

Disparities Persist in Infant Mortality Creative Approaches Work to Close the Gap

By Kauthar B. Umar, MA

Closing the Gap, Working Toward Our Goal • August 2003

During the last several decades, reducing infant mortality has been an ongoing challenge. The Centers for Disease Control and Prevention (CDC) states that despite substantial reductions throughout the United States, Black/White disparities in infant mortality rates persist. From 1980 to 2000, infant mortality rates declined 45.2 percent among all races, although the decline was greater for Whites (10.9 to 5.7 percent) than for Blacks (22.2 to 14.0 percent).

“Insufficient prenatal care resulting in low birth weight is a major factor associated with infant mortality,” said Dr. Fern Johnson-Clarke, chief of the Research and Analysis Division at the District of Columbia Department of Health (DCDoH). According to the DCDoH, in 2000, the percentage of low birth weight infants (those weighing fewer than 5.5 pounds) in the District was 11.9—with low birth weight affecting Blacks almost twice as much as Whites.

Yet, progress is being made through the DC Healthy Start Project. Initiated 10 years ago with funding from the Health Resources and Services Administration (HRSA), the project provides women with access to comprehensive prenatal care services they may not otherwise receive. “Women receive case management throughout the cycle—from pregnancy to delivery,” said Johnson-Clarke.

Since its inception, the DC Healthy Start Project has helped reduce infant mortality by 45 percent in the District. The Project, currently in its third phase of HRSA funding, has broadened its focus in various ways, and now includes outreach to fathers and prenatal depression screening. “As a result, since [the program began] none of the women who have participated in the Healthy Start Project have had an infant die from a preventable death,” said Johnson-Clarke.

REACHing Out

Racial and Ethnic Approaches to Community Health (REACH) 2010 Project is a national demonstration project managed by the CDC that supports Healthy People 2010—the nation’s health promotion and disease prevention initiative. The primary objective of REACH 2010 is to help communities mobilize resources to support programs that eliminate the health disparities experienced by racial and ethnic minorities.

Through Michigan’s Genesee County Department of Health, the REACH Project in Flint takes a slightly different approach to reducing infant mortality. It works to improve the overall health status of women. In Flint, where the infant mortality rate of Blacks is about two and a half times that of Whites, the Department’s division director of Maternal and Child Health Services, Lillian Wyatt, has been working with the community.

“One of the things we needed to do was to get the community involved in reducing infant mortality,” said Wyatt. “First, we needed to identify what the community already knew about infant mortality, what they thought was actually the cause of their babies dying, and areas where they thought they could help to solve the problem.”

In an attempt to fully engage the community and foster community mobilization, the REACH Project has developed three strategies: Community Dialog, Educational Training and Outreach, and Advocacy.

Community Dialog

The dialog strategy brings representatives from across the community to discuss infant mortality, and to develop a community-based intervention aimed at reducing baby deaths. “To be truly effective in addressing infant mortality in the Black community, the project brings together groups that would otherwise not meet to address race and racism as they relate to infant mortality,” said Yvonne Lewis, executive director of Faith Access to Community Economic Development (FACED), a non-profit corporation that provides resources to low-income residents of Flint and Genesee County. “The dialog is a series of four sessions designed to bring 15 to 25 mothers, educators, and health professionals together,” said Lewis. “We engage the community. We ask the community questions like, ‘What is infant mortality? What are the causes?’”

Infant mortality is defined in the first session and its causes are identified in the second. Possible solutions are addressed in the third session, narrowed down to one idea, and then put into action by the fourth session. By meeting with health care providers and discussing the factors to high infant mortality rates in the Black community, some groups have been able to bridge the gap and work together to reduce infant deaths.

All interventions reinforce themes of cultural appropriateness and anti-racism. According to Lewis, the groups focus on how Blacks access health care services in the county, and embrace the notion that racial difference in infant death rates is a symptom of cultural, institutional, interpersonal, and internalized racism. Lewis maintains that this approach includes educating health care professionals about race, racism, and race-based privilege.

“One of our major hospitals didn’t have a real strong role in the African American community and a dialogue group that completed their fourth session decided to do interventions with physicians at that hospital,” said Lewis. “Physicians need to be a part of correcting the problem, so we introduced them to our Maternal and Infant Health Advocacy Support Services program.”

With an audience of obstetricians and gynecologists, the dialogue group discussed disparities in infant mortality and engaged the community in the solution. After discovering that physicians believed the real issue to be non-compliant patients,

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Eliminating Health Disparities: Infant Mortality.”



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the dialog group decided to recruit physicians to participate in the FACED referral process.

“Group members provided an orientation to physicians on utilizing our referral process to get expectant mothers the additional support they may need during their pregnancy,” said Lewis. “The dialog group created this action plan one year ago, and today we have OB/GYN’s and primary care physicians in three hospitals involved in this particular referral system.”

Educational Training

The Project’s Educational Training strategy assists the University of Michigan with cultural competency training of future health professionals, faculty, and staff. The African American Cultural Educational Awareness Center was developed to serve the community with health education in a similar manner.

Through an educational component called Black Unity and Spiritual Togetherness, men and women expecting children are paired with friends or family members labeled “birth sisters and brothers.” The partnership addresses cultural elements from a family perspective and provides education on healthy parental behaviors, which lead to healthy pregnancies, followed by healthy births and ultimately, healthy

children. “All of us together have to work collectively on the issue,” said Lewis.

Outreach and Advocacy

The Outreach and Advocacy strategy utilizes referrals from the Women, Infant and Children Program to identify women who are in the early stages of pregnancy or recently gave birth. Those mothers are then paired with maternal and infant health advocates, who offer support during the pregnancy and up to the child’s first year. Billboards, television, and radio commercials have also been developed to reinforce the message.

“We want that message to ring out loud and clear—babies don’t have to die,” concluded Lewis.

For more information on the DC Healthy Start Project, contact Dr. Fern Johnson-Clarke, District of Columbia Department of Health at 202-442-9032. ❖

For more information on the Flint REACH Project, call 810-257-3194. ❖

For more information on Faith Access to Community Economic Development, e-mail Yvonne Lewis at yvonlewis@hotmail.com or call 810-232-7733. ❖

