Kathryn Hall-Trujillo

The Underground Railroad for New Life

Improving Outcomes for Mothers and Babies of African Descent

Innovations Case Narrative:
The Birthing Project

The Birthing Project, an organization that emerged out of a strategy for improving birth outcomes among African American women, is most often described as the "Underground Railroad for New Life." Much like the original Underground Railroad, through which Harriet Tubman helped to shepherd thousands of slaves out of bondage, The Birthing Project seeks to bring women out of a place we deem unacceptable in terms of health and well-being. Escaping an environment of scarce information, resources, and social support, a woman who comes to us is greeted by the welcoming arms of a community that cares about her and demonstrates what she needs to see—that her life has value. In the end she discovers she hasn't arrived anywhere new at all, because to her and her healthy new baby, these surroundings feel as familiar as coming home. Here she comes to understand that the future of her children—of everyone's children—depends on our collective ability to dream and co-create the world in which we want to live. Here women receive the gift of belonging, and in turn they give the gift of life.

In an attempt to combat the high rates of infant mortality and morbidity among the children of women of African descent, I have helped to create this welcoming experience for women for more than two decades. Beginning as an experimental program I developed while working for the State of California, The Birthing Project has become an international network of small groups of women given support through a central coordinating organization, Birthing Project USA. Our programs help pregnant women identify and use the resources available, both in their communities and within themselves, that they need to care for themselves and their families. Our central aim is to keep more babies alive and healthy by recruiting, training, and supporting community volunteers to provide direction, emotional support, and education to expectant women and new mothers. These

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volunteers, called SisterFriends, organize in groups of ten, and each commits to guiding a pregnant woman through her pregnancy and the first year after the birth of the baby, usually a period of 18 months. During that time, the SisterFriend acts as a real big sister would, helping to connect her little sister to the resources she needs, ensuring that she attends all her prenatal and postpartum appointments, and providing general psychosocial support. Ideally, women who have a child through The Birthing Project return to act as SisterFriends themselves.

Birthing Project women who have a SisterFriend attend 80 percent of their prenatal appointments. Since the program began in 1988, over 10,000 babies have been welcomed into 94 Birthing Projects in five countries reaching from Mississippi to Malawi. At least 30 Birthing Projects take place at any given time, operating out of homes, churches, service groups, places of employment, clinics, health departments, and hospitals. Our international programs in Canada, Cuba, Honduras, and Malawi have allowed African American women to connect to other women of African descent throughout the world. In those countries, we have taken advantage of public health initiatives to train more medical professionals willing to work in the United States and abroad, created new and important roles for traditional birth attendants, and helped strengthen the bonds between women of African descent worldwide.

The Birthing Project's work in New Orleans epitomizes what I have sought to accomplish since I first began this work over twenty years ago—addressing the causes of poor birth outcomes by extending beyond the usual cast of characters of physicians and social workers.

I encountered one of our greatest challenges and had some of my most inspiring moments right here in the United States, when we took on the task of helping to rebuild New Orleans after Hurricane Katrina. The Birthing Project has established an office in New Orleans and developed a relationship with Tulane University, through which we provide a clear path for students to get socially involved in a culturally competent and non-intrusive manner. Through this relationship and the community we formed by holding quarterly baby showers that are funded by Birthing Project groups across the country, we have built a foundation for grassroots ownership and leadership on issues related to the future of our babies.

With this new role comes the responsibility of helping move the residents of New Orleans from victims to community champions. The Birthing Project's work in New Orleans epitomizes what I have sought to accomplish since I began this

work over 20 years ago—addressing the causes of poor birth outcomes by reaching beyond the usual cast of physicians and social workers. Our work embraces issues of employment, housing, environmental and nutritional justice, all of which play a role in improving birth outcomes. We have become deeply involved in the transformative systemic change now underway in New Orleans, a city that once gave the last testimony to the Old South's plantation system. Since Hurricane Katrina, numerous organizations and groups have enthusiastically come together with the common goals of bringing the city back to life and breaking down historic barriers of class, race, and the university/community divide.

THE SISTERHOOD SOLUTION

A visit to the Shelby County Cemetery in Nashville, Tennessee, provides a startling reminder about infant mortality. There, the state has buried thousands upon thousands of dead babies and marked each with a small numbered disc. These tiny graves represent a small percentage of the number of infant deaths, many preventable, that occur in the United States every year. According to the World Bank, the United States had a higher infant mortality rate in 2008 than any other developed country (7 for every 1,000 live births), the same as Serbia, Chile, and the United Arab Emirates. Cuba, Croatia, and Singapore rank higher than the U.S. African American babies bear the brunt of this statistic, with a mortality rate at least 2.5 times the national average. This particular disparity between black women specifically and the rest of the population generally still puzzles me, especially when one considers that these poor birth outcomes among black women do not adjust for age, education, or income. For example, a 40-year-old black woman with a master's degree has the same odds of a poor birth outcome as a 20-year-old unemployed black woman. As such, all African American women have the same level of risk.

Front and center among the probable causes for this incredible statistic sits the absence of early and continuous access to affordable health care due to systemic, programmatic, and/or personal barriers. A less commonly known but increasingly researched culprit, the lifetime of stress experienced by black women in the U.S., may also bear some of the responsibility. Furthermore, services that are available may not be ethnically or culturally appropriate, user friendly, or comprehensive enough to address the realities of a pregnant woman's life, as each has a unique set of circumstances. Government programs have sought to remedy the medical and psychosocial problems of women eligible for their services, yet barriers of communication, information, and perspective between service providers and pregnant women often thwart these efforts. The social workers employed by the government and philanthropic organizations to shepherd women between the agencies that provide services often contend with up to 50 cases at a time, and some individuals inevitably slip through the cracks.

The Birthing Project model gets to the heart of the matter and intervenes on every level, seeking to connect women with the resources they need, encouraging

them to think about their lives, and giving them the strength and confidence to pursue what they need in order to have a healthy baby. It also provides social support to reduce the stress of being an expectant mother. The foundation of The Birthing Project's efforts is the volunteer SisterFriends, who provide expectant mothers with one-on-one mentoring and practical support, focusing especially on prenatal care. Neighborhood agencies, clinics, or individuals identify women at risk of a poor birth outcome and refer them to the program. SisterFriends play the role of a friend, big sister, and partner, which many of these women have never had. They do what a big sister would if her little sister came to her and said, "I'm pregnant and I hadn't planned on it." After her big sister fusses at her, they move forward together to figure out how the pregnant woman can give birth to the healthiest baby possible. SisterFriends provide a nurturing environment, one that not only leads to the formal medical attention that the pregnant mother, and eventually the baby, needs, but also someone to talk to with whom the mother can share her dreams for herself and her baby, and who can connect the new mother with the resources that can make that happen.

SisterFriend interventions occur when a group of ten women decide they want to commit to 18 months of service, after hearing about the program through friends or a public health professional, or from media about The Birthing Project or about me. They then take the next step and contact The Birthing Project USA office. From us they receive initial training and help finding local public health professionals to educate them about the resources available for pregnant women in their community, information they can later pass on to at-risk pregnant women. They also learn about agencies that can refer them to women who could benefit from The Birthing Project, about fundraising strategies, and about organizations in their area with whom they could partner, such as the March of Dimes or Healthy Start.

This arrangement represents a major step forward from the way things worked for almost 21 years, when women interested in starting a Birthing Project in their community contacted me directly. The Birthing Project expanded across the country in a very grassroots manner. In addition to running the clinic, I started to provide resources for the women I helped through the Sacramento Birthing Project (see below for more information), and I provided support to these new Birthing Projects. Now, through the national organization, I can focus on helping these expanding programs and give more attention to advocacy work on issues related to the systemic causes of poor birth outcomes in the United States. We've received funding to start a campaign to reach out to communities on a national level, to raise awareness and recruit volunteers to join or start a project in their communities.

Through the network made up of these small groups, we have come together to work nationwide to improve birth outcomes for women of color. We provide technical assistance and support to communities and organizations to replicate and sustain The Birthing Project model of providing education, support, and access to care and services for at-risk women and families. Our achievements have

spoken for themselves, in terms of the results of our model and of our method of replication. Babies born through The Birthing Project weigh an average of 7.5 pounds, compared to the average of 6.5 pounds for African American babies. Birthing Project women attend 80 percent of their prenatal appointments and 70 percent of their postpartum appointments after being matched with a SisterFriend. We now count over 90 established Birthing Projects, and at any given time can count at least 30 going through the 18-month process. A doctoral dissertation has been written about us, a study of the way we bring together women of such diverse backgrounds. I can confidently claim that we're the grandmother of other prenatal mentoring programs that have sprung up around the country. The achievements of The Birthing Project have earned me recognition from the California state legislature as Woman of the Year, as a Hero in Healthcare by the Coalition for Excellence in Healthcare, an *Essence* Magazine National Community Service Award, and a fellowship as an Ashoka Global Social Entrepreneur, and most recently a CNN Hero for 2010. These accolades have helped bring attention to the issue of infant mortality, and to the work of all the women involved in The Birthing Project.

THE BITTER DISCOVERY OF AN UNEXPECTED PASSION: 1988-1998

I wish I could say that my desire to start The Birthing Project came out of a deep, altruistic gesture or a compassionate humanitarian effort to solve a major problem. Instead, it came out of an attempt to save money for the State of California. In March 1988, I worked as a public health program adviser and fiscal administrator for the California State Department of Health Services, the kind of "big picture" functionary whom the state tasked to get as much public health programming as possible to state residents for as little money as possible. At the time, that particular job had become very difficult—our tax base began to dwindle, the state had begun to lose public health nurses, and we began to see an increase in what we then called "drug babies." The state spent an enormous amount taking care of people who already had health problems. For example, babies born with an illness or disorder whose care the state had to pay for cost about $300,000 for the first 90 days of his or her life, including the social and legal support the families needed. To me, it just made sense to back up and do more intervention at the front end, rather than spend all that money on the back end. It cost us way too much money for mothers to give birth to already sick babies, and I thought if we invested in social supports and services for pregnant mothers, we might see more healthy babies born. Thus we'd end up paying less in the long run and have more money to invest in public health.

I had the idea of deploying an army of volunteers to help the public health nurses do their work on the grassroots, community, neighborhood level. They would provide one-on-one case management/care coordination to women whose care would likely cost the state a lot. To test the idea, I asked nine other women, whom I called SisterFriends, to join me in providing friendship, education, and

practical support to ten high-risk women. If the model worked and we could demonstrate that we improved birth outcomes among the women we counseled, I would submit it to the state as a possible solution to the high cost of infant morbidity.

I had recently relocated to Sacramento from Los Angeles, so I didn't know enough women to recruit into the program. Instead, I asked people I knew in the public health community to refer ten women known for getting things done, and whom others considered powerful and effective. Tchaka Muhammed, a public health advisor and a resource guru in Sacramento, helped me out during this time to find anything or anyone I needed. He helped me identify women who would help me during the testing phase. I eventually managed to recruit nine women, and we began the program in my home in March 1988. I assigned myself and the other women to our "little sisters," and we worked together to connect our new sisters to health care and other resources, listened to their stories, and helped them plan for their babies.

At that moment. . . the issue of infant mortality became personal for me. He gave me the gift of understanding and purpose. My original intention of doing this work to save the state of California money changed to doing this work to save the lives of babies.

My little sister, Frances, gave birth to a child she named Deandre. Ten days after his birth, he died as a result of different doctors prescribing different drugs for his mother, which caused him to suffer massive brain damage. In my role as Frances's SisterFriend, I showed her how to hold her baby and say goodbye. At that moment, as I held Deandre's little body in my arms, the issue of infant mortality became personal for me. He gave me the gift of understanding and purpose. My original intention of doing this work to save the State of California money changed to doing this work to save the lives of babies.

Before having that experience, I had often worked on the issue of infant mortality and morbidity, and I certainly knew about the statistics related to infant deaths. However, I had always thought about it on an abstract level. Deandre's death made those statistics real, and I realized for the first time that those numbers actually counted dead babies. That realization was a lot more intense and a lot more emotional than the way I had thought about the issue before. Moreover, I had worked on this issue as part of my profession, and I wanted to further my progress on the career ladder and earn the approval of my colleagues and supervisors by demonstrating that I could solve problems. But when I held that baby, I felt

more accountable to that baby's mother than I had to anyone in any previous relationship.

After that experience, something changed deep inside of me. At first I couldn't talk about it, I felt simply dumbfounded. Meanwhile, still working for the state, I continued the project, starting with a new group of pregnant women every three or four months. My supervisor submitted the project to management for official authorization but we never received a response. I applied to the Sierra Foundation, which at the time was a brand new health foundation. They awarded us $347,000 in 1991, two years after I had started the first Birthing Project. As a state worker, this new funding compelled me to choose my job or hand the program over to someone else to run. I never planned on leaving the state and running The Birthing Project, but on a long weekend two years after Deandre's death, I stopped in to check on the program on the way to a conference, and never returned to my job.

This decision reflected the internal shift I had experienced through Deandre's death and my work with The Birthing Project. Earlier in my life, before my good job and my graduate degree from UCLA, I had witnessed rampant racism in my native Arkansas. I had received welfare, I had dropped out of high school, and after running away from an abusive marriage, I even did a stint living in a bus station with my two kids. I now had the unique position of bridging the gap between two worlds, bringing my experience and my education together with my hopes and dreams and what I now knew to be true. I had created the perfect job for myself, one in which I could make something happen between policy, programs, and services.

The Birthing Project operated in Sacramento, and I hadn't thought about replicating what we did—I just focused on doing the project we had well. The program's funders, however, tried it out a couple of times themselves, once in a substance abuse community making former substance abusers SisterFriends to pregnant women, and again in a rural community in northern California among survivors of domestic violence. However, the first real replication of our project in an African American community came in 1991 in Phoenix. Linda Parsons, who now serves as vice president of the national organization, had learned about The Birthing Project through a mutual colleague. She came to visit me in Sacramento and followed me around with a tape recorder, saying she wanted to do exactly what I did, but in Phoenix. So although unplanned, Linda brought about the first replication. She drives me crazy, because everything I do she does better—she really figured out how to distill what we had accomplished with our SisterFriend model.

Among the things she did well was promote our work. She invited Susan Taylor, then an editor of *Essence* magazine, to her Birthing Project birthday party. Susan fell in love with the project and included an article about The Birthing Project in an issue of the magazine. When the article appeared, the wave of responses we got followed the magazine's distribution across the country—we received calls first from women on the East Coast, the next day from women in the Midwest, and so it went all the way out to the West Coast. The women were asking

for more information about The Birthing Project and were interested in organizing projects in their own communities. By the time the magazine made it to the newsstands, over two hundred women had contacted me to express an interest in starting a Birthing Project of their own.

At this point, I worked with Linda in Arizona and my volunteers in Sacramento to establish the next steps. None of us had anticipated such a response from the article, and we didn't have any formal way to organize our relationships with these other women. We decided to ask each of them to write a letter telling us who she was and why she wanted to do the project. Once we received all the letters, a few of us got together on the beach and read them aloud to each other. We figured out a game plan, which involved each of us calling a few of the women who had responded to discern whether the applicant had a real interest in starting a project. Out of that initial process, 30 new Birthing Projects emerged across the country.

We could not have developed a simpler guideline for the new groups, as we only required three things: don't give medical advice, don't share confidential information with anyone, and don't drive your little sister around in your car if you don't have car insurance. Outside of that, we limited training to demonstrating how to build and maintain sisterly relationships, identify and collaborate with the local partners the SisterFriends could turn to for the information at-risk pregnant women would need, and increase their leadership skills. But frankly, many African American women truly understand the role of a SisterFriend and can develop their own values and their own understanding of what being a SisterFriend means. I think that rather than a codified training, most African American, Latina, and other women of color only have to go through a process of remembering.

This made more sense when my work with The Birthing Project in Sacramento helped me realize that I wanted to do more than direct women to pre- and postnatal care. I knew that if I wanted to really improve birth outcomes in Sacramento, I needed to start developing appropriate resources. I founded the Center for Community Health and Well-Being as a diverse, comprehensive, and culturally competent provider of social services and health care. Our clients could walk in and relate to the pictures they saw on the walls and the people that gave them care. The familiar way people working at the clinic talked to and touched our clients made them feel they could finally exhale, relax. The people at the clinic understood these women and treated them like they had come home. When a woman missed an appointment, we sent an outreach worker to her house to find out why, and we offered what help we could to reduce her barriers to accessing care. That practice took into account the bigger picture and the realities of the women we served, and we soon learned to ask the right questions because we had a better sense of a woman's possible circumstances.

Building on the foundation that our network of SisterFriends had provided, and as the first babies born in the program began to get older, I continued to develop ways the clinic could use the community we had built to ensure that those chil-

dren continued to have good health. One program offered through the clinic, the Saturday Morning Beauty Salon, helped mothers and their daughters ages 10-12 strengthen communication with one another before the daughter got lost in the teen years. We drew from our memories of the beauty salons of our youth as the place a girl went to learn about "woman stuff." A program for men, called the Barber Shop, paired men with new fathers to provide a support network similar to what we were providing for young mothers. These programs sought to leverage the community forming around The Birthing Project, which had been so critical in the past and which I knew, if recreated, could begin to strengthen families and positively impact the many variables affecting these children's health throughout their lives, including the birth outcomes of the next generation of moms.

I can't tell you how many times I had to refinance my own house to make payroll, and to this day I still haven't taken a real vacation since starting the project. But the reward has been that through our model, women of African descent from the United States and worldwide can conceive of and manage their own clinics and their own lives.

The Birthing Project and the clinic had developed into something unique in Sacramento, but we always had problems with money. Part of the problem came from having to define our own existence because we didn't fit into any normal medical or insurance model. When we first started, the State of California had begun their shift toward managed care, and the insurance companies wouldn't contract with us because they didn't know what kind of animal we were. This meant frequent conflicts with men in suits, and as a former big-picture fiscal administrator for the state, I often found myself in the strange position of running up against regulations I had helped to write. One of our strategies involved not following whatever source the money came from, like a breastfeeding promotion one year or nutrition education the next. As a result, we were able to track our outcomes over time and eventually earned both community and professional credibility.

I can't tell you how many times I had to refinance my own house to make payroll, and to this day I still haven't taken a real vacation since starting the project. But the reward has been that through our model, women of African descent from the United States and worldwide can conceive of and manage their own clinics and their own lives. Fortunately, individual donors have given me the opportunity to work as a rogue health professional. I can have an ad hoc membership in national

organizations like the federal Healthy Start program, but because I don't get money from them, I don't jeopardize any funding by disagreeing with national policy or procedures. That may ultimately mean that we don't have as much money as some organizations, but in return I can be an African American face getting our message out, and can say what we need without waiting for someone else to do it for us.

ANCIENT PRACTICES, NEW STRATEGIES: 2000-PRESENT

Eventually I began to involve myself and The Birthing Project in a variety of projects outside the United States. As the 1990s came to a close, I encountered some unique opportunities for The Birthing Project model and the work at the clinic to emerge onto an international stage. Civil rights heroes like Martin Luther King Jr. and Malcolm X had realized that the African American experience went beyond the United States, and through a variety of new experiences I had begun to see that as well. I came to learn that African Americans shared a wound with people of African descent in other parts of the world, a disease that comes from being disempowered. It comes from having to ask someone else to help us and, moreover, to ask in a way that makes sense to them, that they find acceptable. We end up having someone speak on our behalf, and if we're talking about babies, we're talking about something very personal and sometimes difficult to translate across cultures. As I began to work abroad, I found my ability to act as a bridge between worlds was growing even stronger.

The first experience that really began to open my eyes happened when I visited Cuba for the first time. I really hadn't ever thought about Cuba, but after the Elian Gonzalez drama, a group in Cuba invited a group of woman representing the organization Madres (to which the Sacramento clinic belonged) to go see Cuba for ourselves. Cuba really surprised me, first and foremost by the fact that so many Cubans looked like me and that the majority of Cuba's population has African roots. I realized something else, too—that they had a better infant mortality rate than the United States overall, and a staggeringly better rate than among African Americans. Despite the blockade, they had achieved fabulous things in public health among a population largely of African descent. I wondered how this phenomenal result could come to pass, and I began investigating.

I soon learned more about Cuba's excellent public health programs and the Latin American School of Medicine. The fact that they accept students from the United States piqued my interest. At the Sacramento clinic, we had to hire midwives instead of doctors because we couldn't afford to pay a doctor's salary. Although many young doctors had expressed an interest in working with us early in their careers, because of the tremendous debt many new doctors carry after attending medical school in the United States, they simply could not afford to work for us at the rates we can pay. So I had the idea that we could encourage U.S. students to study medicine and public health for free in Cuba, and they would then come to work for us because they would graduate debt free. In 2000, we began

working with the administrator of the U.S.-Cuba medical school program. The program began with eight students, and to date, 47 have completed their studies. One has completed a residency. These new doctors received their education in an environment that emphasized working with the poor and learning about public health as well as medicine. They have enormous value for critically needy areas throughout the United States, and all are Spanish speakers.

While developing the program in Cuba, I met Dr. Luther Castillo Harry, a student at the medical school in Havana and a member of the Honduran Garifuna community. The Garifuna people's African ancestors landed on Honduras's Caribbean coast after escaping from Spanish slave ships, and they ended up fighting and losing a war with the British. The story fascinated me, as did Castillo Harry's recounting of his effort to develop a health program in his community. Castillo Harry indicated that he would return to his home community in the remote jungle after his schooling in Havana. There he would provide health care to his people, known as the forgotten people because they are truly underserved by their country. He invited me to help. I volunteered to apply my expertise in whatever way the community needed, and became the women's health administrator of the first health-care system for the Garifuna people.

There I helped with the construction of a new clinic and connected with the traditional midwives in the community. I learned a great deal from them, and worked to adapt the SisterFriends model from the United States to create a new role for them that included providing basic prenatal care and connecting their patients to the new doctors. Instead of allowing the formal medical establishment to replace them, the midwives learned to work with the Cuban-trained Garifuna doctors to complement and extend medical care. In exchange for them teaching the U.S. midwives and birth attendants their traditional practices, The Birthing Project provided them with continuing midwifery education, medicine, and medical supplies.

That experience again awoke in me my connection to others of African descent, and something the Garifuna women said struck me—of all those who had come to visit the community or to help with its development, I was the first black woman. It made me realize the importance of having a woman that looks like you as a member of the team that has come to help. As a result, I have organized trips for African American women from the United States to visit the jungle and play their part in the collective healing we all experience by connecting.

The international experience extended even further with a visit to Malawi, where we work within a system that includes traditional birth attendants. The Birthing Project's biggest sponsor, Brian Marks, who is head of the Dr. Miracles line of ethnic hair-care products, visited the country and realized that the work I had done in Honduras would be useful to the development process in communities in Malawi. We treated the traditional birth attendants not only as if they still had a special place, but as if they had something unique to offer—which of course they did. The young doctors we had worked with in Honduras had specifically requested to work with the birth attendants who had "caught" them, and that con-

nection, along with their great care and gentleness, made the attendants a vital component of every woman's health-care team. This model has seen international replication because it reduces the tension between Western and traditional medicine, and also invites traditional healers to participate in the health-care teams rather than face replacement or exclusion.

As such, we work closely with the Malawi program director. She has identified and continues to work with ten midwives in a community in the district of Mchinji, whom she has trained to provide more robust prenatal care and monitoring that extends beyond their traditional roles. They have learned to identify emergency situations in the absence of formal clinics or hospitals and to provide the bridge to formal care, although in this case their expanded role is due to the country's sparse medical infrastructure. Related to this limited access to medical care was my discovery that women in Malawi who are expecting to give birth go to the hospital weeks before they deliver, camp outside the facility, and wait for the baby to be born near the hospital because they live so far from a medical facility. We have mobilized women of African descent in the U.S. to connect with their sisters in Africa by providing cots and energy bars for these women, until the day when medical care and clinics become available in their communities, and pregnant women no longer need to make these trips.

HURRICANE KATRINA AND THE NEW ORLEANS BABY SHOWER: 2005-PRESENT

My 20 years of experience with The Birthing Project has led me to believe we are all born with a sense of resilience: the ability to stay encouraged, inspired, and engaged in spite of what may appear to be defeat. If we don't use that ability, we forget we have it and it goes dormant. In this time of global crisis, each of us has to call forth the resilience in us. We need to tap into that resilience and the spirit of social entrepreneurship based on our individual and collective experiences and perspectives by connecting to our natural empathy and by recognizing everyone's need to contribute, belong, and be valued.

I thought often about resilience as I watched the first images out of New Orleans showing the devastation caused by Hurricane Katrina. I read about a pregnant woman who, in the throes of labor, jumped off a roof holding the hand of her toddler and swam until someone rescued them. The desperation of her situation and her heroism moved me, as did the realization that the storm especially affected women and babies. Before Katrina, we didn't have a Birthing Project in New Orleans because no one from there had approached us. But when Katrina happened, we felt that we just had to come help our sisters who were suffering under such extreme circumstances.

I flew down there with my assistant to see what we could do to help. We brought basic supplies, as well as hair products, lipstick, and soft baby blankets. As we ran into families in shelters, walking down streets, or buying chicken in gas stations, we asked the women how we could be of service to them. They indignantly

told us to go back and tell the rest of America, who like me had seen their pictures on the front pages of newspapers and on the evening news, that the people of New Orleans would not live as refugees in their own country. But they did face long-term problems, and they did not want to be forgotten after the media had left.

I have felt before that we have a dual system in our country, one for those included and one for those not included in the mainstream. In New Orleans after the storm, that fact stared me in the face. In the communities we visited, public health officials had said the water from kitchen faucets, the only water available to drink, was unsuitable, and whole neighborhoods existed on fast and processed food purchased from nearby gas stations. Even now, fresh vegetables come at a premium and are not available in the neighborhoods where I live and work. Even before the storm, New Orleans hadn't provided an environment that would lead to healthy birth outcomes, and since the storm, giving birth to healthy babies has become much more difficult.

While combing the New Orleans neighborhoods for pregnant women so we could explain our program to them, residents told us, "There aren't many pregnant women here." In terms of matching those who lived there with a volunteer SisterFriend, the fact that everyone had been hit by the storm and would be too overwhelmed to help someone else concerned us. So I did what I could to at least make a dent in the first years following Katrina. I went back to California but returned every three months with women from other Birthing Projects to host a baby shower for all the pregnant women we could find. The baby showers were hosted by a woman from a different city each time. She would figure out how to get her boss, or her social club, or her church to pay for her trip and give us $300-$500 to throw the shower, including buying food, drinks, and some baby gifts. The local women who participated said they enjoyed the Dreaming Ceremony and Glamour Shots the most. During the Dreaming Ceremony, a leader gave every woman a clear stone and asked each in turn to say a prayer about what she dreamed for her baby's life, and urged them to keep the stones to remind them of their dreams. The Glamour Shots provided photos of the women looking beautiful and alive, rather than homeless and desperate. Fifteen women attended the first shower; almost one hundred attended the last one.

The delegations that hosted the quarterly baby showers began to pair up with pregnant women in New Orleans, serving as virtual SisterFriends to them until local women, especially those who had already participated in a Birthing Project themselves, could assume responsibility and volunteer as SisterFriends. As always, SisterFriends connected babies and children to pediatric care. We honored our commitment not to forget them, and as they slowly got back on their feet, they knew they had sisters they had never seen to help them find their way home. They also recognized that their babies represented the start of a new life after the storm.

When we first started working in New Orleans, people would say, "Thank god for Mississippi or we'd be at the bottom." A woman who attended one of our baby showers, when asked about her hopes and dreams for her child, ran out of the room crying with hopelessness. I challenged her to become my little sister. Her

daughter is now three years old, and the woman is employed as a neighborhood worker for The Birthing Project program. She has regained her hopes and dreams. Maternal and child health services have gradually returned, more housing has become available, and collectively we have turned our attention to building a New Orleans better than the one that was washed away. I consider the opportunity to be a part of this historic transformation a gift beyond my wildest imagination.

When we first started working in New Orleans, people would say, "Thank god for Mississippi or we'd be at the bottom." Now . . . maternal and child health services have gradually returned, more housing has become available, and collectively we have turned our attention to focus on building a New Orleans better than the one that washed away.

New Orleans has been transformed, and I've changed as well, in a way so deep that it reminds me of the death of Deandre. I again visited a place inside myself where I didn't have words, and I have come to understand the meaning of "home," and how important it is for people to have a place to call home, in a whole new way. While I've always felt that we created a symbolic home out of our SisterFriend communities and the Sacramento clinic, to people from New Orleans, home is a real place. People who had left and gone to places like Utah after the storm felt they had to come back to their city, where they were able to exhale and truly feel they had returned to where they belonged. The people back home knew them, and there they wouldn't have to explain anything. I feel that The Birthing Project can create that feeling, and a community in which we care about each other and about our babies. To me, what New Orleans has always been about and what's growing again there now exemplifies everything for which The Birthing Project has strived.

Although New Orleans still has the greatest need, it also has the most potential. As a result, with recent funding from the Kellogg Foundation, Birthing Project USA has opened a regional office in New Orleans to serve the whole Mississippi Delta region. The project also has partnered with the Tulane University School of Public Health and Tropical Medicine. I'm very excited about our project in New Orleans because I feel like it's the soul of the country in a lot of ways. I think that New Orleans has the same problems seen in parts of the whole country, if not the whole world. If we can make something happen there, we can make something better for the whole world.

THE BIRTHING PROJECT USA AND A NEW GENERATION OF SISTERS

In 2006, I took a major leap of faith by leaving the management of the Sacramento clinic and that chapter of The Birthing Project to establish a national organization. For years I've been running the clinic while also supporting the almost 90 other Birthing Projects out of my back pocket. Becoming an Ashoka Fellow has really helped me take The Birthing Project to the next level. I realize that if I really think it's such a good solution for bringing down the high infant mortality rate among African American women, I damn well better get out there and make that happen. Starting a national organization, however, represents a whole new set of tasks and responsibilities, and I now have to focus on maintaining and expanding existing Birthing Projects and on developing national programs that are coordinated among all the chapters. I breathe a little easier when I consider how much we've achieved in the last 20 years without any central coordination or resources, and I let myself imagine what we can do with a national organization committed to providing ongoing education, support, and assistance to new and existing Birthing Projects.

Something wonderful happened recently that solidified the effort to establish a national organization. Dr. Tchaka Muhammad, the original resource man in Sacramento, remained committed to and involved with The Birthing Project over the years to the point of earning the title of Founding Father of The Birthing Project. He had always said he wanted to win the lottery so he could donate lots of money to the project. A couple of years ago, he did win the California lottery, and he kept his word by donating the first two year's salary for the national organization's director, which allowed me to leave the day-to-day management of the Sacramento clinic. Now we coordinate the national organization from the regional office in New Orleans.

As I get older, creating an international organization that will continue to grow relates to my new top priority of identifying the next generation of leadership for The Birthing Project. We need to pass it on, and I love working with students in public health and medicine from the U.S. and around the world. Young professionals, like our national organization's medical director and the team of younger people who want to put together an organization, will help The Birthing Project turn a corner. So three years from now, when I'm ready to retire, these young leaders will already do a much better job than I, and I'll feel like I've finished a job done well.

Since becoming an Ashoka Fellow, I've felt this drive toward the future even more. I've joined a task force in partnership with Ashoka that brings together fellows focused on maternal health and infant mortality who are committed to searching for the next young leaders in the field. Once identified, they will partner with Ashoka Fellows to hone their talents. Called the Young Champions for Maternal Health, two of these young leaders from Ethiopia and Nigeria will come to New Orleans and work with me at The Birthing Project for a period of nine months. This mentorship program will help pass on the learning it's taken me and

those with whom I work decades to acquire to a new generation of people committed to developing world-changing ideas in infant mortality.

As we consider replicating The Birthing Project and scaling it nationally and internationally, my own vision for what we can accomplish with The Birthing Project has grown as well. I don't think that we as a society will ever reach a point where The Birthing Project is no longer necessary, wherein we've somehow solved the problem of infant mortality for good. Instead, I would like to see a Birthing Project in every community, where having a SisterFriend or a BrotherFriend for a pregnant woman or a future father would be a natural and normal thing. It would be available to anyone expecting a child, and it would be integrated into the fabric of our society. Like food, air, water, and love, people will always need support, and The Birthing Project provides that to ensure that we keep having healthy babies.

And, frankly, I think we have a greater demand for this kind of compassion and engagement than ever before. Although medical care has expanded in general, we've gone to the extreme of losing that human factor, like medicine from an ATM. This holds true not just for women, but for everyone. In that regard, one sees a stark difference between the United States and Cuba—the Cubans may not even have a cotton ball, but at least those who visit a clinic believe their doctor truly cares about them. Before closing, Martin Luther King Jr. Hospital in Compton, California, probably had everything available that one could possibly need or want. After seeing the doctor, getting the x-rays, getting the lab work done, and having a prescription written, did the patient feel all better? Many patients would answer no, because they just didn't believe that anyone cared about them. And it's often that simple. People want to engage with someone who cares about them, who sees their potential and individuality, who encourages them and motivates them to keep going. We all need someone like that in our life.

The results of these struggles and decisions have been many. We've been able to do everything from making sure that grandmothers who are raising their children receive the support they need, to making sure that the fetal death review board has neighborhood women involved in it. I feel strongly that we've served as the grandmother of the prenatal mentoring program, addressing not only medical care but psychosocial support. That support continues every time a woman who has been shown that people care about her remains active in her community and volunteers in turn as a SisterFriend. Now that this activity extends internationally, from Mississippi to Malawi, our dreams are becoming truth. None of us individually has to solve the problems of the world ourselves. We are part of the global community of women who have the same problems, and we can work together to solve these problems. Together we have the opportunity to affect the stories our children will tell and the way they participate in their communities, thus forming a critical mass of people who have come together to define community and people caring for each other.