EXPLAINER

Disparities in Infant Health

NOVEMBER 2026

California Health Benefits Review Program (CHBRP)
University of California

The Disparities in Health Policy Series

CHBRP's explainer series, Disparities in Health Policy, examines barriers to healthcare access in California and how these barriers affect different populations. Disparities are defined as "a particular type of health difference that is closely linked with economic, social, or environmental disadvantage" (Braveman, 2014). This series aims to illuminate underlying systemic challenges while providing a clearer understanding of potential policy approaches to address them. Consistent with CHBRP's commitment to objective, evidence-based analysis, each explainer is grounded in data and empirical research. Together, these explainers seek to inform policymakers and the public about how health policies can have different impacts across communities.

This explainer provides an overview of births, infant mortality, and other birth outcomes in California, along with known health disparities and efforts to mitigate them. Infant mortality is an internationally recognized marker of a population's health. Infant mortality rates and infant health outcomes can reflect a community's access to quality healthcare and its general health status.

Birth Outcomes and Infant Mortality

Births in California

In 2024[1], there were just over 400,000 births in California; this accounts for 1 in 8 of all births in the U.S., which is the highest proportion of any state (CDPH, 2026a). Births varied by demographic characteristics including race, ethnicity and insurance coverage. Additional information about births in California is available in CHBRP's Explainer *Disparities in Maternal Health.*

Race and Ethnicity: Approximately half (48.7%) of California births in 2024 were among Hispanic women[2], one-quarter (25.2%) were among White women, 14.4% were among Asian women, and 4.3% were among Black women. The

[1] 2024 is the most recent data provided by the California Department of Public Health.
[2] CHBRP uses the term "women," but recognizes that some birthing people may identify as male or nonbinary and may also have female reproductive organs.

remaining 3.1% of births were among multiracial, American Indian and Alaskan Native (AIAN), and Native Hawaiian and Pacific Islander (NHPI) women (CDPH, 2026a).

Insurance Coverage: Approximately 40.5% of births were covered by Medi-Cal[3] and 52.4% were covered by private insurance sources (CDPH, 2026a). The share of births covered by Medi-Cal varied significantly by race and ethnicity. Between 2022 and 2024, Medi-Cal covered 57.3% of births among Hispanic women, 54.8% among American Indian/Alaska Native women, and 51.8% among Black women, compared to 22.6% among White women and 17.4% among Asian/Pacific Islander women (March of Dimes, 2026).

Infant Mortality

Infant mortality is the death of an infant after a live birth (delivery of an infant that shows signs of life, such as breathing, regardless of the pregnancy length) during the first year of life[4] (Barfield et al., 2016). Infant mortality can be measured by the age of the infant and is split into neonatal mortality and post neonatal mortality (March of Dimes, 2026).

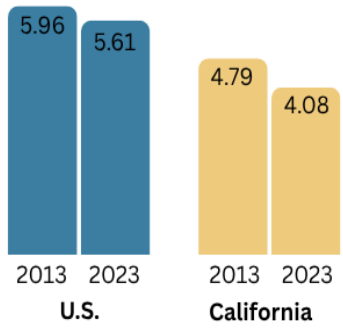
- **Neonatal mortality** is defined as the death of an infant within the first 27 days of life.
- **Post neonatal mortality** is defined as the death of an infant between 28 days old to under one year old.

Please see Appendix A for a brief explainer on fetal mortality, which is the spontaneous death of a fetus before birth.

Causes of infant death vary by timing of occurrence. Neonatal deaths are typically associated with events occurring during the prenatal and delivery periods. The top three causes of neonatal deaths in the U.S. in 2022 were disorders related to preterm birth and low birthweight[5]; congenital malformations, deformations, and chromosomal abnormalities; and if the newborn is affected by maternal complications of placenta, cord, and membranes (NCHS, 2025a). Post neonatal deaths are typically associated with conditions or events that occur after delivery and could reflect environmental factors, such as sleeping environment (March of Dimes, 2026; Boston Children's Hospital, 2012). The top three causes of post neonatal death were: sudden infant death syndrome; congenital malformations, deformations, and chromosomal abnormalities; and accidents (NCHS, 2025a).

From 2013 to 2023, infant mortality rates[6] decreased by 6% in the U.S. and by 15% in California (Figure 1). The total number of infant deaths in 2023 was 20,162 in the U.S. and 1,632 in California (CDPH, 2026f). California is one of 17 U.S. states that met the Healthy People 2030[7] target of an infant mortality rate of 5.0/1,000 or lower, with the sixth lowest infant mortality rate of all states (March of Dimes, 2025a; March of Dimes, 2025b).

Figure 1. Infant Mortality Rate, 2013 – 2023 (per 1,000 live births)



Source: CHBRP based on CDPH, 2026f.

Disparities in infant mortality

Disparities in infant mortality rates existed by several characteristics in California as of 2023[8] (CDPH, 2026f; Figure 2):

Race and ethnicity: Rates among NHPI and AIAN[9] women were more than four times higher than their White counterparts. Black women had mortality rates more than three times higher than their White counterparts.

[3] Medi-Cal is California's Medicaid program, which provides health insurance for low-income children and adults. Adults that qualify for Medi-Cal have income rates at or below 138% of the Federal Poverty Level, with some exceptions (CoveredCA, 2026).
[4] An infant is a child aged 0 to 12 months (CDC, 2026b).
[5] Both "preterm birth" and "low birthweight" are defined in the "Birth Outcomes and Relationship to Infant Mortality" section.
[6] The infant mortality rate is calculated by dividing the number of infant deaths by 1,000 live births during a specific period of time (CDPH, 2026f).
[7] The Healthy People initiative is a data-driven effort that creates national objectives with targets to improve health, eliminate disparities, and more across multiple sectors (CDC, 2026a).
[8] 2023 is the most recent data provided by the California Department of Public Health.
[9] Data for AIAN is not available for 2023, so 2022 data was used instead.

Prenatal care: Rates were more than five times higher among women receiving no prenatal care compared to women who initiate prenatal care during the first trimester.

Insurance coverage: Rates among births covered by Medi-Cal were higher than for births covered through private insurance.

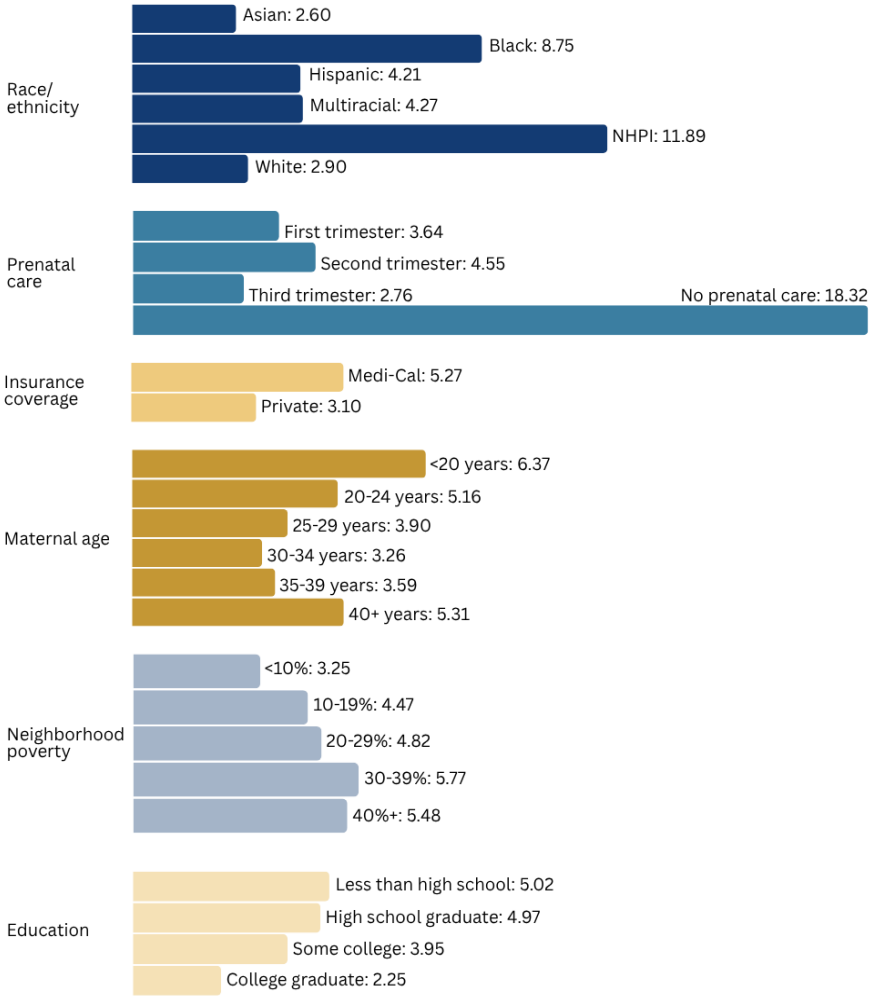
Maternal age: Rates were highest among women younger than 20 years of age and 40 years and older.

Neighborhood poverty10: Rates were highest among women living in neighborhoods where more than 30% of the population lived below the federal poverty level (FPL).

Education: Rates were more than double among women with less than or equal to a high school diploma compared to women with a college degree.

While infant mortality has declined overall from 2013 to 2023, disparities by maternal age worsened and disparities by race and ethnicity, insurance coverage, and education remained generally unchanged.

Figure 2. California Infant Mortality Rates, 2023 (per 1,000 live births)

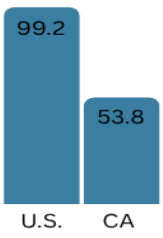


Source: CHBRP based on CDPH, 2026f.

Sudden Unexpected Infant Death

Sudden unexpected infant deaths (SUID) oftentimes occur while the infant is asleep or in the infant's sleep area. SUIDs include deaths from sudden infant death syndrome (SIDS), accidental suffocation and strangulation in a sleeping environment, and other deaths from unknown causes (CDC, 2024; CDPH, 2026m).

Figure 3. U.S. and California SUID Rates, 2021 – 2023 (per 100,000 live births)



Source: CHBRP based on CDPH, 2026l.
Key: SUID = sudden unexpected infant death.

From the period of 2011 – 2013 to the period of 2021 – 2023, SUID rates[11] increased by 5% in California. The total number of SUID deaths for the period 2021 to 2023 was 10,843 in the U.S. and 668 in California (CDPH, 2026l).

In California, SIDS was the most common cause of SUID, with a rate of 25.1/100,000 deaths; 21.4/100,000 deaths were unknown/undetermined and 7.3/100,000 deaths were caused by accidental suffocation and strangulation in a sleeping environment (CDPH, 2026m). To address the most common causes of SUID, policy initiatives frequently target reducing rates of SIDS, including associated disparities.

[10] Neighborhood poverty is defined as the percentage of residents living below the federal poverty threshold in their neighborhood.
[11] The SUID rate is calculated as the number of sudden, unexpected infant deaths per 100,000 live births within a specific timeframe. by dividing the number of SUID deaths during a time period by 100,000 live births during that same period of time (CDC, 2026c).

Disparities in SUID

Disparities in SUID existed by several characteristics in California for the period 2021 to 2023 (CDPH, 2026m; Figure 4):

Race and ethnicity: Rates among NHPI women were almost five times higher than their White counterparts. Black women had an SUID rate almost four times higher than their White counterparts.

Prenatal care: Rates were more than seven times higher among women receiving no prenatal care compared to women who initiate prenatal care during the first trimester.

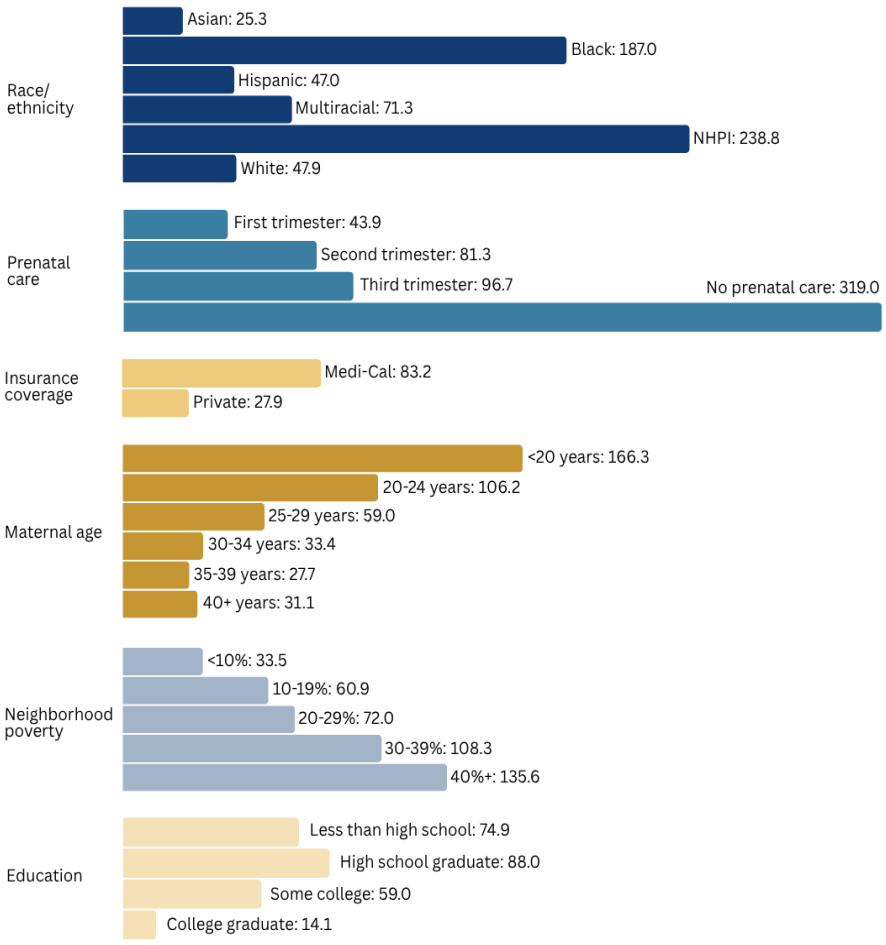
Insurance coverage: Rates among births covered by Medi-Cal were almost three times higher than for births covered through private insurance.

Maternal age: Rates were highest among women younger than 20 years of age, which is about six times higher than the rate for women aged 35 to 39 years. As age increases, the rate of SUID generally decreases.

Neighborhood poverty: Rates were highest among women living in neighborhoods where more than 30% of the population lived below the FPL. As neighborhood poverty rates increase, the rate of SUID increases.

Education: Rates were around five times higher among women with less than or equal to a high school diploma compared to women with a college degree.

Figure 4. California SUID Rates (per 100,000 live births), 2021-2023



Source: CHBRP based on CDPH, 2026m.

From the period of 2011 – 2013 to the period of 2021 – 2023, SUID disparities by prenatal care, insurance coverage, maternal age, neighborhood poverty, and education have worsened while disparities by race and ethnicity remained generally unchanged (CDPH, 2026l).

Key takeaways: Despite infant mortality rates improving between 2013 and 2023 in California overall, disparities exist for Black and Native Hawaiian and Pacific Islander women, those covered by Medi-Cal, women who do not initiate prenatal care, younger women, those living in areas with higher concentrations of neighborhood poverty, and those with lower education levels.

Birth Outcomes and Relationship to Infant Mortality

Early indicators of infant health include gestational age and birthweight (Ryberg et al., 2022). These indicators can be important predictors for infant mortality; preterm and low birthweight infants are at a higher risk for death.

Preterm birth

Infants born preterm are at a higher risk for infant death. Preterm birth is the birth of an infant before 37 weeks of gestation (CDPH, 2026j). A pregnancy is considered full term at 39 weeks to 40 weeks and 6 days (NIH, 2026).

In California in 2024, 9.07% of infants were born preterm (CDPH, 2026j). From 2014 to 2024, preterm births increased by 8% (CDPH, 2026j). The infant mortality rate in California in 2023 was highest among infants born before 32 weeks' gestation (138.6/1,000) and lowest among infants born at 37 to 41 weeks (1.47/1000) (CDPH, 2026j). Similarly, the SUID rate in California for the period 2021 to 2023 was highest among infants born before 32 weeks (199.0/100,000) and lowest among infants born at 37 to 41 weeks (44.7/100,000) (CDPH, 2026l).

Disparities in preterm births

Disparities in preterm births existed by several characteristics in California in 2024 (CDPH, 2026j; Figure 5):

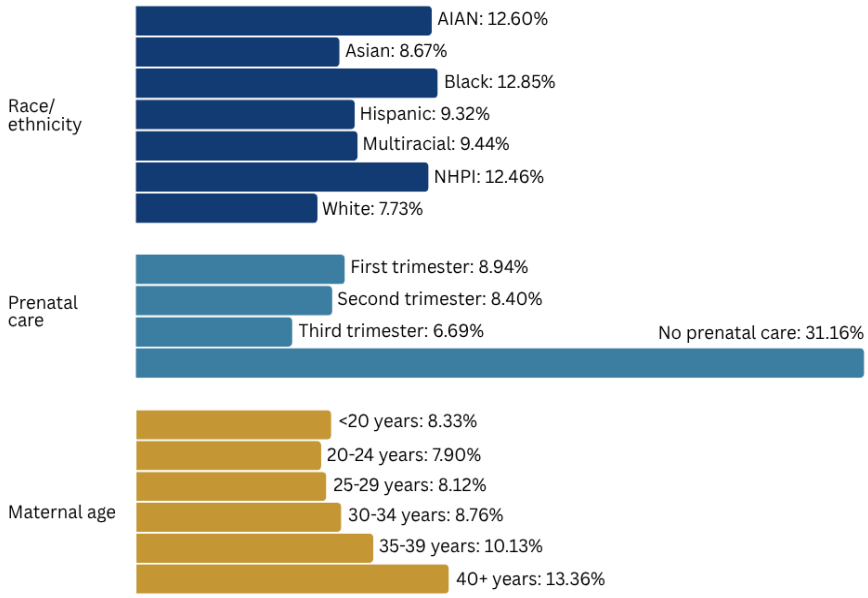
Race and ethnicity: Black, AIAN, and NHPI women had the highest percentages of preterm birth, followed by multiracial, Hispanic, and Asian women.

Prenatal care: Receiving no prenatal care increased the risk of preterm birth by more than three times compared to initiating prenatal care during any trimester.

Maternal age: As age increases, the percentage of preterm births generally increases, with women aged 40 years and older experiencing the highest preterm birth rate.

Rates of preterm birth were similar by insurance coverage, neighborhood poverty, and education.

Figure 5. California Preterm Births, 2024



Source: CHBRP based on CDPH, 2026j.

From 2014 to 2024, preterm birth disparities by race and ethnicity worsened and disparities by prenatal care and maternal age remained generally unchanged (CDPH, 2026j).

Low birthweight

Low birthweight infants are at a higher risk for infant death. Low birthweight is the birth of an infant that weighs less than 5 lbs, 8 oz (less than 2,500 grams). Low birthweight can be further broken down as: very low birthweight (less than 3lbs, 5oz or 1,500 grams), and extremely low birthweight (less than 2 lbs, 3 oz or 1,000 grams) (Stanford Medicine Children's Health, 2026a).

There is often significant overlap between infants born preterm and those born at low birthweight (CDPH, 2026j). In California in 2024, 1.1% of infants were born very low birthweight (less than 5,000 births) and 7.4% of infants were born low birthweight (almost 30,000 births) (CDPH, 2026g). From 2014 to 2024, low birthweight births increased by more than 10% (CDPH, 2026g).

The infant mortality rate in California in 2023 was highest among infants born at very low birthweight (171.7/1,000), followed by infants born at low birthweight (34.22/1,000). Comparatively, the infant mortality rate for an infant born at normal weight was 1.39/1,000 (CDPH, 2026f).

Disparities in low birthweight

Disparities in birthweight existed by several characteristics in California in 2024 (CDPH, 2026g; Figure 6):

Race and ethnicity: Black women had the highest percentage of low birthweight births, followed by AIAN, Asian, NHPI, and multiracial women.

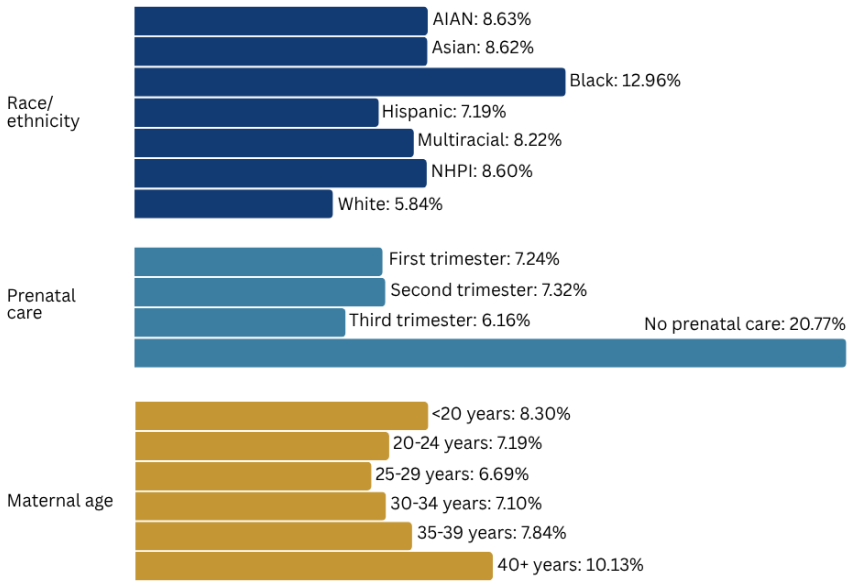
Prenatal care: Receiving no prenatal care increased the risk of low birthweight births by more than three times compared to initiating prenatal care during any trimester.

Maternal age: Low birthweight rates were highest among women aged 40 years and older and women younger than 20 years of age.

Rates of low birthweight were similar by insurance coverage, neighborhood poverty, and education.

From 2014 to 2024, low birthweight birth disparities by race and ethnicity and prenatal care worsened (CDPH, 2026g).

Figure 6. California Low Birthweight Births, 2024



Source: CHBRP based on CDPH 2026g.

Key takeaways: The rate of preterm and low birthweight births has increased in California between 2014 and 2024. For preterm births, disparities exist for Black, AIAN, and NHPI women, women who do not initiate prenatal care, and older women. Similarly, for low birthweight births, disparities exist for Black women, women who do not initiate prenatal care, and older women.

Drivers of Racial and Ethnic Disparities in Infant Mortality and Infant Health

There are many reasons why disparities within infant mortality and infant health exist, including those stemming from social drivers of health, access to and quality of healthcare, and access to and use of family leave. Many factors, such as education, employment, and income, have demonstrated strong correlation with high infant mortality rates and high rates of poor health outcomes, as described earlier. Lower levels of education, employment, and income are also higher among some racial and ethnic groups (Economic Policy Institute, 2025). This demonstrates the influence and underlying causes of many racial and ethnic disparities, which are frequently intertwined with other drivers of disparities; these groups are more likely to lack access to resources that can prevent and treat disease.

Social and Structural Drivers of Birth Outcomes

Exposure to racism is correlated with adverse maternal, birth, and infant outcomes across communities of color (Jang and Lee, 2022). Studies have found that the chronic stress caused by racism and discrimination contribute to elevated rates of

low birthweight. Among Black families, self-reported experiences of racism are associated with rates of preterm birth, low birthweight, and very low birthweight three times higher than other races (Jang and Lee, 2022). These effects can also be transgenerational, with physiologic impacts passed down across generations (Wallace et al., 2017).

Historic and persistent systemic racism has similarly shaped infant health outcomes for Indigenous and Black populations. National policies dating back to the 1800s, including redlining, the denial of voting rights, land dispossession, and forced assimilation, established structural disadvantages that persist today (Jang and Lee, 2022; Marchio, 2022). These factors have likely contributed to the higher rates of preterm birth and low birthweight among Indigenous and Black women compared with their White counterparts, as seen in Figures 5 and 6. For example, recent research has found specific links between redlining and preterm birth. Redlining is a discriminatory practice that dates back to the 1930s that denies people access to mortgages, insurance, and other financial means based on the racial and ethnic composition of their neighborhood (Boilard, 2022). According to a meta-analysis of three studies that examined the link between redlining and preterm birth, the odds of preterm birth were 41% higher among women who lived in redlined areas as compared with women living in non-redlined areas (Kyung Lee et al., 2022). Black families are also more likely to live in neighborhoods that have higher pollution levels, such as allergen counts, which can increase the risk of preterm birth and other health conditions (Jang and Lee, 2022).

Racial and ethnic populations that are at the greatest risk for infant mortality are also those with the highest percentage of adults that do not receive a high school diploma (Jang and Lee, 2022). As previously discussed, education levels are inversely correlated with infant mortality rates and birth outcomes. However, disparities by race and ethnicity still exist even after adjusting for education (Jang and Lee, 2022) and socioeconomic status (SES), particularly among Black women.

Key takeaways: Birth outcomes (including low birthweight, preterm birth, and infant mortality) are affected by social and structural drivers of racism including exposure to racism, discriminatory practices and policies, and access to education.

Racial Disparities in Access to and Quality of Healthcare

Access to and receipt of prenatal care plays an important role in improving infant health and preventing infant mortality; as shown in the “Disparities” sections above, lack of prenatal care is associated with increased infant mortality rates, SUID rates, and preterm birth and low birthweight percentages. The availability of clinicians can impact a pregnant woman’s ability to access health services, including prenatal care. Black and Latina women face barriers when trying to access prenatal care; among 800 Black and Latina women surveyed in California, 26% of women reported having difficulty accessing obstetric and gynecological care and 32% of respondents reported challenges finding a clinician for routine care (Byerly and Ocampo, 2025). Accessing maternity care can also be a challenge because of maternity care deserts and closure of labor and delivery units in hospitals.[12]

Research has found that familiar language and culture between a patient and a clinician leads to improved health outcomes, however there are gaps in language and culture representation in the healthcare workforce. In NICUs[13] across the U.S., there is a lower representation of Black and Hispanic providers (Jang and Lee, 2022). This lack of representation can contribute to gaps in care communication and coordinating for families. A study of Spanish-speaking patients found that patients were less likely to visit the doctor and receive updates on their child’s health and four times more likely to incorrectly identify their child’s diagnosis, when compared to English-speaking patients (Jang and Lee, 2022).

Black and Hispanic infants are more likely to receive care in poor-quality NICUs when compared to their white counterparts. A study of 134 California hospitals measured NICU care with an index called Baby-MONITOR (which measures the quality of NICU care using a standardized index) (Digitale, 2017). Hispanic infants of very low birthweight

[12] More information about access to maternity health services is available in CHBRP’s explainer “Disparities in Maternal Health”.
[13] Neonatal Intensive Care Units (NICUs) are areas of hospitals that provide intensive medical care to newborn babies, with advanced technology and trained healthcare professionals (Stanford Medicine Children’s Health, 2026b).

received lower Baby-MONITOR scores than White infants; White infants had higher scores on measures surrounding whether standard medical practices were being followed. Similarly, Black infants had lower scores than white infants on measures surrounding receiving human milk at discharge. Across NICUs, as Baby-MONITOR scores rose, white infants tended to do better than infants of other ethnicities (Digitale, 2017).

Key takeaways: Black and Hispanic women and infants are more likely to lack access to quality prenatal and NICU care, leading to worsened health outcomes. Language and cultural barriers can oftentimes play a role.

Racial Disparities in Access to and Use of Leave

Lack of access to parental leave is associated with infant mortality and poor health outcomes, and both access to and use of parental leave show persistent racial and income disparities. The Family and Medical Leave (FMLA) Act of 1993 provides 12 weeks of unpaid leave to eligible[14] women within 12 months of delivery. Studies examining the impact of this national law have found it is associated with a significant decrease in infant mortality rates among some women, but not others; specifically, FMLA is associated with a decrease in infant mortality rates among married women with a college education, but not among women without a college degree or who are single (Jang and Lee, 2022). According to the 2017–2018 American Time Use Survey[15], eligibility requirements to use FMLA disproportionately impact Black, Indigenous, multiracial, and Latinx workers, who are less likely to meet the requirements (Goodman et al., 2022). Black and low-to-middle income women are less likely to use their leave, and duration of leave used decreases as income decreases (Jang and Lee, 2022).

Research on city- and state-level paid family leave ordinances has found that disparities in use and duration of use exist by race, ethnicity and income (Jang and Lee, 2022). In a study of San Francisco's Paid Parental Leave Ordinance (PPLO) – which supplements California's existing law of paying new parents 55% pay during their leave and requires employers to pay the remaining 45% for six weeks of leave – lower-income women reported knowing less about their maternity leave benefits than other women. Only 10% of low-income working mothers were aware of their benefits, and less than 2% knew accurate information about the policy. Additionally, low-income working mothers were less likely to be employed by jobs covered by PPLO, and those covered by Medi-Cal were less likely to be eligible for PPLO (UC Berkeley, 2020).

Key takeaways: Federal unpaid parental leave policy is associated with lower rates of infant mortality, but only for married women with a formal education. Black, Indigenous, multiracial and Latinx women; low-income women; and those covered by Medi-Cal face disparities when accessing and using their parental leave at a national and city-wide level.

Efforts to Reduce Infant Health Disparities

Efforts to reduce and eliminate these disparities are occurring at the national, state, and local level. Below, CHBRP describes policy approaches in California that aim to reduce infant mortality and improve infant health.

Longstanding Programs

There are several longstanding California programs that receive federal funding and provide assistance to pregnant women, infants, and families.

California's Women, Infants, and Children (WIC) Program: WIC provides support to low income pregnant and postpartum people, infants, and children through services such as nutrition information, breastfeeding support, assistance

[14] Eligibility requirements for FMLA include being employed for 12 months by an employer with 50 or more employees and working at least 1,250 hours over the previous 12-month period (DOL, 2026).
[15] This survey is run through the U.S. Bureau of Labor Statistics and measures the amount of time people spend doing various activities, such as paid work, childcare, volunteering, and socializing (BLS, 2026).

with accessing healthcare and community services, and benefits to buy healthy foods and formula (CDPH, 2024). WIC has proven to help reduce premature births, low and very low birthweight births, and reduce fetal[16] and infant deaths (NWICA, 2026). While all states have a WIC program, California was one of three states to have a WIC coverage rate above 60% (across all demographic groups eligible for WIC) during 2020 (USDA, 2025). California's WIC program covered more than 85% of eligible infants in 2020 (USDA, 2025).

Title V Maternal and Child Health Block Grant (Title V): Title V is a program run by the federal government since 1935. The Five-Year Objectives in California's 2026 application for a continuation of Title V federal funding for Perinatal/Infant Health are to advance healthy birth outcomes by reducing the rate of Black infant deaths and to increase the percentage of infants breast fed exclusively in the hospital and first three months (HRSA, 2025). Programs funded by Title V that directly relate to infant health include:

- **The Black Infant Health Program** offers individual and group support to pregnant and postpartum Black mothers, with the goal of achieving healthy pregnancy and birthing outcomes for Black infants and mothers (CDPH, 2026b; County of Los Angeles Public Health, 2026).
- **The Breastfeeding Initiative** aims to make breastfeeding the norm for the first year of an infant's life, implements infant feeding programs in hospitals and clinics, and makes lactation accommodations a reality for workers (CDPH, 2026c).
- **The Fetal and Infant Mortality Review** reviews the factors of fetal and infant deaths within cities and counties and identifies actions to prevent deaths (CDPH, 2026d).
- **The Maternal and Infant Health Assessment** collects self-reported information that is used to support public health program planning and policy development (CDPH, 2026h).
- **Regional Perinatal Programs of California** encompass effective prenatal, delivery, postpartum, and neonatal and infant care services that have demonstrated success in preventing or reducing related morbidities (CDPH, 2026k).
- **Sudden Infant Death Syndrome (SIDS) Program** provides education about SIDS, support and training for health professionals, and counseling for those that have lost an infant to SIDS (CDPH, 2022b).

California's Baby-Friendly Hospitals Initiative (BFHI): BFHI is a global initiative launched by WHO and UNICEF in 1991. BFHI fosters understanding and enthusiasm for best practices in infant feeding care, creates standards for successful breastfeeding, and assesses and accredits birthing facilities to meet standards. Baby-Friendly USA, Inc. (BFUSA) is an accrediting body and national authority for the BFHI and there are currently 438 Baby-Friendly facilities in the U.S., including 67 facilities in California (Baby-Friendly, USA, 2026a; Baby-Friendly, USA, 2026b).

Recent California Legislation and Initiatives

California has also implemented several other laws and initiatives within the last several years, either fully or partially aimed at reducing infant mortality and disparities in infant mortality.

Perinatal Equity Initiative (PEI): Established in 2018, PEI was implemented to address racial disparities in infant mortality by providing support and resources for Black families (CDPH, 2026i; Riverside University Health System, 2026). With the goal of improving birth outcomes and reducing mortality for Black infants, PEI works in collaboration with state and local Black Infant Health Programs and includes strategies such as Group Prenatal Care, Fatherhood or Partnership Initiatives, and Home Visitation Programs (CDPH, 2026i; Digital Democracy CalMatters, 2026).

[16] Please see Appendix A for definitions surrounding "fetal death."

Standby Perinatal Services Pilot: Established in 2025 via Senate Bill 669, this pilot permits five rural hospitals to designate, equip and maintain a specific hospital area for standby perinatal services, including obstetric and neonatal care for patients in urgent need, with the goal of eliminating barriers for mothers in labor who must travel far distances (CDPH, 2026l).[17]

Department of Health Care Services (DHCS) Medi-Cal Children's Initiatives: DHCS' Comprehensive Quality Strategy includes "Children's Preventive Care" and "Maternity Outcomes and Birth Equity" as two of three clinical focus areas (DHCS, 2025). DHCS continues to focus on a whole-person care approach through programs such as Population Health Management as part of CalAIM, which aims to address beneficiaries' clinical and non-clinical needs. Goals and initiatives that aim to improves children's access to healthcare and improve infant health include increasing Medi-Cal beneficiary engagement, increasing utilization of primary care, increasing the enrollment of Medi-Cal beneficiaries into CalFresh[18] and WIC, adding doulas and community health workers as covered providers, addressing gaps in infant vaccination rates, and increasing infant well-child visits (DHCS, 2022; DHCS, 2025).

Doula Access: Doulas are health care professionals who provide various types of support during pregnancy, labor and delivery, miscarriage, and abortion, and for up to one year postpartum. According to a review of multiple studies, doula care is significantly correlated with lowering preterm births and improving breastfeeding success (Sobczak et al., 2023). Doula care has also shown to decrease disparities among low-income women and refugees; doulas can also reduce racial bias, gender bias, and other inequities, particularly among Black, Latino, Indigenous, low-income, and LGBTQIA communities by advocating for their clients (Sobczak et al., 2023 and Planned Parenthood, 2021). Through Assembly Bill (AB) 904: Health care coverage: doulas (effective in 2023), DHCS added doula services as a covered benefit for fee-for-service and managed care Medi-Cal members (DHCS, 2026). Additionally, AB 904 requires commercial plans and policies to develop maternal and infant health equity programs to address racial disparities through doula care.[19]

Assembly Bill (AB) 3059 Human Milk: Breastmilk can reduce the incidence of two life-threatening diseases, necrotizing enterocolitis and bronchopulmonary dysplasia, for preterm infants in the NICU (CHBRP, 2024). AB 3059 establishes donor milk as a basic health care service for state-regulated insurance plans[20] and removes a regulatory requirement to acquire a tissue bank license in order to store or distribute human milk obtained from a licensed tissue bank or milk collected from a mother for the mother's own child (CHBRP, 2024).

Collaboratives

California Perinatal Quality Care Collaborative (CPQCC): The CPQCC, housed within the Stanford School of Medicine, is a member-driven organization with a mission to improve the quality and equity of healthcare delivery for the most vulnerable infants, from birth and NICU stays to early childhood (CPQCC, 2026c). Each year, the Collaborative supports births in California by partnering with several state agencies, including CDPH, DHCS, and the Office of the California Surgeon General (CPQCC and CMQCC, 2025). The Collective also partners with hospitals and health care providers, and engages with communities and patients (CPQCC and CMQCC, 2025). The Collaborative's work focused on improving NICU care includes:

- Collecting data on the care provided in NICUs (data are collected from more than 90% of California's NICUs) and on acute transports; this data is used to evaluate quality of care, understand the effects of the Collective's improvement interventions, and conduct research (CPQCC, 2026b).
- Conducting research and analysis to learn how to improve NICU care, including research on disparities in NICU care, context and culture, and provider burnout (CPQCC, 2026a).

[17] HSC 1256.05 and 1256.06.
[18] CalFresh is California's Supplemental Nutrition Assistance Program (SNAP), which provides monthly food benefits to low-income individuals and families (CDSS, 2026).
[19] HSC 1367.626; INS 10123.868.
[20] HSC 1367.624, 1635.1, 1648; INS 10123.864.

- A quality improvement program that prioritizes collaboration and evidence-based toolkits on topics such as increasing breast feeding for very low birthweight infants and improving health-related social needs for infants and their families (CPQCC and CMQCC, 2025).
- Member hospitals of the Collaborative have seen reductions in: neonatal mortality (11% from 2014 to 2024), severe intraventricular hemorrhage (8% from 2014 to 2024), mortality for very low birthweight infants (21% from 2006 to 2015), and hypothermic admissions (77% from 2006 to 2015) (CPQCC, 2026b; CPQCC and CMQCC, 2025). Member hospitals were also able to reach a 99% referral rate for very low birthweight infants to follow-up care (CPQCC, 2026b).

MCAH (Maternal, Child, and Adolescent Health) Action: MCAH Action is a statewide organization comprised of MCAH directors, coordinators, and their designees to represent all of California's 61 local health jurisdictions; MCAH action works towards improving the health and wellbeing of childbearing age people, mothers, fathers, infants, children, adolescents, and their families (MCAH Action, 2026). In collaboration with the California Department of Public Health and other organizations, MCAH Action provides professional development, education, and training to MCAH directors; convenes stakeholders to strengthen policy advocacy; offers expertise and counsel to state agencies, the state legislature, and policy makers; and amplifies the voices of local MCAH programs to shape and influence policy (MCAH Action, 2026).

Conclusion

Disparities in infant mortality and infant health outcomes exist by race and ethnicity, insurance coverage, maternal age, education, prenatal care, and neighborhood poverty. In particular, rates of infant mortality and infant health disparities are substantially higher among Black, NHPI, AIAN, and Hispanic women as compared to White and Asian women. Causes of these disparities are rooted in social drivers of health, access to and quality of healthcare, and access to and use of family leave.

In California, there are several efforts to reduce infant mortality and adverse health outcomes, with an emphasis on reducing disparities. These efforts include longstanding and new funding priorities and collaboratives to drive changes throughout health care delivery systems in California. Addressing infant health inequities requires continued attention to the policies that structure access to care. CHBRP's work contributes to this effort by examining the potential impacts of legislation related to infant health services, coverage requirements, and related health benefits. In line with CHBRP's mission to provide evidence-based analysis, CHBRP considers how proposed health policies affect both overall infant health outcomes and the disparities that persist among different populations.

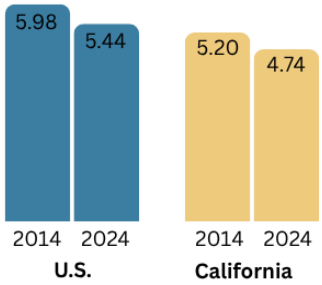
Appendix A. Fetal Mortality

Fetal mortality is the spontaneous death of a fetus before birth; the fetus does not show any evidence of life at birth (Barfield et al., 2016). Most states, including California, require fetal deaths to be reported if the death occurs after 20 weeks of gestation (CDPH, 2026e).

The fetal mortality rate is calculated by dividing the number of fetal deaths at 20 or more weeks of gestation per 1,000 live births[21] and fetal deaths of 20 or more weeks of gestation (NCHS, 2025b).

As shown in Figure 7, from 2014 to 2024, fetal mortality rates decreased by 9% in both the U.S. and California (CDPH, 2026e). The total number of fetal deaths in 2024 was 19,837 nationally and 1,916 in California (CDPH, 2026e).

Figure 7. Fetal Mortality 2014 - 2024 (per 1,000)



Source: CHBRP based on CDPH, 2026e.

The top five causes of fetal deaths in the U.S.[22], which account for almost 90% of fetal deaths, were: unspecified cause; fetuses affected by placenta, cord, and membrane complications; fetuses affected by maternal complications; congenital malformations, deformations, and chromosomal abnormalities; and fetuses affected by maternal conditions that may be unrelated to present pregnancy (NCHS, 2025b).

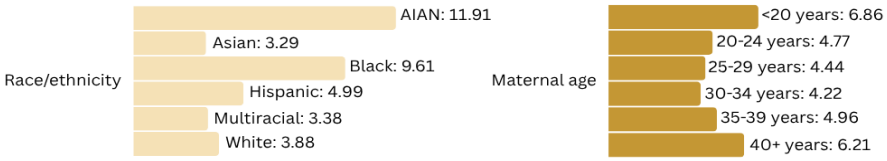
Disparities in fetal mortality[23]

Disparities exist by several characteristics in California in 2024 (Figure 8):

Race and ethnicity: Fetal mortality rates among AIAN women were the highest, followed by fetal mortality rates for Black women. Fetal mortality rates for AIAN women were around three times higher than their White, Asian, and multiracial counterparts (CDPH, 2026e).

Maternal age: Fetal mortality rates were highest among women under 20 years and women age 40 years and older (CDPH, 2026e).

Figure 8. California Fetal Mortality Rates, 2024 (per 1,000)



Source: CHBRP based on CDPH, 2026e.

[21] Live births that occur at the same gestation period as the number of fetal deaths that occur at that gestation period. For example, to calculate the rate of fetal deaths at 30 weeks gestation, the number of fetal deaths at 30 weeks gestation and the number of live births at 30 weeks gestation are both used.
[22] This study included reports from 38 states and D.C.
[23] Data on neighborhood poverty, education, and prenatal care was not available.

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About the California Health Benefits Review Program (CHBRP)

Drawing on the experience and assistance of multi-disciplinary faculty, researchers, and analysts based at the University of California, CHBRP provides the California Legislature with timely, independent, and rigorous evidence-based analyses of introduced health insurance benefits-related legislation. Most frequently, CHBRP analyzes proposed health insurance benefit mandates (e.g., mandates to cover a test, treatment, or service, such as continuous glucose monitors). For more about CHBRP's 60-day analysis process, see the resource Academic Rigor on a Legislature's Timeline.

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