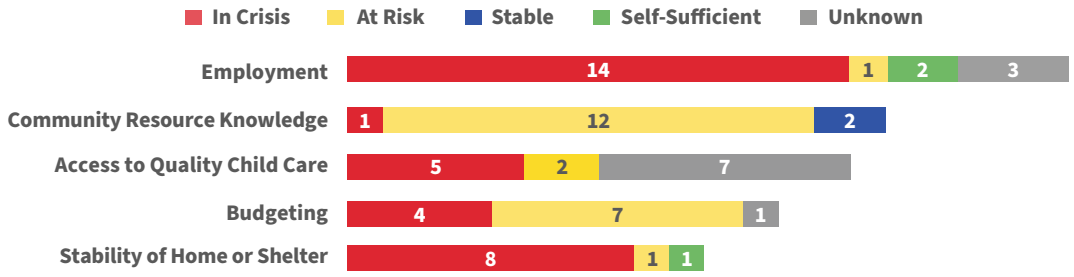
Figure 24 — Top Areas of Improved Perceptions of Parenting Practices between Pre- and Post-Test



Source: EBPP Pre- and Post-Test Matched Set. N = 18. Includes group averages for questions with the largest average improvements (among the questions rated on a scale of 1 = *Strongly Disagree* to 4 = *Strongly Agree*.

Additionally, 45 participants completed an initial FDM assessment with their home visitor to identify key needs and focal areas of interest for their goal plan. The most commonly selected focal areas among these participants were quality of employment status (20); knowledge of community resources (15); access to quality child care (14); budgeting skills and knowledge of financial resources (12); and stability of home or shelter (10). The figure below shows the number of participants selecting the top focal areas by level of need. For instance, 14 of the 20 participants who selected employment as a focal area were “in crisis” as described by “I am unemployed and have difficulty getting a job” at their initial visit.

Figure 25 — RAACD Home Visiting FDM Top Focal Areas by Self-Reported Level of Need



Source: FDM database, initial assessment among MAN Home Visiting participants (N = 45). Includes only the top selected focal areas rather than all possible categories of focus. Participants rated their level of need using categorical responses which ranged from *In Crisis to Self Sufficient*. Chart presented here only includes responses of participants for whom the topic was selected as a focal area for case management.

Participants developed goal plans with their intervention specialist, however, follow-up data are not presented here due to limited documentation resulting from the closure of the FDM tool between visits for several participants.

CRISIS INTERVENTION SERVICES (IS)

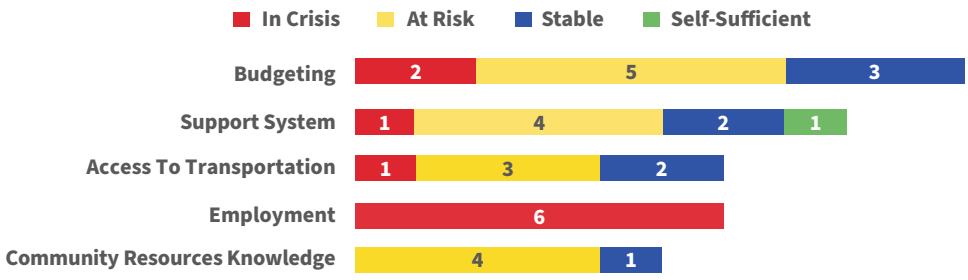
RAACD-funded FRCs also provide intensive, short-term case management to parents/caregivers who are experiencing an urgent crisis such as homelessness, food insecurity, domestic violence, or substance abuse to mitigate the crisis and help the family stabilize. Once a family's crisis is stabilized, they are connected to the other service strategies offered through the FRC, such as social and emotional supports, parenting classes, and home visiting.

MAN Arcade and the SCH Village Program received 205 incoming IS referrals during FY 2022-23,[33] More than half of IS referrals (114/205, 56%) were from a B&B staff, volunteer, or event, and one in five (22%) were self-referrals. In total, 86% of referrals received IS services, and among those served (n = 177), 153 (86%) completed their services. Only a small number referred during this fiscal year dropped out, moved, or were unable to be located.

In total, the RAACD-funded FRCs provided 310 intervention services to 153 adults during FY 2022-23. Services include the light touch (level 1) and more intensive case management for those with higher needs (level 2). Among the Level 2 IS participants receiving case management, 26 completed an initial assessment using the Family Development Matrix (FDM).[34] Part of this assessment included identifying focal or areas for goal planning and support based on the degree of need and the family's preferences.

The most commonly selected focal areas among IS case management participants were budgeting skills and knowledge of financial resources (10), quality of support system (8), access to transportation (6), quality of employment status (6), and knowledge of community resources (5). The figure below summarizes the number of participants selecting the top focal areas by the participants' level of need. For instance, six out of the 26 participants selected employment as a focal area. Among them, all six were "in crisis" as described by "I am unemployed and have difficulty getting a job" at their initial visit.

Figure 26 — RAACD IS Case Management FDM Top Focal Areas by Self-Reported Level of Need



Source: FDM database, initial assessment among IS Case Management participants (N = 26). Includes only the top selected focal areas rather than all possible categories of focus. Participants rated their level of need using categorical responses which ranged from *In Crisis to Self Sufficient*. Chart presented here only includes responses of participants for whom the topic was selected as a focal area for case management.

Participants developed goal plans with their intervention specialist, however, follow-up data are not presented here due to limited documentation resulting from the closure of the FDM tool between visits for several participants.

[33] Includes duplicate individuals when referred at different times throughout the fiscal year.

[34] FDM was implemented for Intervention Services and RAACD home visiting in late FY 2021-22 and was utilized in FY 2022-23 until the creator terminated the site and partners' utilization of the tool. As a result, limited follow-up data are available as staff began preparation to transition case management families to a new assessment tool and goal planning procedure.

SOCIAL AND EMOTIONAL LEARNING AND SUPPORT (SELS)

*247 caregivers and 133 children participated in **1,023 SELS services.***

First 5 provides RAACD funds for FRC supports for African American families with a focus on building strong, resilient families and increasing positive childhood experiences. These activities facilitate social/community engagement to reduce isolation, child maltreatment, and trauma. Social and Emotional Support and Learning activities include "light touch" child development activities, child safety workshops, resource and referral, stress reduction activities and peer support groups, and more.

In FY 2022-23, MAN Arcade and the SCH Village Program provided a total of **1,023 RAACD-funded SELS services**, including but not limited to Sistah to Sistah and Colorful Connections group meetings, distribution of resources (e.g., diapers, backpacks), Family Hui Peer Support, MRT presentations, anger management courses, and other pop-up activities and outreach. Additionally, 68 parents/caregivers received transportation services, and 15 families received Play Care services for their children while attending various events such as Family Hui group sessions, Self Care Club, the Motherly Postpartum Group, or Community Baby Shower.

CLIENT SUCCESS STORY: HOME VISITING

Serena (fictional name) is a young mother who was referred to the Village program by her healthcare provider because she had a new baby and was dealing with complicated life situations. She initially participated in home visiting through the Village program in May 2021. At this time, she received Safe Sleep Baby education workshop, poison prevention, and car seat education, and began working toward gaining appropriate tools to provide a safe space and environment for her children.

Serena's life circumstances made it difficult for her to maintain a reliable phone service and, as a result, she lost touch with the Village program staff. However, she soon got reconnected and restarted home visiting services in July 2022. During this time, Serena maintained regular weekly visits, engaged in parent-child bonding activities, and shared ways she encourages her child's development. Serena shared her long-term complications related to housing and employment with her home visitor. She was homeless, couch surfing at family members' houses, and continued to have unreliable phone service. Due to these complications, Serena once again became non-responsive to her home visitor.

However, a month later, Serena reconnected with her home visitor and indicated that she had nowhere to go and was in dire need of housing. At this time, Serena's home visitor connected her with the Housing Agency where she was waitlisted for support. In the meantime, Serena stayed connected to her home visitor for periodic support.

Unfortunately, things got more complicated for Serena when a CPS case was opened which required her to connect with specific services aligned with her safety plan. The home visitor at the Village program helped Serena connect with counseling, parenting classes, and additional supplies for her child. A week later, the Housing Agency reached out mentioning they had housing availability. Serena was able to secure housing and furniture from the housing agency. She was speechless and shared her gratitude with the home visitor, and thanked the program for all of the support they provided including never giving up on her. Serena was connected with the FRC closest to her new home in order to continue her safety plan with the support of the Birth & Beyond Collaborative's programming.

OPPORTUNITIES FOR IMPROVEMENT

FY 2022-23 brought continued efforts to implement and fine tune the Effective Black Parenting Program as well as other unexpected changes (i.e., interpersonal and community tragedies impacting staff's well-being and availability; the closure of the Family Development Matrix data tool; vacancies; and training staff on the curriculum). Program staff have to be very intentional to build trust and engage African American families with this new targeted strategy and have been working to strengthen their messaging and address challenges as they emerge. For instance, the ongoing pandemic continued to impact families across the communities served. Additionally, families have varying experiences with social services. Thus, trust building to highlight the benefits of program involvement takes time. Based on the ongoing implementation challenges, MAN and SCH may consider working toward:

01 Develop a shared procedure to "meet families where they are" **and strengthen rapport and program outcomes** by empowering home visiting participants to self-identify their needs and control the pace of information, without losing sight of the curriculum benchmarks.

02 **Increase program enrollment**, including gaining support within the Birth & Beyond Collaborative by sharing the information about the RAACD Black Parenting Program's opportunities and benefits of the curriculum and connecting African American parents/caregivers with culturally-matched facilitators.

03 Together with First 5 and ASR, continue **streamlining program curriculum** across RAACD sites including data collection tools and data entry procedures, in order to ensure more robust future evaluations without added burden on program staff or families. This includes the important addition of qualitative, detailed stories from program participants in order to provide a more well-rounded depiction of curriculum impact on Black/African American families in Sacramento County.

04 Work with First 5 Sacramento to improve clarity about **program milestones and the Persimmony database** for this newer program, including developing an accessible dashboard for staff and leadership to monitor engagement efforts and make timely improvements.

05 Establish a plan for staff to become certified specialists to become certified experts to lead in **Family Hui peer support groups**, working toward the program's efforts to utilize the Family Hui model, tailored for African American families.

Safe Sleep Baby

SSB participants consistently show significant improvements in safe sleep knowledge and practices.

Cribs4Kids provided free Pack-N-Plays to nearly 550 families to safely sleep their infants.

Safe Sleep Baby (SSB) is an education campaign managed by the Child Abuse Prevention Council (CAPC) of Sacramento to increase knowledge and change behaviors about infant safe sleeping practices. The overarching goal is to decrease infant sleep-related deaths in Sacramento County, especially among African American infants. Specific strategies include:

- Perinatal education campaign to share SSB messages.
- Direct education for expecting and new parents with a child under twelve months old
- Education for hospital staff, health professionals, and social service professionals
- Cribs4Kids program to provide education and a free crib to expecting or new parents with a child under twelve months old who do not have a safe place to sleep their baby.
- Quarterly SSB Collaborative meetings
- Systems change efforts related to safe sleep education policies and procedures at local birthing hospitals and clinics serving pregnant and new parents.

SAFE SLEEP BABY PERINATAL EDUCATION CAMPAIGN

Since the beginning of the Campaign, CAPC has sought to ensure that education and messages regarding safe sleep are created and delivered in a culturally relevant and sensitive manner consistently throughout Sacramento County. All SSB materials were created with extensive input from African American community members, including parents engaged in SSB workshops, and distributed through the neighborhoods with the highest rates of African American infant sleep-related death in Sacramento County.

Additionally, SSB Parent Health Educators continued utilizing SSB social media pages to further communicate safe sleep education and factors that result in infant sleep-related deaths. Social media campaigns help to ensure messages reach an intergenerational audience and help mitigate the ongoing impact of the COVID-19 pandemic, as community members were less likely to see flyers, posters, and informational resources in physical, public spaces.

- In FY 2022-23, @SafeSleepBabySacramento social media pages (Facebook and Instagram) had 42 posts, which is 350% of the annual target. Posts received a total of 226 "likes."
- The Facebook page had a total of 2,210 followers, including 232 new followers in FY 2022-23.
- The CAPC SSB team continued to co-promote the SSB program through the Black Infant Health (BIH) social media pages, highlighting SSB's purpose and details on how to schedule a workshop.

SSB education was also included for all BIH Prenatal and Postpartum groups and provided in BIH's safety checklist given to all BIH program participants.

SAFE SLEEP BABY DIRECT EDUCATION

SSB Education for Community Service and Health Providers

SSB conducted "Train-the-Trainer" workshops for professionals who work with pregnant or new mothers to increase providers' knowledge about infant safe sleep practices and promote referrals to SSB parent workshops for infant safe sleep education and cribs. Trained providers included representatives from select community-based organizations, working with families, who became Cribs for Kids (C4K) partners. The C4K partners are trained to provide the one-hour parent workshops, pre- and post-tests, and distribute cribs.

Between July 1, 2022 and June 30, 2023, 206 community-based service providers were trained (compared with 131 trained in FY 2021-22). Additionally, 64 healthcare workers were trained during FY 2022-23, including providers from hospital systems and neighborhood medical offices. Community and medical providers trained include representatives from:

- Birth & Beyond Family Resource Centers
- Community Incubator Leads
- Connections Café
- Comprehensive Perinatal Services Program
- Her Health First
- Kaiser Permanente South Sacramento Medical Center
- Mercy San Juan Medical Center
- Methodist Hospital of Sacramento
- Pacific Clinics
- Sacramento County Nurse Family Partnership
- Sacramento County Office of Education
- Safe Kids Coalition
- Sutter Medical Center, Sacramento
- Sutter Teen Program
- UC Davis Medical Center
- Women, Infants, and Children (WIC)

SSB trained 94% of its annual target of community providers and 107% of its annual target of hospital providers.[35]

[35] Sum of YTD target of 60 nurses and hospital staff and eight staff from neighborhood medical providers

SSB Education for Parents

SSB provides education to families through home visits and one-hour-long workshops. While families of all ethnicities participate in the program, there is a special emphasis on reaching African American families. Home visits and workshops are valuable tools to increase knowledge about infant safe sleep practices as parents receive information from a trusted source in a private and welcoming setting. Each session offers several key pieces of knowledge, including statistics about infant death due to sleep-related causes, the Six Steps to Safely Sleep Your Baby, and an educational video. After successfully completing the training, parents receive a free Pack-N-Play crib if they do not have a safe place to sleep their infant.

> *"...My baby sleeps in the [provided] crib every night."* – SSB Participant

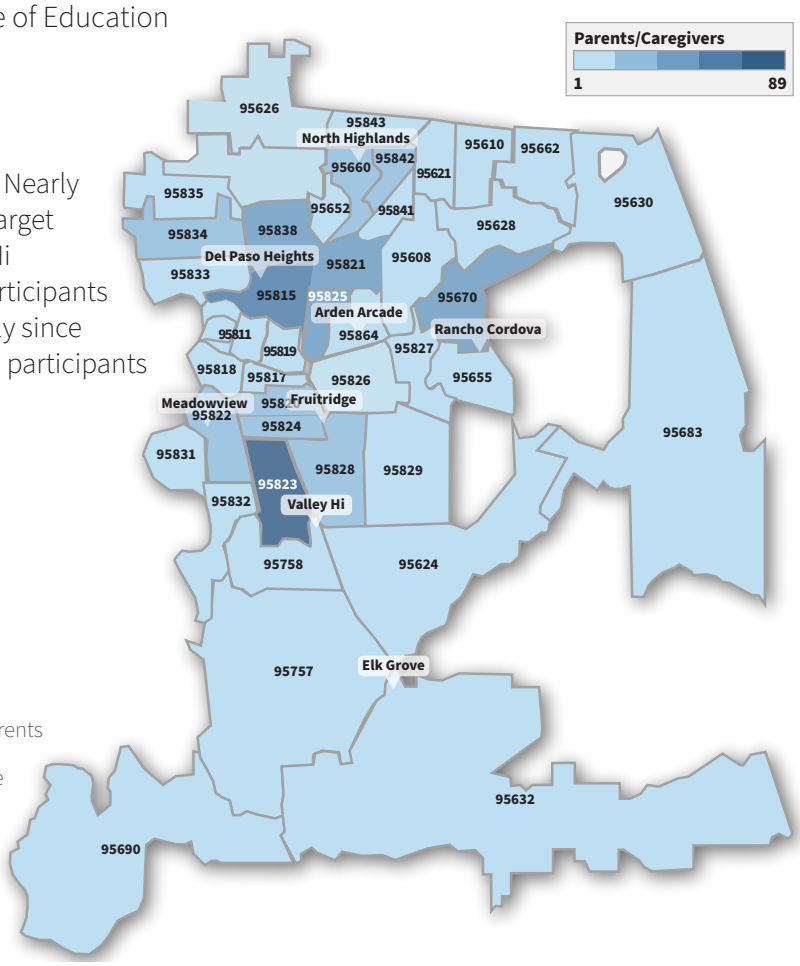
During FY 2022-23, First 5 Sacramento funded SSB trainings for **832 unduplicated parents and caregivers**. Among them, nearly one-third (29%, 243/832) were African American. Additionally, 28 participants took the SSB course more than once,[36] resulting in a total of 860 SSB workshops provided.[37] The number of workshop participants increased 56% compared with FY 2021-22 (535 unduplicated participants) with counts approaching pre-COVID participation (984 unduplicated participants in FY 2019-20).

The following Cribs for Kids partners provided the FY 2022-23 workshops:

- CAPC
- Her Health First
- Liberty Towers
- Nine Birth & Beyond Family Resource Centers
- Rose Family Partnership
- Sacramento County Office of Education
- Sutter Health Teen Program
- The Children's Better Life Service

Figure 27 — Location of Safe Sleep Baby Training Participants

The map displays the locations of SSB participants.[38] Nearly two-thirds (64%, 500/777) resided within the RAACD target neighborhoods, with most participants in the Valley Hi neighborhood (zip code 95823). The proportion of participants residing with RAACD focus zip codes decreased slightly since FY 2021-22 (68%, 324/479), however the total reach to participants in these areas increased substantially.



Source: First 5 Sacramento Service Records (N = 777). Map excludes participants who did not have an address on file.

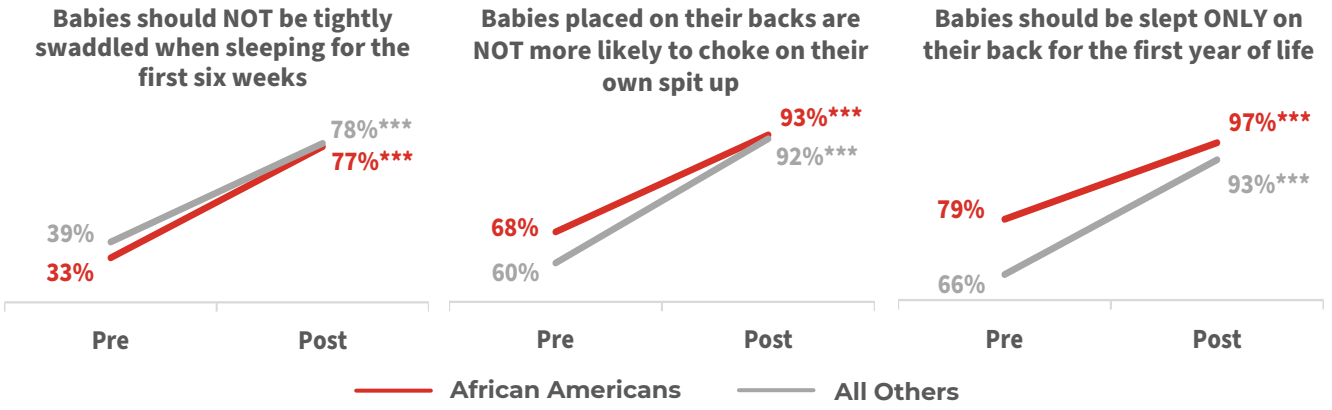
[36] This could include parents/caregivers taking the course for a subsequent baby or to repeat the education. SSB's priority is for parents to understand *and* follow the education in their behavior of safely sleeping their baby no matter how many times they need to receive the information.

[37] Count includes First 5 funded only and excludes additional trainings provided using other funding sources.

[38] N = 777; excludes participants who did not provide an address or were unhoused at the time of their program involvement.

Short-term program impact is measured using a pre- and post-test assessing changes in **safe sleep knowledge** before and after the SSB training. In total, 847 participants completed both a pre- *and* post-test.[39] Among them, 29% (249/847) identified as African American. Participants showed significant improvements across the various measures of safe sleep knowledge. The figure below highlights knowledge changes for the top three questions with most improvements. Because of SSB's focus on African American infant sleep safety, African American participants' responses are displayed separately from all other races.

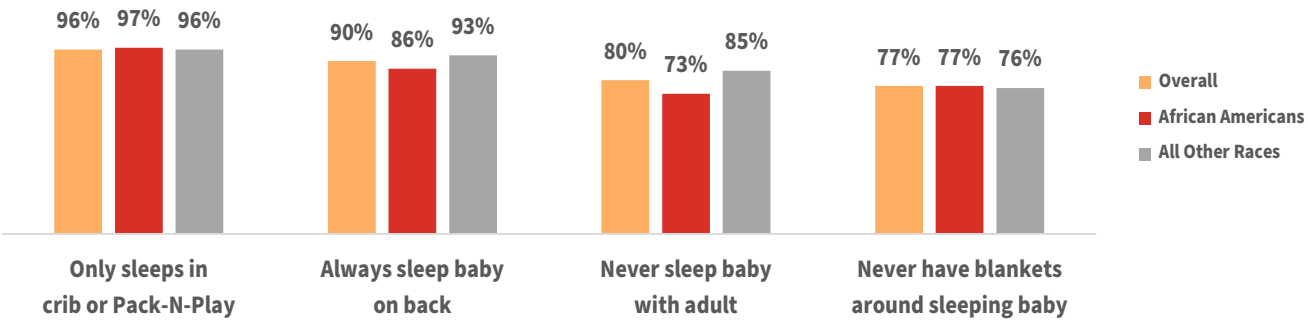
Figure 28 — Increases in Correct Answers about Infant Safe Sleep Knowledge in Pre- and Post-Test



Source: SSB Pre- and Post-Tests. African American N = 249, All Others = 598. *** Indicates statistical significance at $p < .001$.

Safe Sleep Baby's medium-term program impact is measured by participants' **safe sleep intentions and practices**. After completion of the SSB workshop, follow-up calls were made to parents/caregivers that received a crib following the SSB training. In total, 235 participants completed a follow-up assessment, including 99 African Americans (42%). At follow-up, nearly all caregivers reported their child was *Sleeping in a crib or Pack-N-Play* (96%, 226/235) and 90% were *Always sleeping their baby on their backs* (211/235). Additionally, 80% of caregivers *Never slept their baby with an adult*, although proportions were slightly lower among Black/African American participants (73%).

Figure 29 — Percent of SSB Participants Practicing Infant Safe Sleep Behaviors at Follow-Up, by Race



Source: SSB Follow-Up Survey. N = 235 (All Follow-Ups in fiscal year). African American N = 99; All Other Races N = 136.

[39] Includes duplicate participants who completed the training more than once. Parents/caregivers are able to participate in the training as many times as needed.training as many times as needed.

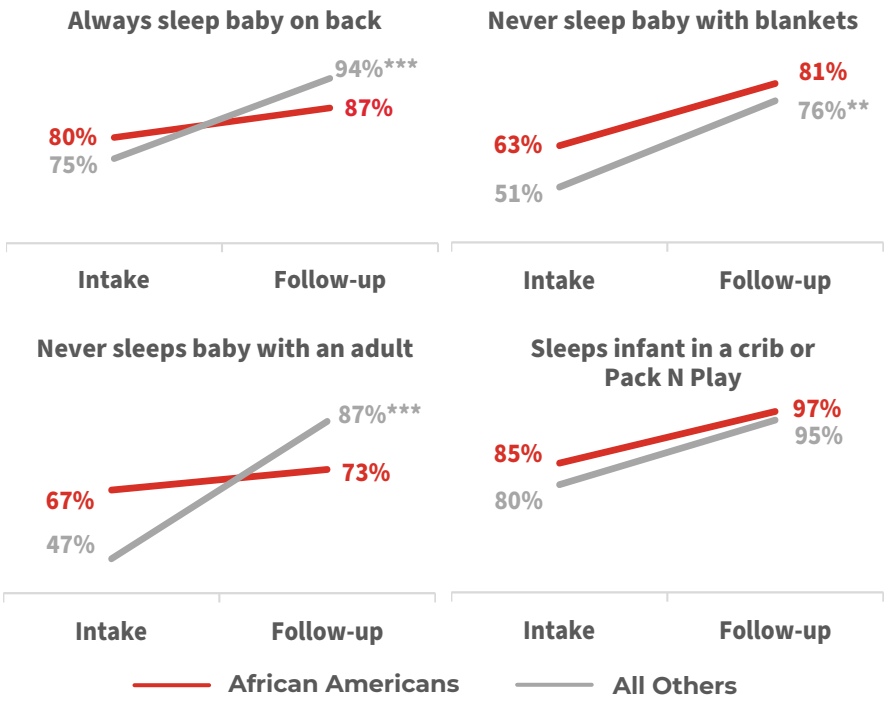
"I would have had to co-sleep with [my baby] if not for SSB. I was also educated on matters I did not know of such as the importance of having infants sleep on a firm mattress." – SSB Participant

Intentions for infant safety practices described at the start of the Safe Sleep Baby workshop were compared with their reported practices at follow-up to further identify the impact of the SSB program. **Safe sleep practices improved significantly compared to intentions prior to the workshop**, among the group with intake *and* follow-up data (223/235).

The figure below demonstrates changes between intention and follow-up for African American participants and participants of all other races. Black/African American participants were significantly more likely to report that they (would) *Never sleep their baby with blankets* at follow-up (81%) compared to intake (63%), and were significantly more likely to report *Sleep their baby in a crib or Pack-N-Play* (97%) compared with their initial intention (85%).

The increase in use of cribs or Pack-N-Plays is an important highlight, particularly because FY 2021-22 Black/African American participants decreased their use of cribs or Pack-N-Plays, as a group (94% to 88% in FY 2021-22). Following anecdotal evidence about some families' difficulty using the Pack-N-Plays (e.g., unstable housing, challenges with the size of the Pack-N-Play), Safe Sleep Baby staff began updating trainings and incorporating insights from focus groups to mitigate challenges. Improvements in FY 2022-23, may be attributed, in part, to these efforts.

Figure 30 — Differences Between Intentions at Intake and Behaviors at Follow-Up in Infant Safe Sleep Practices (Matched Pairs)



Source: CAPC, SSB Intake and Exit Surveys. Note: * indicates statistically significant difference at $p < .05$ **indicates statistically significant difference at $p < .01$. *** indicates statistically significant difference at $p < .001$. African American N = 95; All Other Races N = 128.

CRIBS FOR KIDS (C4K) PROGRAM

CAPC also manages the Cribs for Kids (C4K) Program, which partners with community hospitals and local organizations to provide expectant or new parents with infant safe sleep information and Pack-N-Play cribs, funded by First 5 Sacramento and Sacramento County Department of Child Family and Adult Services (DCFAS). Participants who did not have a safe location to sleep their infant were able to receive a free crib after completing a one-hour SSB workshop with CAPC or other C4K partners.

Between July 1, 2022 to June 30, 2023, crib distribution partners included:

- Nine Birth & Beyond Family Resource Centers
- CAPC
- Her Health First, Black Mothers United
- Kaiser Permanente South Sacramento Medical Center
- Mercy General Hospital
- Mercy San Juan Medical Center
- Methodist Hospital of Sacramento
- Rose Family Partnership
- Sacramento County Office of Education
- Sutter Medical Center, Sacramento
- UC Davis Medical Center, NICU, and Labor and Delivery

In FY 2022-23, **C4K partners provided 546 cribs to parents and caregivers** in need.[40] About one-third of the cribs (31%, 171/546) were provided to African American parents and caregivers. The proportion of cribs distributed to African American parents and caregivers was relatively consistent with FY 2021-22 (33% of total).

SAFE SLEEP BABY EDUCATION POLICIES AND PROCEDURES

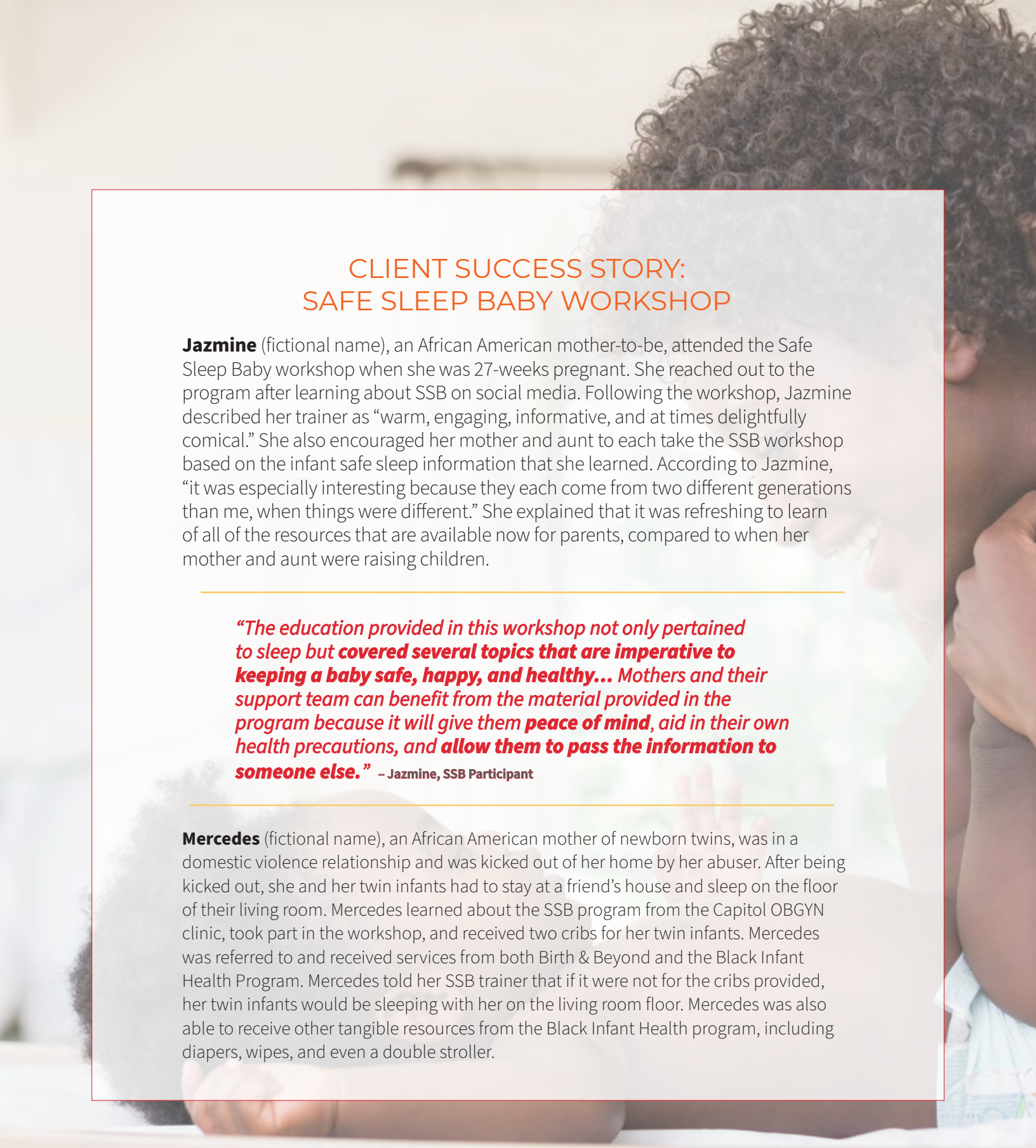
SSB also works to ensure the program's sustainability by encouraging the adoption of SSB policies and education with hospitals and medical providers. SSB education is being implemented in **all four main hospital systems** of Sacramento:

- Dignity Health
- UC Davis Medical Center
- Kaiser Permanente
- Sutter Medical Center

Prior to the implementation of the SSB campaign in 2015, hospitals did not uniformly provide infant safe sleep education. In FY 2022-23, **all eight birthing hospitals** in Sacramento County continued to successfully implement SSB education policies.

Additionally, SSB informational videos were broadcasted in labor and delivery hospitals, as well as pediatric and OBGYN waiting rooms. Nurses provide a unique opportunity to engage parents in an infant safe sleep conversation, asking expectant or new parents the SSB question: "***Where will you sleep your baby when you return home?***" This wording offers the opportunity to begin a non-judgmental conversation about infant safe sleep practices and the risk of infant sleep-related death. In hospital settings, parents receive information and a referral to CAPC for follow-up.

[40] Includes cribs provided through additional leveraged funding sources.



CLIENT SUCCESS STORY: SAFE SLEEP BABY WORKSHOP

Jazmine (fictional name), an African American mother-to-be, attended the Safe Sleep Baby workshop when she was 27-weeks pregnant. She reached out to the program after learning about SSB on social media. Following the workshop, Jazmine described her trainer as "warm, engaging, informative, and at times delightfully comical." She also encouraged her mother and aunt to each take the SSB workshop based on the infant safe sleep information that she learned. According to Jazmine, "it was especially interesting because they each come from two different generations than me, when things were different." She explained that it was refreshing to learn of all of the resources that are available now for parents, compared to when her mother and aunt were raising children.

> *"The education provided in this workshop not only pertained to sleep but **covered several topics that are imperative to keeping a baby safe, happy, and healthy...** Mothers and their support team can benefit from the material provided in the program because it will give them **peace of mind**, aid in their own health precautions, and **allow them to pass the information to someone else."*** **– Jazmine, SSB Participant**

Mercedes (fictional name), an African American mother of newborn twins, was in a domestic violence relationship and was kicked out of her home by her abuser. After being kicked out, she and her twin infants had to stay at a friend's house and sleep on the floor of their living room. Mercedes learned about the SSB program from the Capitol OBGYN clinic, took part in the workshop, and received two cribs for her twin infants. Mercedes was referred to and received services from both Birth & Beyond and the Black Infant Health Program. Mercedes told her SSB trainer that if it were not for the cribs provided, her twin infants would be sleeping with her on the living room floor. Mercedes was also able to receive other tangible resources from the Black Infant Health program, including diapers, wipes, and even a double stroller.

OPPORTUNITIES FOR IMPROVEMENT

01 Continue identifying and building **relationships with diverse community-based organizations**, such as refugee support programs, who may benefit from integrating SSB into their work. Leverage these partnerships to increase community outreach and strengthen cultural responsiveness (e.g., translation support, tips for reaching and sharing program messaging with new populations).

02 As SSB grows its partnerships and engages in additional systems work, ensure that there is **coordination across the multiple initiatives** (i.e., SSB 1.0 through SSB 3.0).

03 Continue **quality assurance activities** with C4K partners to ensure consistency of messaging and service delivery. Assess C4K partners' participation level and seek out additional partners, if needed.

04 Develop and implement a **"closed loop referral"** practice for hospital systems and community-based medical clinics to promptly receive a referral disposition update from the CAPC SSB team indicating whether or not the referred parent/caregiver received SSB education. This closed-loop process can further build relationships between CAPC and the referring system and encourage future referrals.

The Model of Caring (MOC) campaign began as a groundbreaking partnership with Sacramento County Public Health to raise public awareness of institutionalized racism as the root cause of the racial disparities in safe births for both infant and mother.

Perinatal Education Campaign (PEC)

The PEC team hosted a birth storytelling event to share the experiences of real moms in the community and how providers could improve prenatal and postnatal care.

The fourth strategy funded by First 5 is the Perinatal Education Campaign (PEC), which includes public outreach and education about perinatal causes of death. Her Health First (HHF) manages the PEC strategy, together with partners XTG Media and Runyon Saltzman, Inc. (RSE). PEC activities include organic social media content, websites, podcasts, blogs, public community events, and oversight by a Community Advisory Team.

PEC includes two primary education campaigns: Sac Healthy Baby and Model of Caring (formerly Unequal Birth). **Sac Healthy Baby** (SHB) is focused on reaching African American expecting and new parents and families to provide them with information and to connect them to local resources. The **Model of Caring** (MOC) campaign began as a groundbreaking partnership with Sacramento County Public Health to raise public awareness of institutionalized racism as the root cause of the racial disparities in safe births for both infant and mother. During the second quarter of FY 2022-23, the PEC team implemented rebranding of the Unequal Birth campaign based on feedback that the campaign messaging led to perceptions of further marginalization and despair. The rebranded Model of Caring campaign aims to be more hope- and solution-oriented.

SOCIAL MEDIA CAMPAIGNS

During FY 2022-23, the PEC team continued the process of rebranding and updating website and media content based on community feedback and the revitalized campaign goals. The PEC team also implemented a Google survey for community feedback about the organic social media content. Quarterly meetings with the Community Advisory Team solicited valuable feedback to benefit the media and website content for each campaign, including but not limited to, suggestions to add self-referral resources and birth stories from community members with positive experiences.

XTG Media developed and edited three **blog posts** for inclusion on the SHB website. Blogs focused on Motherhood and Mindfulness, including how to practice mindfulness throughout pregnancy and parenthood.

XTG Media also developed three Prezi **learning courses** for the SHB website, with topics including:

- Fatherhood (e.g., balancing new commitments, financially preparing for a baby, and managing mental health while balancing baby and work)
- Supporting Your Partner through Labor & Delivery
- Taking Care of Your Health (e.g., morning sickness, nutrition, exercise, and meal prep)

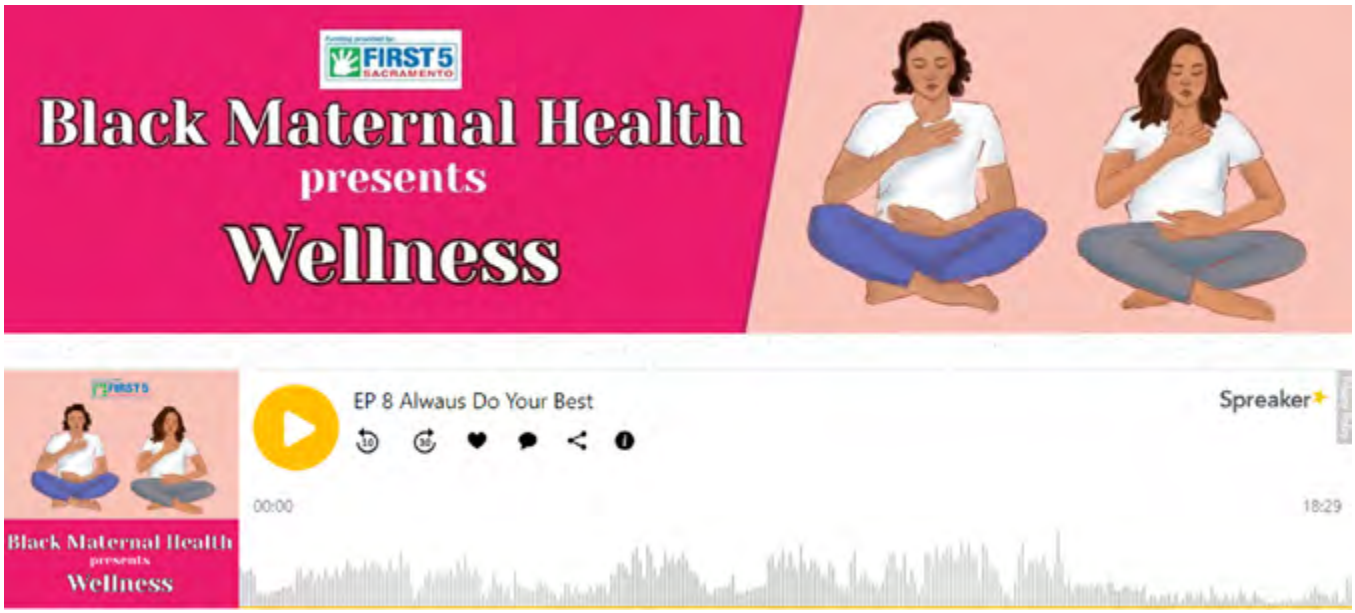
Organic[41] **social media posts** on the Sac Healthy Baby, Unequal Birth, and Model of Caring Facebook and Instagram pages included a combined total of 299 posts receiving 4,457 impressions. The total reach of social media posts is lower compared with previous years as a result of campaign rebranding as well as changes to algorithms across social media platforms which impact the reach of organic campaigns.

> *"I love that I had a Black nurse. That was amazing. I felt like I could relate to her."* – **SSB Participant**

[41] Organic social media are the free content (e.g., posts, stories) that all users share on their feeds.

PODCASTS

During FY 2022-23, XTG media led the development, recording, and publishing of 12 **podcast episodes** surrounding mental health and perinatal health in motherhood. Episode topics included perinatal depression, postpartum healing, mental wellness throughout motherhood, common prenatal health concerns for Black women, building a partnership with doctors throughout pregnancy, and building a birth plan. Podcast episodes were recorded in partnership with topic experts and community leaders. The XTG Media team also recorded an additional 15 episodes for the 2023-24 fiscal year.



During the fourth quarter, HHF also held a special recorded **birth storytelling event**, featuring eight mothers who participated in the Black Mothers United program. Participants were encouraged to bring their baby and spouse/partners to the event. After recording their birth story, each family was treated to a photo shoot, food, and gifts. The two podcast episodes resulting from this event were posted on the Model of Caring website as part of the campaign's rebrand to share the experiences of real moms in the community and how providers could improve prenatal and postnatal care by listening to and supporting African American mothers.

COMMUNITY EVENTS

In FY 2022-23, the PEC Team co-hosted the Champions of Maternal Health Mixer with Be Mom Aware and shared information about the rebranded Model of Caring campaign at the annual Juneteenth Community Event.

Champions of Maternal Health Mixer

Her Health First, in collaboration with Be Mom Aware, hosted the Champions for Maternal Health Mixer at Urban Roots, in Downtown Sacramento. The mixer connected exemplars in Sacramento's birth work and maternal health field as an opportunity to celebrate unapologetic champions who have shown dedication and innovation in improving maternal and infant health outcomes for Sacramento's most marginalized birthing populations.

The mixer allowed attendees to meet peers from the industry, learn about promising practices, and celebrate the strides being made to build pre/postnatal services that truly meet the needs of those receiving care. The evening highlighted individuals who have shown great dedication to improving birth outcomes for underserved families in Sacramento. The evening highlighted individuals who have shown great dedication to improving birth outcomes for underserved families in Sacramento, including a holistic health and wellness doctor, a journalist, a Program Manager at Anthem, Inc., a First 5 Sacramento Program Planner, a Latina Community Ambassador, and a Community Engagement leader. Discussions highlighted successes and continued efforts to spread awareness and provide solutions to improve prenatal and postnatal care.

Community Juneteenth Event

The Juneteenth event was held at William Land Park. XTG Media created flyers for SHB, MOC, and community resources, as well as business cards to hand out during the event. The PEC team also created two pop-up posters that featured a QR code to link attendees directly to the MOC website. Attendees, including community members, advisory committee members, and partner agency staff, reported that the campaign materials resonated with them, and they loved the poster photos. Attendees also felt encouraged to share their own birth stories based on the photos/materials shared. Participants scanned the QR codes and reviewed the MOC website while HHF Staff and Program Director shared with attendees the purpose of the campaign and the importance of increasing awareness to help end birth inequities in the community.

OPPORTUNITIES FOR IMPROVEMENT

As the PEC strategy continues to grow, HHF has noted emerging challenges related to the interconnected needs of various subcontractors and the public relations requirements outside the expertise of these direct service providers. This expanding role paired with ongoing revitalization and rebranding of the program campaigns resulted in a number of insights regarding opportunities for improvements.

01 Explore strategies for **campaign sustainability** beyond the end of the contract period to ensure continued expansion and use of the critical messages.

02 Continue to develop **durable media content** for the MOC campaign including social media for Instagram, Facebook, and Tik Tok, as well as videos with birth stories and provider/champion interviews to ensure active engagement and expand the campaign's reach, including strategies to reach intended audiences given changes to social media algorithms outside the control of program staff.

03 Strengthen MOC campaign **relationships with the birth worker community** including:

a. Forging more intentional partnerships with medical providers, doctors, nurses, and clinics in the Sacramento area, as well as health networks to help promote/utilize MOC website, and possible sponsorships and promotion of virtual tool kits.

b. Expanding "Call to Action" opportunities to invigorate medical provider community and allies to become champions for change, possibly by making MOC a "status symbol" that Medical Providers strive to obtain.

c. Recruiting more medical providers/birth workers to participate on the PEC Advisory Committee and encourage them to make employer/co-workers aware of the campaign.

04 Continue efforts to **streamline internal PEC team approval process** to reduce delays, resolve issues, and move campaign elements forward more efficiently.

05 Identify opportunities to **measure the impact** of campaign messaging on community members, service providers, and systems based on strategy goals.

Countywide Trends

Countywide, African American infants remain twice as likely to die compared with all other races, although there have been major improvements in the RAACD focal areas since the 2012-2014 baseline.

The four programs funded by First 5 Sacramento (Pregnancy Peer Support Program, Safe Sleep Baby Initiative, Family Resource Centers, and Public Perinatal Education Campaign) aim to help reduce the rate of African American perinatal, child abuse and neglect, and infant sleep-related deaths in Sacramento County.

The following section includes population-level data about infant deaths, by cause, consistent with the focus areas of the Blue Ribbon Commission report. The Blue Ribbon Commission goals to reduce African American child deaths by 2020.

The Blue Ribbon Commission Goals Included:

- Reduce the African American child death rate by **10-20%**
- Decrease the African American infant death rate due to infant perinatal conditions by at least **23%**
- Decrease the African American infant death rate due to infant safe sleep issues by at least **33%**
- Decrease the African American child death rate due to abuse and neglect by at least **25%**
- Decrease the African American child death rate due to third-party homicide by at least **48%**

To measure progress toward these goals, population data from Sacramento County Public Health include:

- All infant deaths (by race)
- Preterm births
- Low birth weight infants

Additionally, data from the Child Death Review Team (CDRT) include:

- Infant deaths due to perinatal conditions
- Infant deaths due to sleep-related conditions (ISR)
- Child abuse and neglect homicides (infants and children ages 0-5)

It is important to note that countywide data lag behind data for the First 5-funded initiatives reported earlier. Countywide data is current as of 2021, while First 5-funded program data reflect FY 2022-23 activities. Additionally, 2012 is the countywide data baseline year as the RAACD efforts by First 5 and other partners began following the 2013 publication of the Blue Ribbon Commission recommendations.

To account for the effect of small population size, death rate data represent three-year rolling (overlapping) rates (total number of infant deaths in the three-year period divided by the total number of infant births on those three years). Please also note that child death rates (ages 0-5) are presented as deaths per 100,000 children and infant death rates are reported as deaths per 1,000 live births. Additional technical details related to these data and calculations can be found in Appendix 4.

OVERALL INFANT MORTALITY

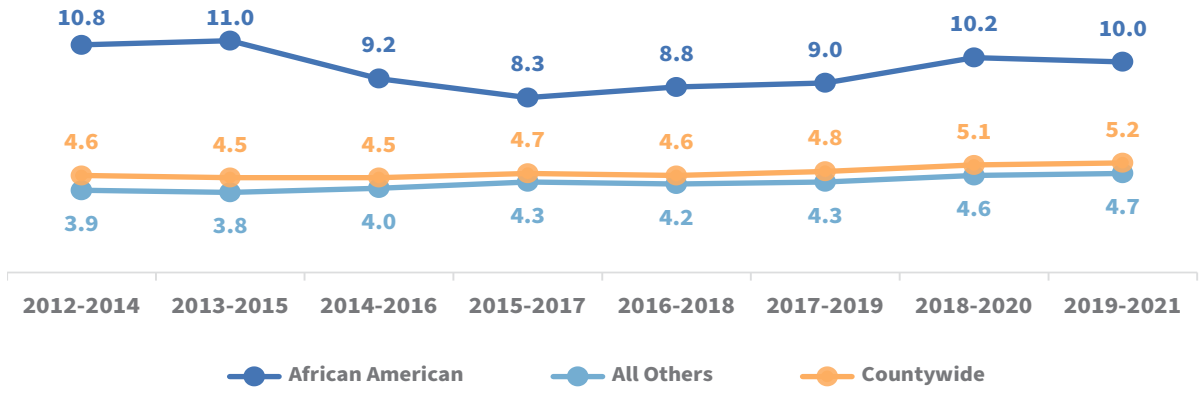
During the three-year baseline period (2012-2014), African American infants died at a rate of 10.8 per 1,000 births. During 2019-2021, the African American infant death rate was 10.0 per 1,000 births, a reduction of 8%. African American infants comprised 18% of all Sacramento County infant deaths during 2019-2021 compared with 24% of infant deaths during 2012-2014.

The rate of African American infant deaths per 1,000 African American births (10.0) decreased slightly compared with 2018-2020 (10.2). Additionally, the disparity between African American infant deaths and all other race/ethnic groups decreased 24% compared with 2012-2014, yet **African American infants remain twice as likely to die compared with all other groups combined**.

Multiple factors may influence recent increases and fluctuations. For instance, most current rates include the height of the COVID-19 pandemic in 2020 and 2021. Economic and health concerns as well as shelter-in-place orders in 2020 resulted in fewer births, a slightly elevated number of deaths, and a reduction of the in-person reach of community support services.[42],[vii] Structural racism is a likely contributor to the ongoing disparities in infant mortality among African Americans with patterns persisting countywide as well as across the nation.[viii] Because countywide rates (including infant death rates among all other races) have been increasing in recent three-year rolling rates, it may be beneficial to conduct additional research identifying other intersecting characteristics, which may further inform and highlight necessary systems-level, preventative approaches, potentially reducing infant death rates as well as racial disparities.[ix]

[42] While birth rates have been declining nationwide, COVID-related fertility declines may relate to reduced access to partners or intentional delays in childbearing (among those with the means and resources to do so). While the proportion of births to younger people with fewer resources increased, this population was also more vulnerable to COVID-19 which also had impacts on birth outcomes, including increased chances of preterm births and infants being in NICU after birth (Frueh, 2022).

Figure 31 — Three-Year Rolling Rate of Infant Death in Sacramento County, by Race

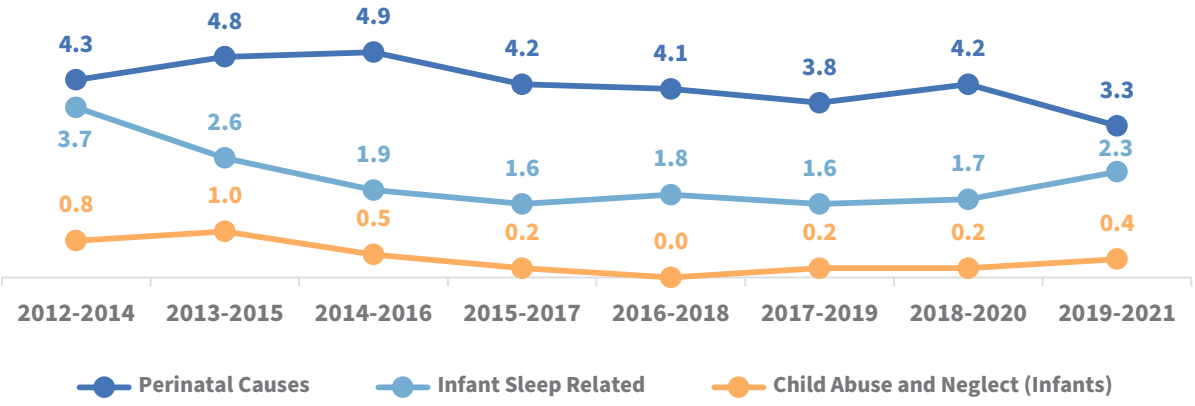


Source: Sacramento County, Department of Health Services, Public Health Division, Epidemiology Program, Birth Statistical Master Files. Rate is per 1,000 infants.

The figure below summarizes infant death rates for each of the three First 5 Sacramento RAACD initiative's focal areas for African American infants alone. Between the 2012-2014 baseline and 2019-2021 (most recent data), infant sleep-related (ISR) deaths had a net decrease of 37%, child abuse and neglect (CAN) deaths (among infants) decreased 54%, and deaths due to perinatal causes decreased 24%.

The rate of perinatal deaths among African American infants dropped substantially during 2019-2021 following a brief spike in the 2018-2020 rolling rate. On the other hand, African American infant sleep related and CAN deaths increased compared to the previous rolling rate. Despite these increases, all rates remain lower than the 2012-2014 baseline and exceed the established goals of the Blue Ribbon Commission. However, the increases in countywide infant sleep related deaths are particularly alarming as the single year rate for 2021 (4.1 per 1,000 African American births) doubled compared with 2020 (1.8 per 1,000 African American births).

Figure 32 — Three-Year Rolling Rates of African American Infant Death: Sleep Related, Perinatal Causes, and Child Abuse and Neglect



Source: Sacramento County Child Death Review Team Report 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, and 2021. Rate is per 1,000 births.

The following sections will further explore countywide infant death rates by RAACD focal area, with comparisons between African American infants and infants of all other races

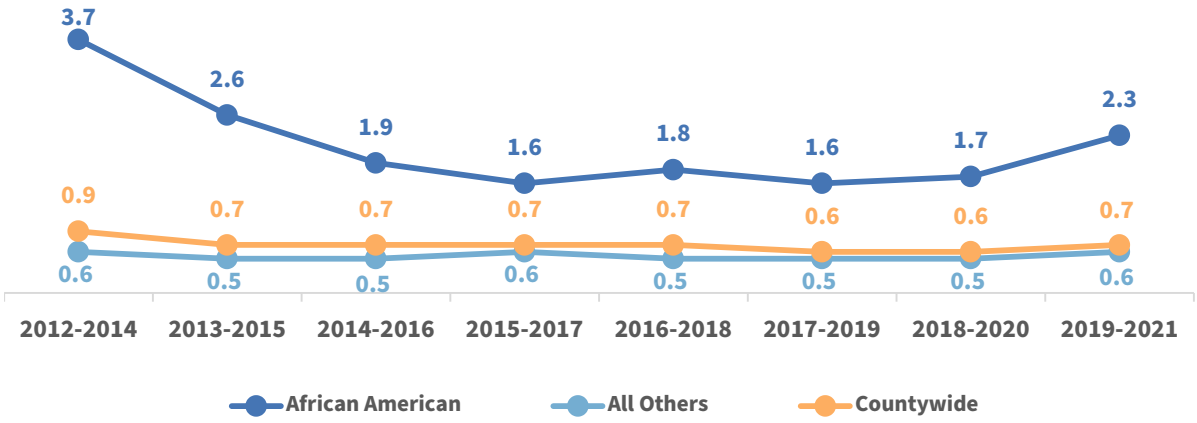
INFANT SLEEP-RELATED DEATHS

The term "Infant Sleep-Related Deaths" (ISR) refers to any infant death that occurs in the sleep environment, including Sudden Infant Death Syndrome, Sudden Unexpected Infant Death Syndrome, and Undetermined Manner/ Undetermined Natural Death. Rolling rates of African American ISR deaths occurring in Sacramento County have recently increased following a significant long-term decrease between 2012-2014 (3.7 per 1,000 births) and 2017-2019 (1.6 per 1,000). Rates for 2018-2020 increased to 1.7 per 1,000 African American births and 2019-2021 ISR deaths increased another 36% (2.3 per 1,000).

Since 2012-2014, countywide African American infant sleep-related deaths decreased 37%, including a 43% decrease in the disparity gap between African Americans and other ethnic groups.

The 2019-2021 rate remains slightly lower than the established BRC Goal (2.5 per 1,000) and the disparity gap between African American ISR deaths and all other ethnic groups had a net decrease of 43% since 2012-2014. However, in 2019-2021, African American infants were four times as likely to die from infant sleep related causes than all other races (2.3 per 1,000 African American births compared with 0.6 per 1,000 births among all other groups).

Figure 33 — Three-Year Rolling Rates of Infant Sleep Related Deaths in Sacramento County

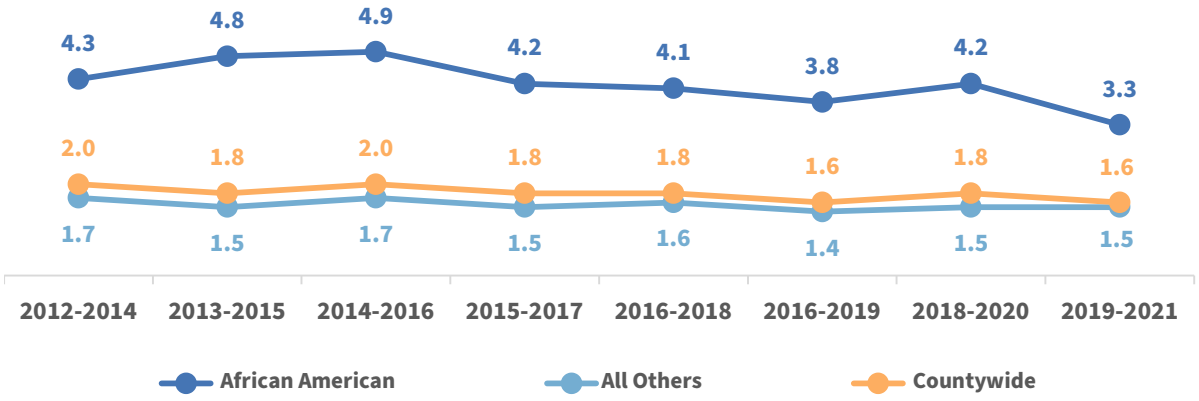


Source: Sacramento County Child Death Review Team Report 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, and 2021. Rate is per 1,000 births.

INFANT DEATHS DUE TO PERINATAL CAUSES

Perinatal causes include deaths due to prematurity, low birth weight, placental abruption, and congenital infections and include deaths through one-month post-birth. During the 2012-2014 baseline period, African American infants died from perinatal causes at a rate of 4.3 per 1,000 births. Following an unfortunate increase in 2018-2020 (4.2 per 1,000), the 2019-2021 rate decreased substantially (-21%) to 3.3 per 1,000 African American births, meeting the established BRC Goal. Since the 2012-2014 baseline, the disparity gap between African American infants and all other races decreased 31%, although African American infants remain twice as likely to die from perinatal causes than all other infants.

Figure 34 — Three-Year Rolling Rates of Infant Death Due to Perinatal Causes in Sacramento County



Source: Sacramento County Child Death Review Team Report 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, and 2021.
Rate is per 1,000 births.

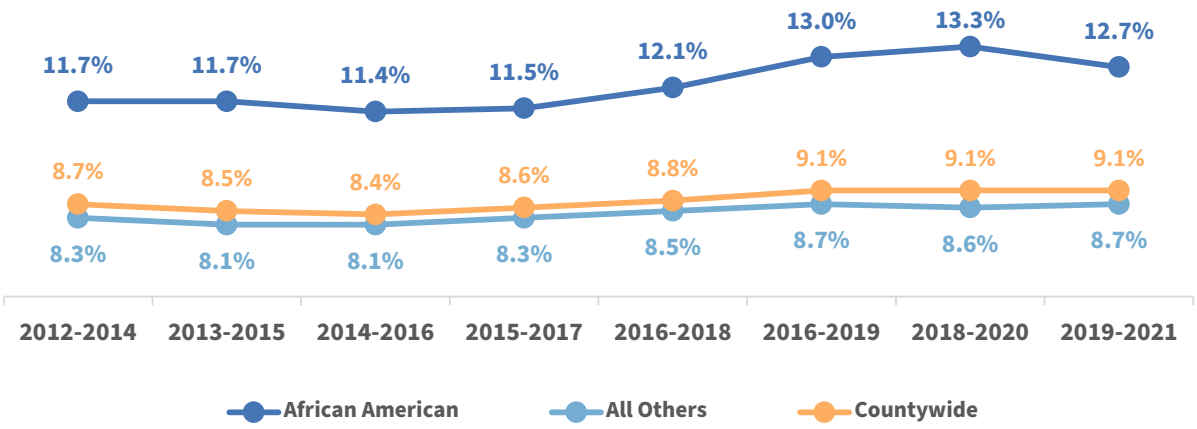
PRETERM BIRTHS

Preterm births include infants born before 37-weeks of gestation. In Sacramento County, nearly 13% of all African American babies born during 2019-2021 were preterm. The percentage of preterm African American births decreased slightly from 2018-2020 (13.3%) yet remain one percentage point higher than the 2012-2014 baseline (11.7%). It is important to note that the proportion of preterm births among infants of all other races and countywide also increased since 2012-2014. While alarming, this pattern is consistent with statewide and national concerns. According to Healthy People 2030, preterm births are "getting worse" (10.5% of live births in 2021). [x]

More focused work needs to be targeted in this area to decrease the number of preterm births in the African American community, as well as Sacramento County as a whole. The Healthy People goal is to reach 9.4% by 2030. However, it likely that COVID-19 continues to impact preterm births. COVID-19 infections have been linked to significantly increased likelihood of adverse birth outcomes, including preterm births. Additionally, the COVID-19 pandemic has had a disproportionate impact on communities of color, including increased exposure and health disparities (e.g., structural racism, homelessness, low wage jobs, hazardous environments, less access to health care/COVID-19 testing, and underlying health conditions).[xi]

Additionally, within Sacramento County the proportion of preterm African American infants remained 1.5 times the rate of all other races in 2019-2021. In addition to potential COVID-related barriers, this substantial gap reflects national discrepancies and may be linked to structural barriers as well as racism-related stress,[xii] hhighlighting the need for more structural and systems approaches to address the root causes of racial disparities in preterm births and the associated long-term conditions.

Figure 35 — Three-Year Rolling Total Percentage of Preterm Infants Born in Sacramento County

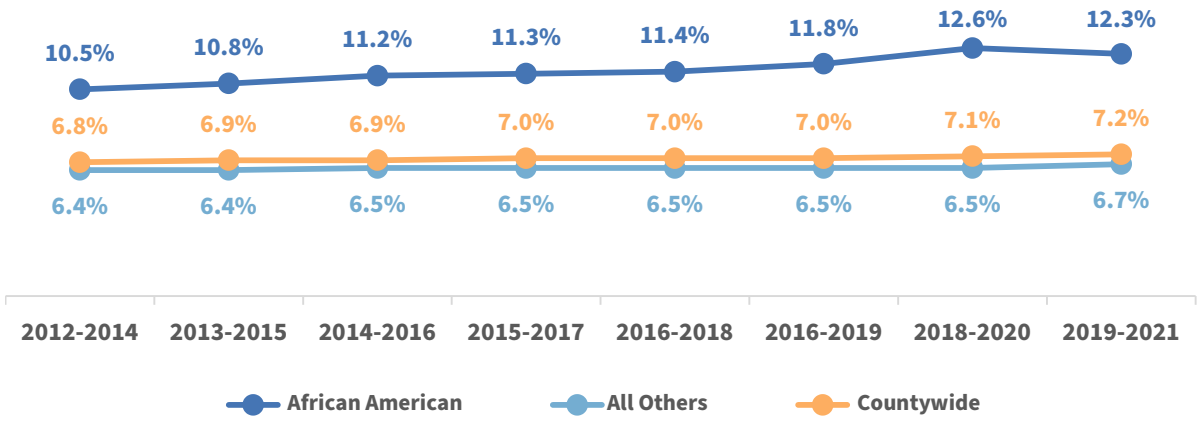


Source: Sacramento County, Department of Health Services, Public Health Division, Epidemiology Program, Birth Statistical Master Files.

LOW BIRTH WEIGHT

Low birth weight (LBW) newborns are those weighing less than 2,500 grams (5 lbs., 8 oz.). The figure below displays the percentage of African American LBW births between the 2012-2014 baseline and 2019-2021 (rolling total percentages) compared to infants of all other races. The percentage of African American babies born LBW during 2019-2021 is 17% higher than the baseline rolling rate (10.5% in 2012-2014, 12.3% in 2019-2021).

Figure 36 — Three-Year Rolling Total Percentage of Low Birth Weight Births in Sacramento County



Source: Sacramento County, Department of Health Services, Public Health Division, Epidemiology Program, Birth Statistical Master Files.

While increasing trends are concerning, nationwide estimates also show larger proportions of newborns born at a low birth weight in recent years. National Vital Statistics (2023) reported a 3% increase in LBW births between 2020 and 2021.[xiii] Countywide rates (7.2% overall, 12.3% African Americans) remain lower than national estimates (8.5% overall, 14.2% African Americans.

COVID-19[xiv] as well as persisting racial disparities and the chronic stresses of discrimination and racism are known contributors to health/birth inequities. For instance, research on the negative impacts of racism on mothers and babies indicate that exposure to racial discrimination and segregation during childhood have more negative health consequences than other common contributors (e.g., diet, exercise, smoking, poverty). Similarly, studies commonly found a negative effect of interpersonal discrimination and chronic worry about racial discrimination on preterm birth and birth weight.[xv]

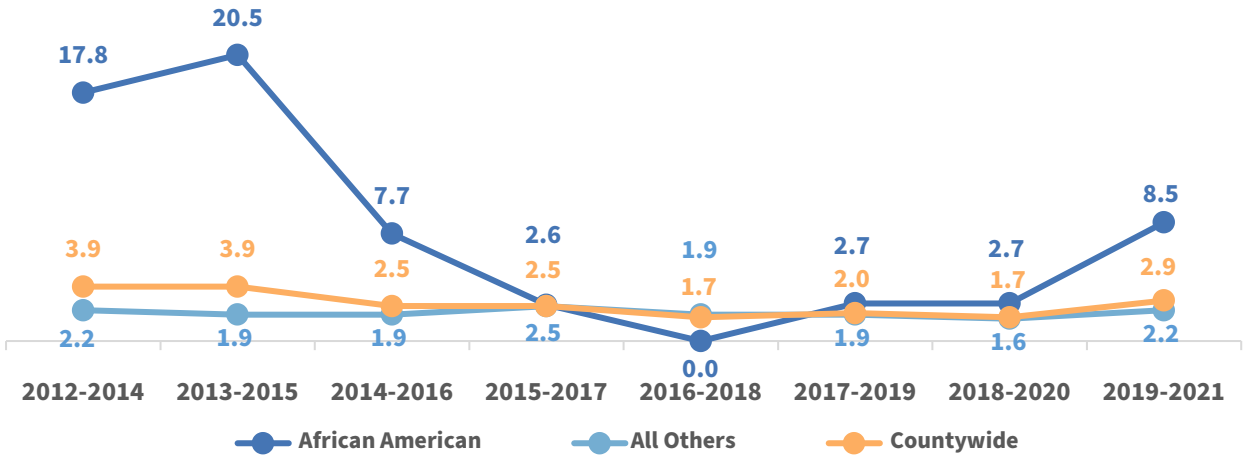
DEATHS DUE TO CHILD ABUSE AND NEGLECT (0-5)

Among all **children ages 0-5**, African American children died from child abuse and neglect at a rate of 17.8 per 100,000 children during the 2012-2014 baseline period. Due in large part to the broad RAACD initiative efforts throughout Sacramento County (including the Family Resource Centers, the Child Abuse Prevention Center (CAPC), and the cultural broker program at the Department of Child, Family, and Adult Services (DCFAS), this rate drastically declined, reaching zero African American CAN deaths during 2016-2018. Rates increased slightly to 2.7 per 100,000 in 2017-2019 and 2018-2020, and unfortunately increased substantially during the 2019-2021 period (8.5 per 100,000 African American children). Most recent rates reflect three children, while 2017-2019 and 2018-2020 each reflect one child.

Since 2012-2014, deaths due to child abuse and neglect (ages 0-5) decreased 52% among Sacramento County African Americans. The disparity gap between African Americans and all other races decreased 60%.

Prior to 2019-2021, the disparity rate between African American children and all other races reduced substantially (93% decrease between 2012-2014 and 2018-2020). As of 2019-2021, the disparity gap reduced 60% compared with the baseline. However, this unfortunately also reflects a higher rate of CAN deaths among all other races (2.2 per 100,000 children).

Figure 37 — Three-Year Rolling Rates of Child (0-5) Death due to Child Abuse and Neglect in Sacramento County



Source: Sacramento County Child Death Review Team Report 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, and 2021. Rate is per 100,000 children ages 0-5.

Summary and Conclusions

Although infant deaths due to perinatal causes decreased, preterm and low birth weight births are increasing across Sacramento County, and as a larger national trend.

RAACD strategies continue to have meaningful impact on Sacramento County families. In FY 2022-23, First 5 Sacramento funded four strategies each using a range of modalities to promote the health and well-being of African American families and support the reduction of African American child deaths (ages 0-5).

BLACK MOTHERS UNITED:

Consistent with previous years, more check-ins with Black Mothers United (BMU) coaches were a significant predictor of healthy birth outcomes (including healthy birth weight and gestational age), and BMU clients showed significant improvements in their protective factors and reduced barriers to healthy birth outcomes. Importantly, **among the 76 children born in 2020 whose mothers participated in the BMU program, there were zero infant deaths up to a year post-birth**. Participants continue to resonate with the support of the BMU program and staff, including the valuable peer support and doula care for Black mothers.

FAMILY RESOURCE CENTERS (FRC):

The MAN Arcade Stronger Families, Stronger Generations and SCH Valley Hi Village programs utilized light touch activities, crisis intervention case management, group parenting education workshops, and home visiting with a focus on culturally specific curriculum and strategies to support Black and African American families. The FRCs continued implementing the Effective Black Parenting Program and conducting outreach to encourage families to enroll. On average, participants increased parenting education scores, especially in the areas of *Self-Care, Stress, Anger Management,* and *Communication Skills*. Effective Black Parenting Program home visiting participants improved culturally-specific parenting strategies to **foster healthy self-esteem and pride in Blackness**.

SAFE SLEEP BABY:

Safe Sleep Baby (SSB) workshops continued to impact providers and caregivers, with **significant improvements in knowledge** about infant safe sleep and **increased safe sleep practices**. More than 800 caregivers participated in the one-hour workshop and 270 community-based service providers and health care workers were trained on facilitating the safe sleep training workshops. Additionally, Cribs 4 Kids partners distributed nearly 200 cribs to African American caregivers in need of a safe place to sleep their babies, and 96% of African American caregivers reached at follow-up reported only sleeping their child in a crib or Pack-n-Play.

PERINATAL EDUCATION CAMPAIGN:

The Perinatal Education Campaign (PEC) continued rebranding and revitalizing media content and messaging following the strategy's overhaul in FY 2021-22, including implementing the Model of Caring campaign, a rebrand of Unequal Birth based on a need for **more hope- and solution-oriented messaging** about maternal and infant mortality among Black/African Americans. The PEC team also shared information about the campaigns at the annual Juneteenth event, co-hosted a mixer with Be Mom Aware to highlight individuals who have shown great dedication to improving birth outcomes for underserved populations in Sacramento County, and held a special recorded birth storytelling event to share the experiences of real moms in the community and how providers could improve prenatal and postnatal care by listening to and supporting African American mothers.

COUNTYWIDE TRENDS:

The RAACD initiative contributes to countywide reductions in African American child deaths, particularly among the individuals directly reached. However, most recent three-year rolling rates indicate some countywide trends moving in undesired directions . Overall, African American infants remain twice as likely to die compared with all other races. During 2019-2021, African Americans were four times as likely to die due to infant sleep related causes or child abuse and neglect compared with all other races. Economic and public health shifts due to the ongoing impact of COVID-19 during this period, as well as ongoing structural, systemic, and institutional racial discrimination, contribute to these disparities and warrant further exploration across systems.

RAACD programs are appropriately positioned to explore the larger patterns in these trends and "scale up" efforts to address them at a county level and reach even more Sacramento families. In addition to direct services and public education, policy/systems change are needed to effect real and lasting change. First 5 continues to advocate for policy and systems change across Sacramento County and the state of California as a whole and has incorporated more deliberate and specific systems-change initiatives and efforts to promote racial equity, diversity, and inclusion in their 2024-2027 strategic plan.

Additionally, now that the Blue Ribbon Commission's target year of 2020 has passed, it is important to revisit the County's long term goals and re-commit to the reduction of African American child deaths, utilizing the insights gained since the last goals were set, incorporating community and systems perspectives which may help identify lingering disparities.

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Appendix 1 — Factors Associated with Poor Birth Outcomes

	Unhealthy Birth Outcome				Mother's Characteristics						Program Support	
Birth Type	**Low Birth Weight**	**Birth Weight**	**Preterm**	**Gestational Age**	**Weeks pregnant at entry**	**1st Trimester Prenatal Care?**	**# weeks prenatal care began**	**Socioeconomic barriers at intake**	**Health risks and pre-existing conditions at intake**	**Medical conditions developed during pregnancy**	**# of weekly check-ins**	**Received Doula Support?**
Singleton	**Y**	5 lb., 5 oz	N	39	17	Y	8	None	None	None	15	**N**
Singleton	N	5 lb., 9 oz	**Y**	35	5	Y	2	Unemployed, looking for work; No high school diploma	Prior LBW; Prior gestational diabetes; Prior preeclampsia; 2+ prior miscarriages; has child < 1 year	Gestational diabetes	42	**N**
Singleton	**Y**	5 lb., 3 oz	**Y**	32	28	**N**	14	Unemployed, looking for work; No high school diploma; Unstable housing; No transportation; Income less than $15K; *Pressing Needs*: Prenatal Care, Food/ Nutrition, Counseling, Transportation, Housing	2+ prior miscarriages; age 35+; drug use; Depression; Domestic Violence; High blood pressure	None	4	Y
Singleton	**Y**	5 lb., 7 oz	N	37	25	Y	10	Income less than $15K; *Pressing Needs*: Alcohol/ Drug Treatment, Transportation	Depression; Drug use	None	21	**N**
Singleton	**Y**	4 lb., 15 oz	N	37	16	**N**	-	Income less than $15K; *Pressing Need*: Housing	Anxiety; Depression; Other health risk	Other Health Condition	16	**N**
Singleton	**Y**	5 lb., 0 oz	N	37	18	Y	10	Single, no partner; *Pressing Need*: Housing	Depression; Age under 20	High Blood Pressure;	19	Y
Singleton	N	6 lb., 11 oz	**Y**	36	10	Y	5	Income less than $15K; *Pressing Needs*: Prenatal Care, Counseling	None	Gestational diabetes	15	**N**
Singleton	**Y**	2 lb., 8 oz	**Y**	29	18	Y	6	None	Nutritional deficiencies; Asthma	Gestational diabetes; Preeclampsia; High Blood Pressure	25	**N**

Appendix 2 — BMU Correlation, Chi Square, and Regression Details

First, correlational analyses[43] were conducted to identify significant relationships between the factors listed in the table above and the birth outcomes above. Significant correlations mean variables are related to one another, though correlations do not mean that one variable caused an outcome. The characteristics that were significantly correlated to birth outcomes are shown in the figure below (variables that were not significantly correlated are not displayed).

Figure 38 — Factors that Correlate with Birth Outcomes[44]

Protective/Risk Factors at Intake	Healthy Birth Outcome (Dichotomous; Y/N)	Birth Weight (Continuous)	Gestational Age (Continuous)
Number of BMU Check-Ins	.16*		.21**
Sexually Transmitted Infection at Intake			-.14*
Prior Gestational Diabetes			-.17*
Regular Prenatal Care at Intake	3.53t		.12t
Trimester of First Prenatal Visit	9.52**		
Able to Fulfill Food Needs at Intake	2.82t		.13t
2+ Prior Miscarriages		-.12t	-.12t
Number of Pressing Needs at Intake	-.13t		
Prior Low Birth Weight Birth		-.12t	
Prior Preterm Birth			-.11t
Has a Child Under One Year of Age	2.94t		

Source: Health Assessment Form, Pregnancy Outcomes Form, and Exit Form. * = $p < .05$; ** = $p < .01$; *** = $p = .001$; t = $p < .10$. Sample sizes for each correlation vary due to missing data and some variables only being implemented in one of the fiscal years, but overall N = 223.

All dichotomous variables included in the regressions were coded based on how they are presented in the tables (e.g., for the variable "regular prenatal care," 1 = *Did have regular prenatal care* and 0 = *Did not have regular prenatal care*)

[43] Includes Chi-Square test of independence, Point-Biserial Correlation, and Pearson Correlation Coefficient tests.

[44] All dichotomous variables included in the regressions were coded based on how they are presented in the tables (e.g., for the variable "regular prenatal care at intake," 1 = *Did have regular prenatal care* and 0 = *Did not have regular prenatal care*). All significant associations were in the expected directions (e.g., more visits with a BMU pregnancy coach were associated with being more likely to have a healthy birth).

Logistic Regression Predicting Dichotomous Healthy Birth Outcome (yes/no).

	B	S.E.	df	*p*	*OR*	95% CI
Regular Prenatal Care at Intake	.36	.87	1	.684	1.43	.26 - 7.91
Prenatal visit in 1st trimester vs. 2nd or 3rd	-.97	.74	1	.194	.38	.09 – 1.63
Prenatal Visit in 1st or 2nd Trimester vs. 3rd	**2.67**	**1.11**	**1**	**.016**	**14.48**	**1.64 – 128.08**
Number of BMU Check-Ins	**.06**	**.03**	**1**	**.051**	**1.06**	**1.00 – 1.12**
Able to Fulfill Food Needs at Intake	.62	.68	1	.365	1.85	.49 – 7.01
Number of Pressing Needs at Intake	**-.36**	**.17**	**1**	**.028**	**.70**	**.50 – .96**
Has a Child Under One Year of Age	**-1.52**	**.58**	**1**	**.009**	**.22**	**.07 – .68**
Constant	-.63	1.36	1	.644	.53	-

Note: bolded variables are statistically significant at $p < .10$; N = 199.

Linear Regression Predicting Continuous Birth Weight

	B	S.E.	*t*	*p*	*95% CI*
Constant	**7.06**	**.09**	**76.46**	**<.001**	**6.88 – 7.25**
2+ Prior Miscarriages	**-.62**	**.36**	**-1.71**	**.088**	**-1.33 – 0.93**
Prior Low Birth Weight Birth	**-.73**	**.42**	**-1.74**	**.084**	**-1.56 – 0.98**

Note: bolded variables are statistically significant at $p < .10$, N = 223.

Linear Regression Predicting Continuous Gestational Age

	B	S.E.	*t*	*p*	*95% CI*
Constant	**36.75**	**.66**	**55.37**	**<.001**	**35.44 - 38.06**
Regular Prenatal Care at Intake	.70	.58	1.20	.233	-.45 - 1.85
2+ Prior Miscarriages	-1.08	.79	-1.37	.172	-2.63 - 4.7
Sexually Transmitted Infection at Intake	-.30	1.18	-.25	.801	-2.62 - 2.03
Able to Fulfill Food Needs at Intake	.75	.52	1.45	.148	-.27 – 1.77
Number of BMU Check-Ins	**.05**	**.02**	**2.99**	**.003**	**.02 - .08**
Prior Gestational Diabetes	**-1.26**	**.54**	**-2.33**	**.021**	**-2.33 - -.19**
Prior Preterm Birth	-.89	.64	-1.40	.163	-2.15 - .36

Note: bolded variables are statistically significant at $p < .05$, N = 223.

Appendix 3 — Countywide African American Births and Infant Deaths 2012-2021

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Number AA Births	2,078	1,979	1,941	1,901	1,826	1,947	1,817	1,796	1,681	1,714
Number AA Infant Deaths	22	24	19	21	12	14	23	13	18	21
AA Infant Mortality Rate (per 1,000 births)	10.6	12.1	9.8	11.0	6.6	7.2	12.7	7.2	10.7	12.3
Three-Year Rolling Rate (Period end year)	-	-	10.8	11.0	9.2	8.3	8.8	9.0	10.2	10.0

Appendix 4 — Technical Notes Related to County Trend Data

Since 2019, representatives from First 5 Sacramento, Sierra Health Foundation, Sacramento County Public Health, and the Child Abuse Prevention Center have met annually to discuss and agree upon core parameters for gathering and sharing RAACD data. The following presents the highlights of these discussions as of fall 2022.

BASELINE YEAR

The Blue Ribbon Commission report cited data from 2007-2011, and set goals based on the change desired after that period. Specifically, 2012 is being used as the starting period for RAACD partners, although implementation began to get underway in 2014 and 2015. Because of the instability of one-year estimates, this report uses the three-year period of 2012-2014 as the baseline period, and tracks change in subsequent, rolling three-year periods relative to that baseline.

CODING OF RACE

Birth data is based on maternal race indicated on birth certificates and includes individuals who identify as African American alone. Individuals whose race is listed as “Multiracial” are not included in the Sacramento County Public Health’s (SCPH) category of African American. Death data is gathered by the SCPH from the coroner’s office and is based on the race of the deceased on the death certificate. The race listed on the birth certificate and death certificate may not always match and may not be fully representative of individuals identifying as Black/African American.

DATA SOURCES AND RATES

Partners agreed to use data from Sacramento County Public Health as the source of overall infant death rates, low birth weight, and preterm births and to use CDRT data to track infant deaths by cause. It was also agreed to show trends per 1,000 births, and not 100,000 population, with the exception of 0-5 child abuse and neglect deaths, which remain per 100,000 population.

Measure	Data Source		Measured as:
	Numerator	Denominator	
Low birth weight infants	SCPH	SCPH (total births)	Percentage of Births
Preterm infants	SCPH	SCPH (total births)	Percentage of Births
All Infant Deaths (<1 year)	SCPH	SCPH (total births)	Rate per 1,000 births
Infant Sleep-related Deaths (<1 year)	CDRT	SCPH (total births)	Rate per 1,000 births
Infant Perinatal Condition Deaths (<1 year)	CDRT	SCPH (total births)	Rate per 1,000 births
Infant Child Abuse and Neglect Deaths (<1 year)	CDRT	SCPH (total births)	Rate per 1,000 births
0-5 Child Abuse and Neglect Deaths (< 6 years)	CDRT	County Population (0-5)	Rate per 100,000 children

Three-year rates are calculated as the sum of the totals for each year for the topic of interest (e.g., number of infant deaths) divided by the sum of the total population measure for the three years (e.g., number of births). This is then multiplied by the rate measurement, when applicable. For instance, the rolling rate for infant mortality calculation is:

((# infant deaths Year 1 + # infant deaths Year 2 + # infant deaths Year 3) /

*(# births Year 1 + # births Year 2 + # births Year 3))*1000*

Disparity gaps described in this report reflect the difference between the group with the highest rate divided by the group with the lowest rate. For instance, the disparity gap between infant mortality rates are calculated as:

(African American Mortality Rate / All Others Mortality Rate)

Changes in total rates between single year or three-year rolling rates are calculated as follows:

(New value-Previous or Baseline value)/Previous or Baseline value

Calculations for changes in disparity rates between groups are as follows:

((New AA rate – New All Others Rate)-(Previous AA rate – Previous All Others Rate)/

(Previous AA rate – Previous All Others Rate))

Appendix 5 — References

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The photographs on pages 44, 45, 46, and 47 were provided by First 5 Sacramento and/or their RAACD partners. All other photographs in this report are stock photos that are posed by models.

RAACD Resources

If you would like to learn more about the Reduction of African American Child Deaths initiative, please contact one of the following partners:

First 5 Sacramento
(916) 876-5865

Black Mothers United and Public Education Campaign
Her Health First
(916) 558-4812

Safe Sleep Baby and Birth & Beyond
Child Abuse and Prevention Council
(916) 244-1900

Black Child Legacy Campaign
(916) 993-7701