

Responses to Q&A at April 11, 2008 Call to Action on Black Infant Mortality

1. What is being done to improve smoother transition for eligibility for Medicaid and sustain that eligibility throughout the pregnancy?

Eligibility is determined by the Department of Children and Families and anyone who does not qualify can apply for the Primary Care Grant through Broward Health's Community Services.

Maxine James-Francis, PhD.

2. Does the issue of black infant mortality come down to overall racism & economics?

A. (Michaella Valbrun-Pope, MS Ed)

There are many studies which stop at explaining the disparities between black and white infant mortality with health related factors. These include the diseases which black women are at a higher risk of contracting, health habits which negatively impact pre-term infants, and many of the causes the physicians discussed at the Call to Action summit.

There are many more studies now looking to find a 'black gene' that will explain this phenomenon.

None of these studies answer the following questions:

Why aren't black babies dying at the same rates across the U.S., or even across the globe? What accounts for the differences in rates?

Could the differences be related to culture, environment, or access, as opposed to availability of culturally relevant health services? Could the difference be related to systematic discriminatory practices on the part of well meaning health professionals of all races working within the constraints of organizations that are not truly patient centered?

I can't say for sure that racism and economics are what it all comes down to, but I do think these issues are worth exploring. One such exploration can be found in the July issue of the American Journal of Public Health. It is a study co-authored by Richard David, who is affiliated with Children's Memorial Hospital, and James Collins, professor of pediatrics at Northwestern University.

B. (William Petersen, MD, FACOG) Racism? Society is spending at least 10 times more for these infants than a normal infant. I think we need to define racism. This term is loosely used to explain many social woes which may, or may not, meet the strict definition. I also feel that society can do so much, but ultimately it's up to the individual to educate themselves, and be responsible for their own actions. Should we say the public educational system is racist? After all, the minority drop out rate is up to 70% in some areas. This is where our greatest societal failure ends up showing up with a higher infant mortality rate. Keep in mind that drugs, sexually transmitted diseases, homicide, co-bedding, and obesity are some of the risk factors that create this outcome. This doesn't even begin to answer some of the problems that minority males end up being involved with gangs, and violence, and associated with the drug culture. It is more dangerous in most major metropolitan areas to young males, than it is to be in Iraq (looking strictly at statistics). The health care dollar spent on our young males is much higher than individuals not involved in gangs and drugs. We can blame our society as being "Racist", and give up, or we can empower the individual and assist the youth in continuing education (not easy) but do we have a choice?

3. How do we reach the population for education? (Not just pre-identified groups but all pre-conceptually, prenatally, and particularly postpartum for parent education and support) and what about funding?

Start earlier in primary? And middle school.

William Petersen, MD, FACOG

4. Now that moms who are not citizens are not eligible for Medicaid, how are we going to reach these moms and care for them in the 1st trimester?

The prenatal sites which are associated with Community Health Services/ Broward Health (North Broward Hospital District) do offer Primary Care Grant through Broward Health.

Maxine James-Francis, PhD.

6. We talk a lot about educating the parents but does anything need to be done with the medical community, and if so, what?

The medical community is available 24x7. The majority of the patients with the bad outcomes have decreased prenatal care. Changing the perception of patients through education, and encouraging early prenatal care, and improving education can prevent up to 40% of the bad outcomes.

William Petersen, MD, FACOG

7. Have there been studies comparing the black and white premature births & infant mortalities to see what the similarities & differences are between the two groups to help determine cultural or genetic causes in African American high death rates?

Keep in mind that in the early 90's bad outcomes were nearly the same between black and white infants. Social changes such as drugs, school drop out, gangs, single mothers, STD's, have become more common. Although genetics could be a contributing factor, this would be a difficult dilemma to design such a study. It would mean allowing some infants to have a complication, and see if this is a statistical difference. Then how often would this gene occur in normal patients? How would we counsel these patients? Remember this problem did not occur in the early 90's despite the same gene pool.. Liability issues with pregnant patients, also the influence of undocumented immigrants, and the nation of origins gene pool, is this what may be influencing this outcome? Patients are usually unwilling, or fearful of divulging this information.

William Petersen, MD, FACOG

8. Has there been any research done to determine how many mothers of deceased infants were suffering from PTSD?

There is a higher than normal stress factor, especially with the co-bedding group, more unintended suffocations of infants leading to increased infant deaths. This group may be exposed to more violence within their neighborhoods. i.e. fear of guns going off during the night, and sleeping with the infant to protect them. There is a higher reported racial discrimination in black women. But again, how would you quantify the amount of "racism", and what act is considered racist, with secondary cause and effect. These are self perceptions, and very difficult to scientifically evaluate a cause and effect. But overall more work has to be done in this area. It is difficult to separate emotional self reported, non scientific (statistically significant) concerns, and end up with measurable usable information, that when acted upon, will lead to better outcomes. By reducing STD's, drugs, smoking obesity, co-bedding, and school drop out rate, and increasing prenatal care, we can make a statistically significant positive effect.

William Petersen, MD, FACOG

9. Is there any information available on how many mothers whose infants expire or suffer a fetal demise have male partners living in the home earning incomes @ or above 150% of the Federal Poverty Level?

I addressed some of these issues above, utilizing self reported and death certificate information is not easily gathered. There are social pressures not to include this data because the male partner may be held financially responsible for the infant's health care. But in the 1920's (in Britain) this information of poor fathers, was related to worse outcomes.

William Petersen, MD, FACOG

10. How has the influx of immigrants to the state / Broward County affected the Black Fetal / Neonatal mortality rates?

There is only limited evidence as to the impact of immigration on fetal and infant mortality in Broward County. Birth and fetal/infant death certificates lack information on country of origin for the parents or length of residence in the United States. Persons who have recently immigrated to the United States, and those who may be undocumented, face many barriers in accessing care. In addition, there may be health beliefs and practices from their native cultures that can have adverse outcomes. Anecdotal information suggests that recent Haitian immigrants may be at particularly high risk of bad outcomes compared to persons from other Caribbean nations.

Should we be looking at some specialized/culturally sensitive interventions for this historically underserved & underinsured group (or is this not an issue)? I believe that it is only through the development and implementation of culturally sensitive interventions that we will be able to improve the remaining disparity in black deaths in Broward County. Interventions that improve early access to care are needed to reduce barriers to appropriate prenatal care, and provide support to high risk women throughout the first year of life.

John Livengood, MD, Phil

11. What specific infections impacted the death rate?

The two groups in which the disparity between black and white deaths was attributable to infections were the early (20-28 week) fetal loss and the post-neonatal deaths (age 29-265 days of life). In the early fetal death group, the infections most often presented as chorioamnionitis caused by bacteria including sexually transmitted infections, and other bacteria normally present in the vaginal area. For the post-neonatal group, the infection was mostly unrecognized pneumonia, caused by viruses and bacteria such as pneumococcus and staphylococci.

John Livengood, MD, Phil

12. Has there been an evaluation of fetal and infant mortality rates between blacks enrolled in a fee for service Medicaid vs. managed Medicaid?

I have not seen data on this for Broward County.

John Livengood, MD, Phil

13. What does the data available in Broward County reveal regarding differences in Black infant mortality, B/W African Americans, and African Caribbean's (Haitian, Jamaican)?

Although the race of the infant and parents is recorded on the birth and death certificates, the country of origin for the parent is not recorded. Anecdotal information suggests that recent Haitian immigrants may be at particularly high risk of bad outcomes compared to persons from other Caribbean nations.

John Livengood, MD, Phil

14. What can we do about the problem of inaccurate death certificates?

The accuracy of the listing of cause of death is a major limitation of studies that use this important source of information. In the Pediatric Autopsy Project, many infants, particularly those in the first month of life, and most fetal deaths had incorrect information listed as the cause of death. However, this did not differ substantially between black or white infants. This indicates that we can be fairly confident about the general statements about the overall disparity and the differences in causes of death. While better ascertainment of the cause of death would be helpful, interventions to improve this are not well established, except for cases referred to the Medical Examiner or other autopsy-diagnosed causes.

John Livengood, MD, Phil

15. Do you think that the Pathology Autopsy program was useful?

The answer is clearly affirmative. The autopsy program and the related epidemiological analysis, permitted a much more clear view of what types of death are more frequent in infants, and particularly in black infants in Broward County, and which are the most critical risk factors. This knowledge enables us to direct efforts for reducing the increased black infants' mortality in a much more effective and efficient ways.

Joshua A. Perper M.D., LL.B., M.SC
Chief Medical Examiner

16. What is occurring during resident programs to educate the residents regarding mortality issue, and promoting social & community obligation?

Educating the special needs of our patients, and extensive screening programs, with special emphasis on improving access to prenatal care, while educating these women on special programs through the health department, and soon, implementing some of the non traditional educational programs. All the residents and medical students provide years (5+ years) of little to no pay, providing services to the disadvantaged.

William Petersen, MD, FACOG

17. What can be done about maternal infection?

Patients educated to access early and ongoing prenatal care.

William Petersen, MD, FACOG

18. General Comments

A. I truly agree with Valbrun's perspective of why Black babies are dying at a faster rate. I see the disparity daily on how our disadvantaged minorities are treated differently from women who are not. As healthcare professionals, we treat our mothers as if they are incapable of directing their healthcare. We fail to work in collaboration with parents. We want to be in control instead of empowering our mothers to take the wheel in directing and being responsible for their health care as well as their children's healthcare. Cultural sensitivity and awareness is a major issue.

Needed: support services for Teen Mothers during pregnancy, due to hormonal/psychosocial and psychological stressors that need to be addressed.

B. I was sorry to see infant mortality at the bottom of the list of critical issues of public health. All others, except cancer tend to be consequences of poor decisions by adults. Infants have no say in negative impacts on their lives.

C. Per Dr Grossman, point of information for Dr. Commodore:
There are health plans such as United that do pay for 17-Hydroxy progesterone for mothers that had their 1st preterm birth.