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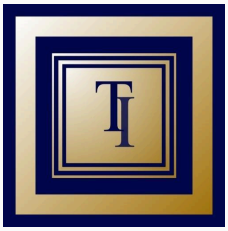
VOLUME I
REPORT #003

EMPOWERING CITIZENS THROUGH PRIVATE SECTOR ENGAGEMENT

SUPPORTING MATERNAL WELLBEING: UNDERSTANDING MATERNAL HEALTH INDICATORS

A GLOBAL ASSESSMENT

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ABOUT US

OUR MISSION

Tetelestai International is a philanthropic organization tasked with a mission to support vitality by delivering life-saving resources, in partnership with our community stakeholders. Tetelestai International's operational objectives are structured to yield transformational impact, based the following four-fold approach to community service: i) food assistance for low-income individuals, ii) new clothes for the homeless, iii) neonatal kits for new (and veteran) moms, iv) support for educational initiatives. We are purpose-driven to serve the under-resourced. Our vision is to continue to expand our operations, both locally and internationally. Tetelestai International is a registered 501(c)(3) that relies on selfless volunteers; generous donors; and partnerships with angel investors to fulfill its organizational mandate.

OUR TEAM

Our team is made up of dedicated professionals whose industry backgrounds range from government, to private sector, and non-profit fields. We are passionate about providing vital support to undergird the social wellbeing of the communities we serve.

OUR PARTNERS

We work to partner with individual donors, a variety of organizations, and businesses in our community to provide philanthropic services to the members of the local communities we serve.



EMPOWERING CITIZENS
THROUGH PRIVATE SECTOR
ENGAGEMENT

Tetelestai International is dedicated to empowering citizens through initiatives fueled by the private sector and generous angel investors.

NEONATAL INITIATIVE

This report spotlights our neonatal initiative, which is centered on supporting low-income moms.



NEONATAL KITS

Our neonatal initiative is structured to increase access to newborn essentials, which would otherwise be inaccessible to low-income citizens, due to cost restrictions.

We work to provide low-income moms with neonatal kits, which will include baby bottles, formula, diapers, onesies, and bath-time essentials. Moms caring for newborns deserve all the support available to them. Our goal is to ensure that moms, who need assistance with newborn essentials, are not denied access, based on their financial status.

ISSUE IDENTIFICATION

Global Maternal Health and C-Sections

Maternal health is a broad-based term that encompasses factors affecting a woman's health and well-being during antepartum, peripartum, and postpartum stages. Maternal and infant mortality rates find parallels with the quality of available health care; and oftentimes, a caesarean section (C-Section) very quickly becomes the difference between life and death for both mother and child (Arowolo, 2016). A C-Section is as procedurally intensive as it is costly. Globally, the numbers of babies born alive through caesarean sections continues to increase – for example, in 2010, an estimated 25% of all births were by caesarean section, as compared to a mere 2% in 1950 (O'Neill, 2014). However, in low-resource contexts, C-Sections have become increasingly linked to a significant risk of maternal morbidity and mortality (Riches et al. 2024).

Globally, in 2018, the top-five countries reporting the highest caesarean section rates are the Dominican Republic (58.1%), Brazil (55.7%), Cyprus (55.3%), Egypt (51.8%), and Turkey (50.8%) – these countries also recorded the highest rates in the Americas, Asia, and Africa (Thomaidi et al. 2025). In Europe, Romania reported the highest CS rate at 46.9%, with the Netherlands (14.9%) reporting the lowest. In 2024, Mississippi (37.9%) ranked highest in the United States, with Idaho reporting the lowest (24.5%) (CDC, 2026). The lowest CS rates in the world were observed in Africa, with Chad (1.4%), Niger (1.4%), Ethiopia (1.9%), Madagascar (2%), and Cameroon (2.4%) reporting the lowest rates (Thomaidi et al. 2025).

The difference in the number of caesarean sections is observably greater between urban and rural areas – for instance, urban areas in South Asia record a C-Section rate of 14% versus 5% in rural areas; Africa records a C-Section rate of 5% in urban areas versus 1% in rural areas; “Burkina Faso, Chad, Ethiopia, and Niger all have rural caesarean section rates of almost zero” (Lawn et al., 2011, p. 5). Unskilled birth attendants and little-to-no caesarian section services contribute to high stillbirth rates maternal deaths in developing countries (Addo et al., 2023). Birth outcomes and infant mortality rates are unequally distributed globally; and deeply contrasting cross-country and within-country patterns exist, even among western industrialized nations (Kim & Saada, 2013, as cited in Arowolo, 2016).

Tracking Maternal Health

Tracking global maternal health figures requires monitoring crucial physiological and epidemiological indicators, mortality and morbidity ratios, as well as structural determinants (macroeconomic and social resource distribution systems) that affect disparities in maternal health outcomes. The Maternal Mortality Ratio (MMR) is a core metric that captures the number of maternal deaths per 100, 000 live births.



The World Health Organization (WHO) defines MMR as the number of maternal deaths during a given time period per 100, 000 live births during the same time period (2026). In 2015, the WHO, in union with her partners, developed a consensus, to strategize ending preventable maternal mortality (EPMM) (WHO, 2026). The global MMR target reduction goal was established at less than 70 per 100,000 live births, by 2030 (WHO, 2026).

Figure 1 is a visualization of trends in the global MMR status between 2000 and 2023. According to UNICEF (2025) data, between 2000 and 2023, maternal mortality decreased globally by 40% -- from 328 deaths to 197 deaths per 100,000 live births, which is equivalent to an average decline of around 2% per annum. Though commendable, realizing the Sustainable Development Goal (SDG) of 70 maternal deaths per 100,000 live births by the targeted 2030 date necessitates a declining rate of approximately 15%, between 2024 and 2030 (UNICEF, 2025).

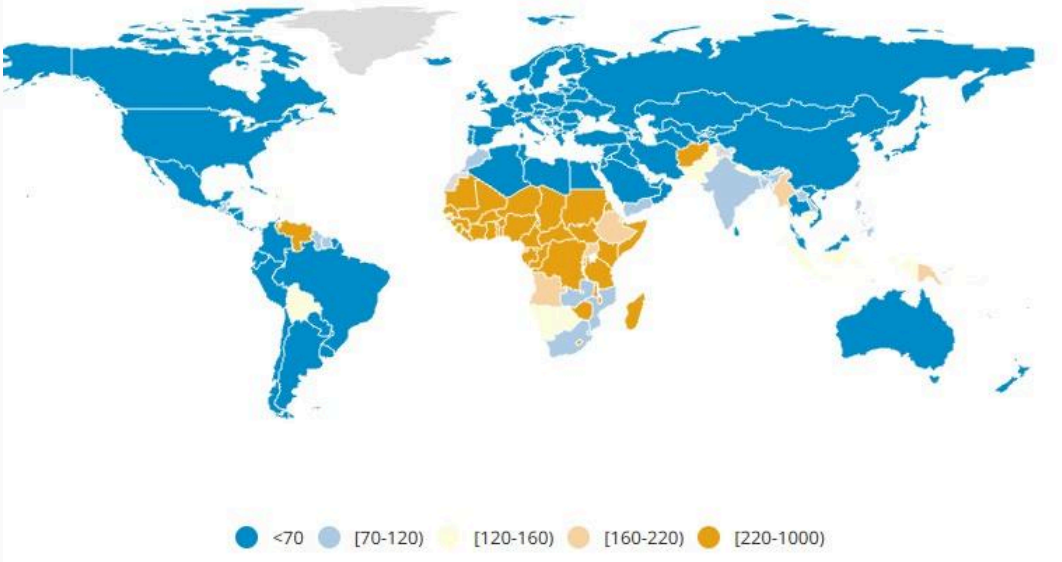


Figure 1. Maternal Mortality Ratio (MMR) - maternal deaths per 100,000 live births around the globe[1].

Despite the significant strides made towards decreasing global MMR between 2000 and 2015, progress has seen stagnation, based on the average rates of reduction reported between 2016 and 2023. Globally, progress has slowed since the start of 2010, and without increased dedication to amplify MMR reduction efforts, multiple countries risk missing proposed target figures – particularly locales battling ongoing humanitarian crises that contribute to and exacerbate already high maternal deaths (UNICEF, 2025). A concerted commitment to progress is thus the clarion call for international agencies to continue partnerships and alignments with country governments to further advance progress in the areas of maternal and newborn health (UNICEF, 2025).

[1] WHO, UNICEF, UNFPA, The World Bank Group and the United Nations Population Division, Trends in Maternal Mortality: 2000 to 2023 WHO, Geneva, 2025.

Every Woman, Every Newborn, Everywhere (EWENE) – a joint partnership between the World Health Organization (WHO), UNICEF, and UNFPA – is a global and national movement dedicated to ending preventable maternal, newborn, and child deaths, as well as stillbirths (UNICEF, 2025; EWENE, 2024). Through joint strategies, the EWENE coalition works to improve maternal health outcomes, and ensure that pregnant women can access essential interventions – including antenatal care visits, childbirth assisted by skilled birth attendants, and newborn postnatal care (2024).

Quist-Nelson et al. (2024) performed a retrospective study of pregnant patients who gave birth between 2016 and 2020. The authors used a Severe Maternal Morbidity (SMM) algorithm to assess data collected during antepartum, peripartum, and postpartum stages. The study found evidence of carry-forward data from pre-delivery events that may have affected the accuracy of reported data: Approximately 19.0% of SMM diagnoses recorded during birth hospitalizations were carried over from prior health encounters, and did not represent new events (Quist-Nelson et al., 2024). The authors concluded that using administrative and electronic health record discharge codes as sole data sources can contribute to significant overestimation of true, de novo SMM rates (Quist-Nelson et al., 2024). Their findings highlight the importance of accurately reporting SMM rates, not only as a means of providing early intervention solutions, but also to establish effective guideposts for inter-institutional, interstate, and international maternal outcome research focused on reducing incidences of maternal mortality.

Maternal Health Indictors

Maternal Health Indicators (MHIs) are broad-ranging measures of maternal healthcare quality, and serve to identify areas of improvement, wherein pregnancy-related complications can be reduced (Agency for Healthcare Research and Quality (AHRQ), 2026). MHIs are location-specific measures of Severe Maternal Morbidity (SMM), preventable maternal deaths, and other potential risk factors that are avoidable with high quality care – such as delivery-related behavioral health conditions and post-partum periods (AHRQ, 2026). These measures are tracked based on delivery discharge filings, and find value in population-based health analyses; health surveillance data; pregnancy-related quality assurance procedures; and, maternal health research studies.

According to Taylor et al. (2021), the peripartum period -- i.e., pregnancy and the 12 months after delivery -- is a critical time for mother and child, and access to healthcare is crucial. MHIs around the peripartum period reveal serious risks for low-income expectant moms (CDC, 2024; Daw and Sommers, 2019; Taylor et al., 2021; UNICEF, 2025).

The U.S. Centers for Disease Control and Prevention (CDC) oversees a surveillance project – Pregnancy Risk Assessment Monitoring System (PRAMS) – in participation with state health departments across the nation (2024). PRAMS indicators provide a comprehensive list of pregnancy risk health indicators from nutrition, to oral health, and breastfeeding practices. PRAMS aggregates scores based on an unweighted sample size of pregnant women, and tracks maternal behaviors and health patterns before, during, and after pregnancy. Participant tracking begins pre-conception and continues through infancy – up to six months post live birth (Illinois Department of Public Health (IDPH), 2026). PRAMS draws data from 46 states, the District of Columbia, New York, the Northern Mariana Islands, and Puerto Rico -- capturing roughly 81% of U.S. live births. The PRAMS database provides valuable data accessed by health professionals, hospital administrators, policymakers, and researchers working to improve maternal health outcomes across the United States (IDPH, 2026).

Peripartum Risk Factors

Diabetes, high blood pressure, and depression are some of the health issues that can affect both mother and child, during the prenatal, perinatal, and postnatal stages of pregnancy (CDC, 2024). A study by Basu et al. (2014) highlights the prevalence of behavioral risk-related issues in the perinatal population. Of the 6,894 survey participants, a substantial proportion of women scored at or above the benchmarks for elevated posttraumatic stress (2,979 [43%]), anxiety/depression (2,138 [31%]), and loneliness (3,691 [53%]) (Basu et al., 2014). Figure 2[2] represents the sample proportion of women with symptoms of elevated PTSD, depression, and anxiety. The outcome of the sample is compared with a study on the mental health of the general U.S. population, as well as research on perinatal behavior-related issues reported prior to COVID-19.

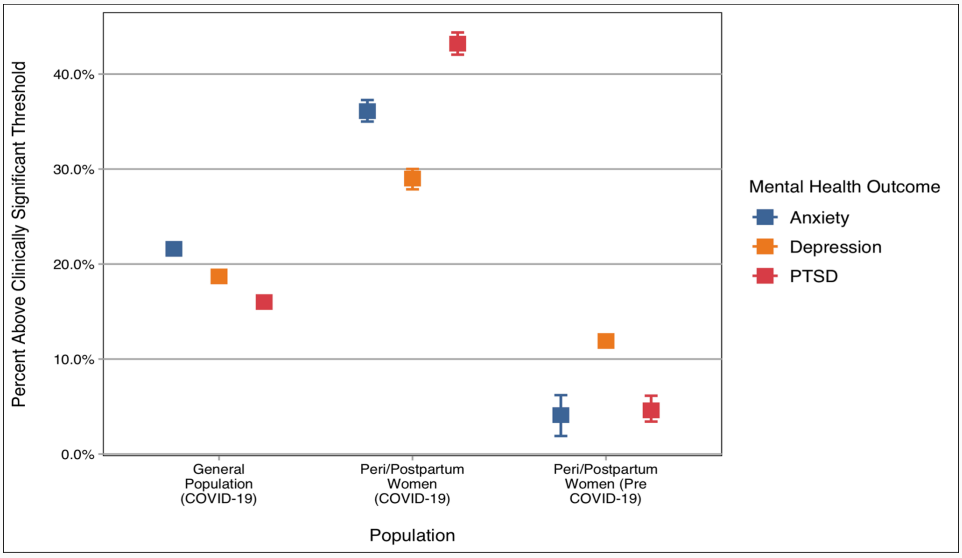


Figure 2. Comparing anxiety, depression and posttraumatic stress levels between the general population, peri/postpartum women during the COVID-19 pandemic, and peri/postpartum women prior to the pandemic.

Basu et al. (2014) found that approximately 86% of the women surveyed reported being somewhat or very worried about COVID-19, with the most dominant worries involving pregnancy and delivery, including family being unable to visit after delivery (59%), the baby contracting COVID-19 (59%), and lack of a support person during delivery (55%).

Factors contributing to increased levels of anxiety, and linked with significantly higher odds of post-traumatic stress, anxiety/depression and loneliness -- involved children (i.e., inadequate childcare, susceptibility to infection) and missing medical appointments (Basu et al., 2014).

Beyond screening and monitoring mental health symptoms, Basu et al. (2014) posit that finding interventions that alleviate women's worries about access to medical care; providing assistance in support of the well-being of their children; and developing solutions to combat loneliness are strategic considerations that should be factored into intervention efforts for perinatal women struggling to cope with the identified behavioral-risk factors.

Maternal Health: U.S. Report Card

According to The Commonwealth Fund (2024), amongst highly developed nations, the United States continues to report the highest rate of maternal deaths, marked by severe geographic and racial disparities. Currie and Hotz (2003) explain that, in the United States, trends in child death rates show differences based on cause of death, age, and race – with the sizable mortality rate gap between black and non-black children narrowing only in the last two decades of the twentieth century (see Arowolo, 2016). In 2012, only 55.7% of pregnant women in Dallas County received adequate prenatal care, and the infant mortality rate was recorded at 6.5%, in the same year (Children's Medical Center, 2013; Arowolo, 2016). Serious birth defects, preterm birth or low birth weight, sudden infant death syndrome (SIDS), maternal complications during pregnancy, and unintended accidents or injuries were listed among the top five causes of newborn deaths in Dallas County (Children's Medical Center, 2013; Arowolo, 2016).

Njie et al. (2026) assessed cause-specific proportionate mortality between 2005 and 2024, based on a five-year interval. Altogether, 14,310 pregnancy-related deaths were identified during the study period. The authors used joinpoint analyses to group significant changes in joinpoints (trends), and significant changes in annual percent change (APC) across distinct time periods. Figure 3 is based on Pregnancy Mortality Surveillance System (PMSS) data, curated by the CDC, concerning pregnancy-related deaths which occurred between 2005 and 2024. The Pregnancy-Related Mortality Ratio (PRMR) was calculated as the number of pregnancy-related deaths per 100,000 live births overall – and by cause of death and year. The authors sourced birth data used in assigning denominators (when calculating PRMRs) from U.S. natality files, archived by the National Vital Statistics System, 2005–2024.

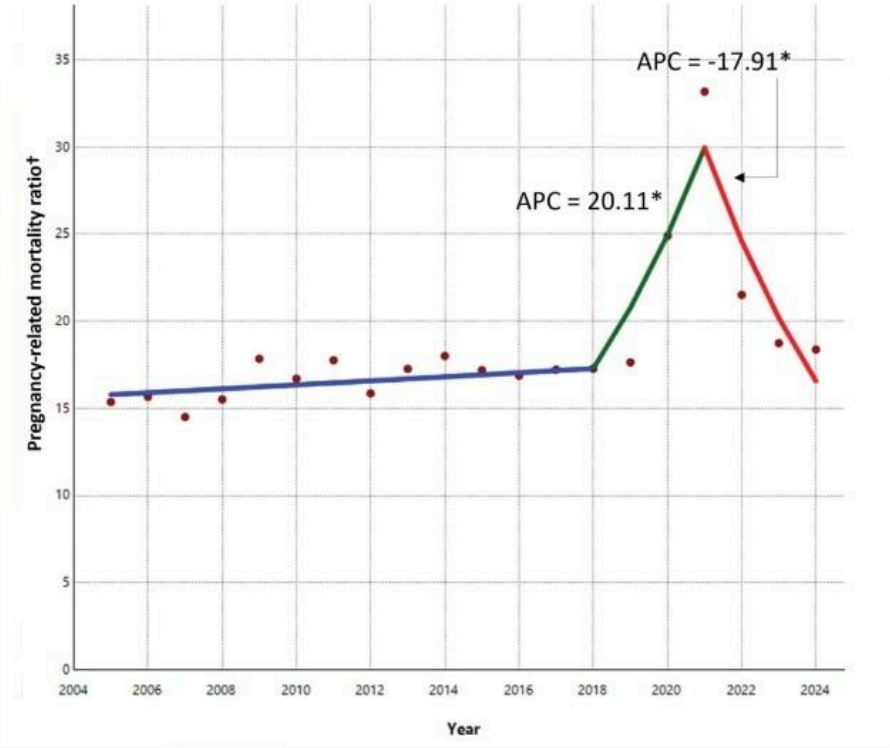


Figure 3. Joinpoint regression analysis of pregnancy-related mortality ratios, Pregnancy Mortality Surveillance System, United States, 2005–2024.

This figure was sourced from Nije et al (2026). Source note: **Annual percent change (APC) is significantly different from 0 at α <.05. †The Pregnancy-Related Mortality Ratio is defined as the number of pregnancy-related deaths per 100,000 live births. Line segment color changes represent joinpoints.*

The overall Pregnancy-Related Mortality Ratio peaked in 2021 (33.17 pregnancy-related deaths/100,000 live births) and dipped in 2007 (14.50) (Nije et al., 2026). Of the maternal deaths reported between 2005 and 2024, the four top-identified causes of death were cardiovascular conditions (24.3%), infection or sepsis (17.8%), other noncardiovascular medical conditions (12.2%), and hemorrhage (11.5%) (Nije et al., 2026).

A similar pattern in the trending behavior of the PRMR, within the same time-period, is identifiable in a separate study conducted by the CDC: The Pregnancy Mortality Surveillance System (PMSS) is a national survey undertaken by the CDC to assess the causes of pregnancy-related deaths in the United States. The CDC requested that the 54 reporting areas (50 states, plus Puerto Rico, the Commonwealth of the Northern Mariana Islands, New York City, Washington, DC) voluntarily send death records for all women, aged 10-60 years, who died during or within 1 year of the end of their pregnancy, irrespective of the cause of death (CDC, 2025). If the death was linked to a live birth or fetal death, those records were also requested (CDC, 2025). When possible, public health agencies – including jurisdiction-based maternal mortality review committees – also shared supplemental information sources (e.g., media reports and/or individual case reports) with the CDC.

Figure 4 provides visualization of the PRMR data gathered by the CDC, and was generated based on the CDC's Pregnancy Mortality Surveillance System. The PMSS defines a pregnancy-related death as a death that occurs during or within the first year a pregnancy ends – due to any factors related to or exacerbated by the pregnancy.

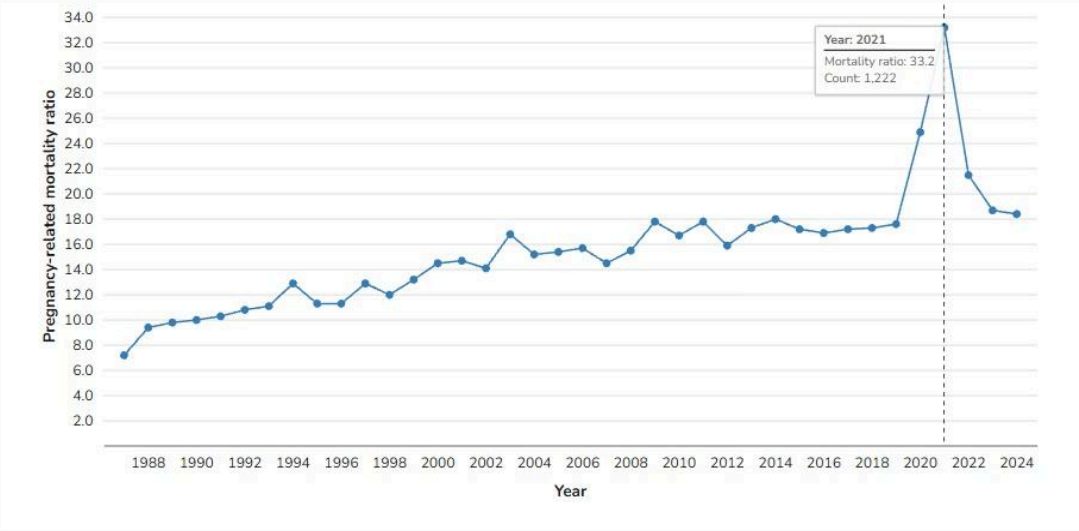


Figure 4. Pregnancy-related mortality ratio in the United States: 1987–2024.

Source: CDC Pregnancy Mortality Surveillance System (PMSS).

Figure 5 is also based on the same Pregnancy Mortality Surveillance System data curated by the CDC, and shows causes of pregnancy-related deaths in 2024. The cause of death is unknown for 6.9% of all 2024 pregnancy-related deaths. The data revealed that, in 2024, cardiovascular conditions are responsible for the majority of pregnancy-related deaths in the United States.

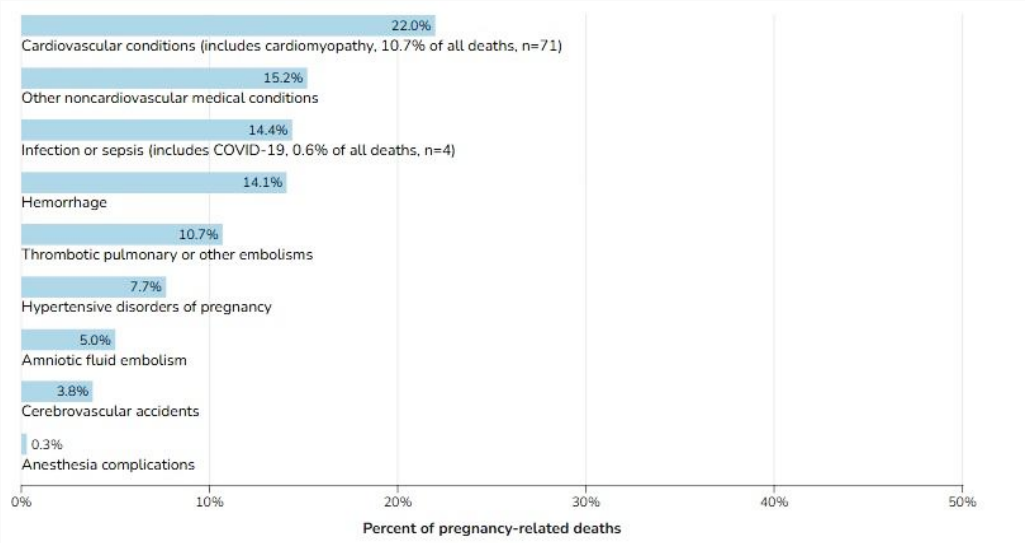


Figure 5. Causes of Pregnancy Related Deaths, 2024.

Source: CDC Pregnancy Mortality Surveillance System (PMSS)

Maternal Health and Low Income

According to Schultz et al. (2018), socioeconomic status (SES) plays a measurable, significant role in cardiovascular health events. Lack of income creates breeding ground for poverty related issues to thrive (Arowolo, 2014). Biologic, behavioral, and psychosocial risk factors associated with a lack of income underscore the association between SES and cardiovascular disease (Schultz et al., 2018). Studies (Daw and Sommers, 2019; Dore et al., 2026; Taylor et al., 2021) show a direct relationship between low income (and poverty) and lower positive outcomes in perinatal care among women in the United States. Anand and Ravallion (1993) explain that the ability to command commodities is often equated with a person's well-being, however, the non-income dimensions of poverty (e.g., health, education) are significant in terms of measuring poverty and providing interventions (see Arowolo, 2016, p. 10; Arowolo, 2014, p. 5).

The Behavioral Risk Factor Surveillance System (BRFSS) project – with over 400,000 U.S. adults surveyed annually – is the world's largest continuously conducted health surveillance system, and is designed to collect state-level data, from all 50 states, concerning health-related behavioral risks, acute chronic conditions, comorbidities, and the use of preventative services. Figure 6 is a map of the national responses to a BRFSS health access survey carried among U.S. adults. Texas ranks among the top-10 states wherein survey respondents reported the highest amount of difficulty when trying to access health care – with around 19.3% of Texas-based respondents indicating, in the affirmative, that accessing healthcare/coverage was difficult for them.

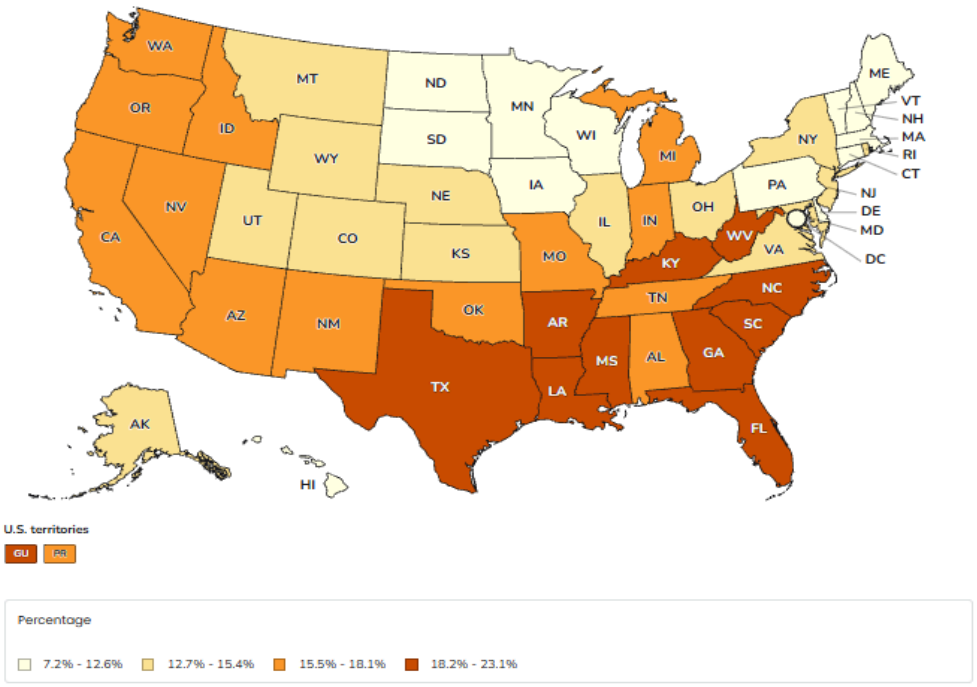


Figure 6. National Responses to Survey Concerning Access to Healthcare.

Source: Behavioral Risk Factor Surveillance System (BRFSS)

Figure 7 shows the outcome of the BRFSS survey for adults in Dallas-Plano-Irving, TX Metropolitan Division who were asked about their access to health care/coverage, to assess how well they are coping with health care costs. The survey asked: *Was there a time in the past 12 months when you needed to see a doctor but could not because of cost?*

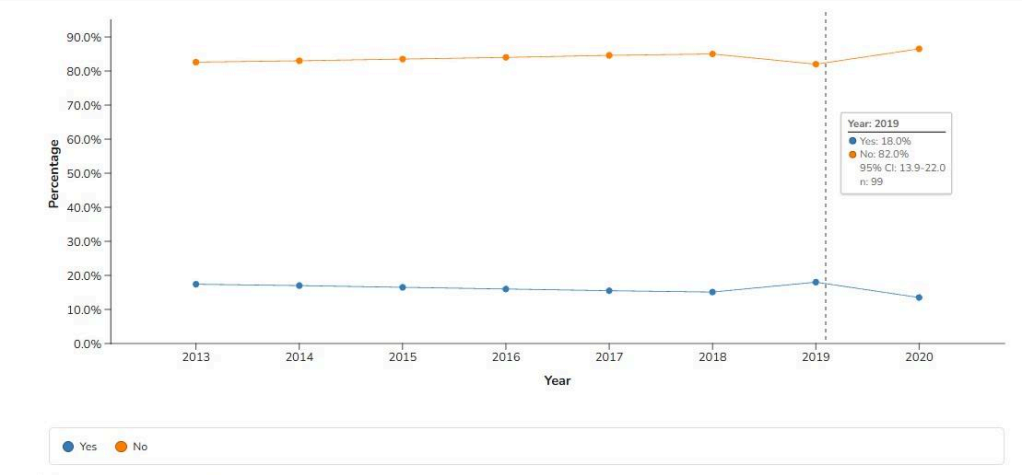


Figure 7. Surveying Adults in Dallas-Plano-Irving, TX Metropolitan Division Concerning Access to Healthcare.

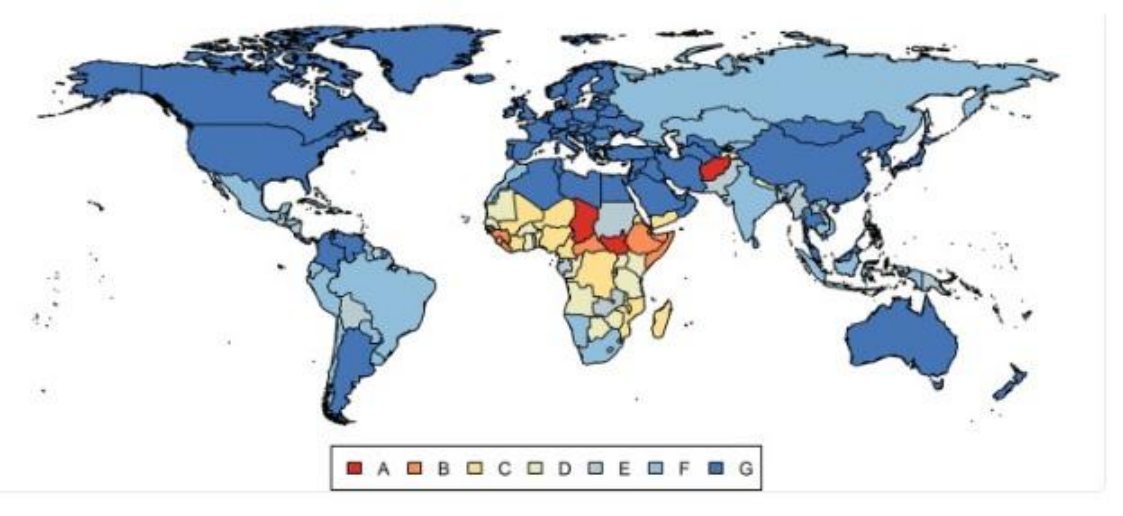
In 2019 (which saw the highest response rate concerning barriers to access), 18% of adult respondents indicated that they had difficulty accessing healthcare because of the cost. Dore et al. (2026) posit that poverty increases for women during the perinatal period, particularly as nutrition and medical costs accumulate during this stage. Navigating the perinatal period whilst faced with socioeconomic challenges can have adverse, lasting effects on both mother and neonate (Dore et al., 2026). The authors suggest that macroeconomic policies that alter poverty-related risk levels can be effective in establishing directives that alleviate the deleterious effects of poverty and its relationship with birth outcomes (Dore et al., 2026) in low-income settings.

According to the City of Dallas (2026), low-income expectant moms have a high level of susceptibility to preterm births, infant mortality, and maternal health complications – with risk levels showing high concentrations in under-resourced locales, where limited access to healthcare compounds with socioeconomic stressors. Texas Medicaid enrollees report a range of maternal mental health conditions, including prenatal and postpartum depression and anxiety – further exacerbated by economic constraints and social isolation (Margiotta et al., 2022).

Global Maternal Health Clusters

Ward et al. (2024) provide a global perspective on MHIs and policy impacts by country group. Using estimates from a Global Maternal Health microsimulation model, the authors define groups of countries based on maternal mortality ratio and lifetime mortality risk (LTR) estimates. The authors define LTR as the sum of age-specific MMRs between the ages of 15-49, and interpret LTR as the probability that a 15-year old female will die from a maternal complication in her lifetime, holding fertility and mortality risks constant at current levels (p. 2). K-means clustering was used to define countries based on a range of fertility, process, and mortality indicators. The mean impact of policy indicators were also assessed. Seven country typologies (A-G) were identified, varying in salient characteristics: High burden countries (A-B) showed MMRs of 500 or more, with LTRs of more than 2%, accounting for nearly 25% of global maternal mortality. See Figure 10.

Figure 10. Maternal Health Typologies by Country



Group	MMR	LTR (%)	Maternal Deaths	C-Section Rate (%)	Community-based and linkages to care
A	1174	5.8	32,000	2.5	18.3
B	647	2.98	51,700	2.4	27.9
C	435	2.39	113,200	4.4	12.4
D	288	1.29	43,100	9.2	18.8
E	151	0.43	30,800	21.4	14.9
F	78	0.18	50,300	27.8	13.1
G	25	0.05	17,900	41.9	5.6

Source: Wald et al. (2024). Source notes: Group-level indicators weighted based on population size, with the exception of Maternal Deaths, which are sum totals. MMR: Maternal mortality ratio (number of maternal deaths per 100,000 live births). LTR: Lifetime risk of maternal death. Facility Births: Percentage of births which occur in a health facility. C-Section Rate: Percentage of caesarean section deliveries (both elective and emergency).

Wald et al. (2024) define middle burden countries (C-E) as typically showing MMRs ranging from 100 to 500, and LTRs ranging from 0.5% to 3% – these country-groups account for 55% of global maternal death, and the authors suggest that increased use of facility births and improvements in the quality of care could ameliorate their MMRs. Low burden countries (F-G) were identified as usually having MMRs of less than 100, and LTRs less than 0.5%; thereby accounting for approximately 20% of global maternal mortality (Wald et al., 2024). The authors suggest that increased access to family planning and community-based interventions would benefit countries in this group.

Wald et al. (2024) report a trend wherein increases in facility births and c-section rates accompanied decreasing country burden – however, it is noted that wide variations exist at the country level, compounded by access disparities. Suggestions for community-based interventions centered on antenatal care, skilled birth attendants, and increased access to healthcare facilities (p. 3).Wald and colleagues conclude that policy interventions differ based on country typology, therefore policymakers need to make considerations based on multiple, country-specific indicators when tailoring solutions.

Perinatal Health Interventions: U.S. Report Card

Taylor et al. (2021) examine the relationship between financial strain (including lack of access to healthcare due to cost restraints and general financial stressors) and the well-being of peripartum women. The authors weighted a cross-sectional study of 3,509 peripartum women as a representative sample of over a million women hailing from different races, age groups. The authors used multivariate logistic models to estimate odds ratios, and adjusted their modeling approach to incorporate factors that could contribute to the risk of financial hardship -- including but not limited to race, age, income-to-federal poverty level ratio, education, marital status, employment status, and insurance type. See Figure 9[3].

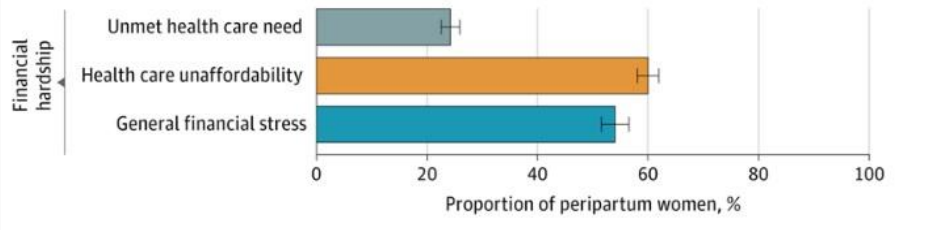


Figure 9. Survey-weighted outcome proportions of financial hardship reports among peripartum women between 2013 and 2018.

[3] Note about this figure, sourced from Taylor et al. (2021): The figure shows unadjusted, survey-weighted proportions of individual outcomes reported by peripartum participants between 2013-2018. Error bars reflect 95% confidence intervals.

The study found that, between 2013 and 2018, 24.2% (95% CI, 22.6%-26.0%) of peripartum women reported having unresolved health care needs due to financial constraints; 60.0% (95% CI, 58.0%-61.9%) reported inability to afford health care; and, 54.0% (95% CI, 51.5%-56.5%) reported general financial strains (Taylor et al., 2021).

Figure 10 compares unadjusted survey-weighted reports of financial hardship by study year, gauging three main factors: i) unmet health care needs, ii) health care unaffordability, and iii) general financial stress. Health care unaffordability ranked highest, consistently (2013: 65.7% [95% CI, 61.1%-70.0%]; 2018: 58.8% [95% CI, 53.4%-64.0%]), with general financial stress coming in a close second (2013: 60.6% [95% CI, 55.2%-65.8%]; 2018: 53.8% [95% CI, 47.8%-59.8%]) (Taylor et al., 2021).

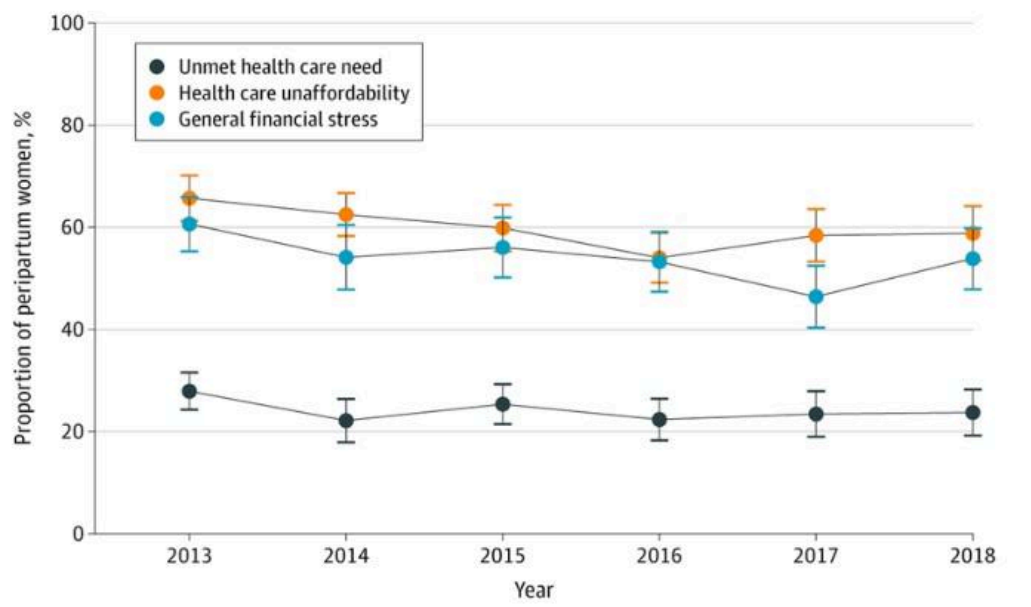


Figure 10[4]. Unadjusted, Survey-Weighted Proportions of Financial Hardship Among Peripartum Women, 2013 - 2018.

Daw and Sommers (2019) estimated the relationship between the Affordable Care Act (ACA), access to health care, and health insurance coverage among pregnant and reproductive-aged women. The authors argue that pre-pregnancy coverage can facilitate access to interventions that minimize exposure to behavioral risk factors associated with maternal and infant outcomes (Daw and Sommers, 2019).

[4] Source: Taylor et al. (2021). Note: Representation of unadjusted, survey-weighted proportions of each outcome reported by peripartum women, per annum. Error bars represent 95% confidence intervals.

According to Schultz et al. (2018), interventions targeting low SES patients have found success in focusing on modifying behavioral susceptibility to cardiovascular risk factors. As a result, programs that can be implemented on an individual, community, or population basis to reduce income-based disparities are growing in number (Schultz et al., 2018).

Better understanding of community-level factors contributing to low SES and high cardiovascular risk stratification are necessary to programmatic interventions that involve creating and establishing solutions tailored to decrease cardiovascular events within the peripartum population. Behavioral counseling to reduce cardiovascular risk factors – including cholesterol levels, blood pressure, and diabetic incidences – has seen success in the general population, and is recommended by the U.S. Preventive Services Task Force (LeFevre, M. L., & U.S. Preventive Services Task Force, 2014; Lin et al., 2014). In addition to structured behavioral educational counseling, social programs designed to strengthen good-health markers among low SES expectant moms must primarily prioritize and aggressively target traditional cardiovascular risk factors that have strong associations with low SES (Davis et al., 2007).

Basu et al. (2014) posit that, beyond screening and monitoring mental health symptoms it is necessary to consider interventions that alleviate women's worries about access to medical care and women's concerns about providing assistance in support of the well-being of their children. Of the 6,894 survey participants tracked in the study by Basu et al. (2014), a substantial proportion of peripartum women scored at or above the benchmarks for elevated posttraumatic stress (2,979 [43%]), anxiety/depression (2,138 [31%]), and loneliness (3,691 [53%]). Developing solutions to combat loneliness are among the strategic considerations that should be factored into intervention efforts for perinatal women struggling to cope with the behavioral-risk factors that contribute to maternal mortality identified in this report – especially cardiovascular events, identified as the highest behavioral-risk factor and contributor.

Dore et al. (2026) explain that poverty increases for women during the perinatal period, particularly as nutrition and medical costs accumulate during this stage. Navigating the perinatal period whilst facing income-related challenges can have adverse, lasting effects on both mother and neonate (Dore et al., 2026). Macroeconomic policies that alter poverty-related risk levels can be effective in establishing directives that mitigate the deleterious effects of poverty and its influence on both birth outcomes and maternal health in low-income settings.



OUR SOLUTIONS-ORIENTED APPROACH TO COMMUNITY SERVICE

At Tetelestai International, our vision is to mobilize the power of community to connect under-resourced citizens with vital resources needed to achieve optimal well-being. We take a holistic approach to philanthropy, by providing practical, tangible solutions to meet immediate, pressing needs. We endeavor to ensure that low-income citizens can access vital resources. Through our program initiatives, we work to ensure that citizens in under-served, under-resourced communities have access to food, clothing, books, and neonatal kits.

OUR NEONATAL INITIATIVE

Our goal is to alleviate income constraints that create barriers to basic needs for peripartum moms. Our neonatal initiative works to anticipate newborn essentials, in hopes to decrease the financial strains low-income moms may face with accessing neonatal supplies. Our neonatal initiative is structured to increase access to newborn essentials, which would otherwise be inaccessible to low-income citizens, due to cost restrictions.

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