

AMCHP 2007 ANNUAL CONFERENCE

HEALTHY COMMUNITIES

March 3rd to 7th, 2007

Stagnant or Increasing Infant Mortality: The MCH Director's Role in Responding

BELINDA PETTIFORD: --team members, especially my travel team members. And they were on the first slides, so don't you-all tell them I didn't give you their names. Also, you don't have a copy of this presentation, but if you would like a copy, if you'll just give me your e-mail address, I will e-mail it to you this afternoon. If you don't have e-mail for some reason, I can get you a copy tomorrow when the Business Center opens. Didn't realize it wasn't open today.

The goals of the North Carolina program are listed here. First, to develop a new picture of infant mortality and related women's health issues in North Carolina. Our second goal was really to develop strategies to address infant mortalities, specifically in the context of women's health, and specifically on health disparities. And third, we really wanted to develop and implement a plan which included diverse partners. Health disparities is one of our departments overriding issues in our whole state and infant mortality is one of those areas.

The first thing we did of course was an analysis. We're very fortunate to have a very strong state Center for health statistics in North Carolina under the

leadership of Dr. Paul Butcher. So we have tons of quantitative data. So we really spent time going back and just reviewing that data again. And this is kind of some of the information we found out. The downward trend in our infant mortality rate has slowed quite a bit since the mid-'90s. We actually had an increase in 2004 and then in 2005 it stayed the same. So it became a little stagnant, and that's a concern to us. A bigger concern though is our racial disparity increased over this time period. So as you've heard from many other states, this is true of North Carolina as well. The top red line represents our African-American community. Kind of the greenish line below is our white rate. So as you could see, we have had a blip back in about 1999, but since then, our gap began to continually to get wider. Some of the other things that we found out is that while the percentage of live births that are low birth weight has increased steadily, the mortality rates during this time period continually decrease. So even though we've had more live births that were born smaller, they are tending to still live.

The percent of increase of low birth weights by weight categories range from 8% all the way up to 67% from '99 up to 2005, with our greatest increase with babies born less than 500 grams. So we know there are some medical interventions there that appear to be working for us some. Our birth weight specific infant mortality rates, again, from '91 to 2005, the overall neonatal mortality rate declined by 15%. But our death rate for infants less than one day old also decreased for us. So during that same time period, we saw declines in both areas. The fetal death rate decreased by 17% over this time period.

And so this for us suggests that we've had some improvement in both fetal and neonatal survival. Again, we are thinking much of this is back to medical intervention. The post neonatal mortality rate declined 20% during this same time period. Our racial disparities though, was a little different. Our infant death rates have declined less between '89 and 2003 among our African-American as well as our American-Indian families. And this has really caused us to have an increase in our racial disparity over time. But at the same time this was going on in our state, we had a dramatic increase in Hispanic births in the whole state of North Carolina. In North Carolina Hispanic births, most of our Hispanic births have been first generational births. So actually, what we're seeing, at least we think we're seeing, is that our Hispanic birthrates are so good that it's protecting our white birthrates.

So our white rates continually improve, which also helps to kind of widen that gap for us. But a lot of that is because our Hispanic numbers are so good. This past year in 2005, actually was the first year that we've seen a slight increase in our Hispanic birthrate. I mean, not the rate, but in our Hispanic infant mortality rate. So as we watch that over the next couple years we could actually see even the gap may close, but it may not be the reason we want it to close. It could be that our white rate starts getting worse because our Hispanic numbers get worse. So we're watching that very closely in North Carolina. We already know that second

generational Hispanic births in our communities, the birthrates don't tend to be, they're infant mortality rates are not as positive.

The neonatal survival advantage also of low birth weight African-American babies has decreased over this time. At one point, even though our African-American births were, the babies were small, they were still surviving. And now we no longer see that. They're not surviving as well as they did at one point in time. One of the things our state infant mortality collaborative wanted to do is because we do have such great quantitative data, we really wanted to hear from the voices of the families. Very similar to Missouri. So early on in our process, our group split up. I mean, not split up meaning we never spoke to each other, but mean, we wanted part of us to really look at the voices of families. So we did a lot of qualitative work. We did over 20 focus groups with families in our communities. And these are some of the questions we asked. The full report could be found at the NorthCarolinaHealthyStart.org Website, or if you need that report, I can also e-mail that to you as well. But we found interesting information there that I can share with you a little bit later.

The racial disparities in birth outcomes in measures of women's health increased with maternal and fetal age, but they continued to decrease with education. So what are some of our interventions? One of the key interventions for us was convening the experts and resources to review and look at all of the data and look at all of the information. We really wanted to focus on partnerships. We had

a lot going on in our state, and we were trying to bring people together. People that sometimes may not felt like they needed to partner in this because they weren't clear what all of the issues were. So we have probably 25 to 35 partners around our table that are consistently meeting about these issues.

We did presentations around our state too. You know, we did presentations in small community groups. I know I was on the road for quite a while going from church to church to church. Because, you know, in our state, we still feel, many of our people in our community still feel that we have high African-American infant mortality rates because of our teenagers. And it was a big myth to still try to dispel because most of our teenage African-American births are healthy births. Now what we do see is by the second or third pregnancy, because she may have been a teen mom earlier on, those births are worse. But every church that I went to, as well as other colleagues, every pastor, every first lady or first man, they always said, we need to work on teen pregnancy so we can improve this. And we agree, but we were still at the same time trying to dispel some of those myths.

Women's health initiatives that are underway. We've applied for some funding to address chronic disease control and prevention with some of our existing infant mortality projects. And we're really trying to focus more on the pre-conceptual inter-conceptual focus area. We have selected five proven health messages and we're trying to coordinate and make that message into one message, because we have multiple campaigns in our state, and I think we're confusing our citizens

because everybody's coming at them with something. And we're really trying to merge it all together and have one consistent message. We are addressing smoking by women. Specifically in our local health departments that provide maternity and family planning services. All of those health departments are now required, in order to get the funds from our office, to offer and provide the five-eighths counseling for women who smoke. So the ask advisor sets the system range. So they are all required to do that. This past year was the first year when we let them practice. Starting July 1, we will be monitoring their efforts. And then we've got a pre-conceptual health inventory. Our minority health, our governors, or actually our General assembly appoints a minority health advisory Council. And the minority health advisory Council this past year submitted a bill to actually address community focus eliminating health disparities. And we were able to get infant mortality as one of those health disparity issues. And in that time period, some of our infant mortality projects were funded. Six of 45 newly funded projects were focused on infant mortality. And then the vast majority in our state were focused on HIV and AIDS. But they just issued a new RFA, and we have worked with more of our infant mortality sites to apply for those funds.

We also have worked with our Child Fatality Task Force, which is another legislative body. And they have been able to champion and get funding for 17 alpha hydroxyl progesterone. And during this time period, we've gotten one-time fundings, so that we can use this time period to do focus groups with women to see if you were able to get this, would you in check, take advantage and go with

the injections. If you've had a previous pre-term birth, we've used this time to also train providers, as well as to purchase some of the medicines so that women don't have to worry about the cost. We also have support now from our General Assembly to require Medicaid to reimburse for it. So we're in the process of moving that along. We still have our family planning labor. It begun this past year. We're not at 200% of poverty, we're at 185% of poverty, but that takes women right from our Baby Love Program, which is the Medicaid for Pregnant Women straight into the family planning waiver. And we were able to get some additional funds to do that. Our lessons learned thus far, qualitative data is critical to us. I mean, we had been looking at quantitative data for years. Now the mindset is, we always need to hear from the voices of the families. So not only have we done those initial qualitative focus groups, but now we're moving into doing more, we're doing key informant interviews, and we're really trying to spend time hearing from families out there. We continue to work with the child fatality task force and have actually encouraged the Child Fatality Task Force to work more closely with our Minority Health Advisory Council, since they're both legislative bodies. Legislatively mandated bodies. And they have now sponsors and joint legislation.

Projects that are kind of pending that we're looking for the future, we're getting ready to release a report card on pre-conceptual health. And we're also working in a few of our communities to look at community-based dismantling racism efforts. We realize that this is not just a public health issue. This is an issue much

broader than public health. And we have a couple of our communities, and specifically local health directors in our communities that have come to us and we started a dialogue. One of our communities is way ahead of anybody else in our state, and we're really spending time trying to get some lessons learned from them. And they've pulled in people in their community to really deal with issues of institutional racism. So we're excited about the opportunity there and we know we have much more to do. The general public still looks at infant mortality as not one of those high priority health issues, so for us it's again about couching the message. So thank you, and I'll be around for questions.