



# WISCONSIN CHRONICLES ON BLACK HEALTH DISPARITIES

**\*\*Special Issue on Infant Mortality\* Special Issue on Infant Mortality\*\***

## ***Our Babies Are Dying, We Must Save Them!***

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When one looks at the photographs of infants on this page, your heart melts and you think of how precious and sweet the babies seem. You think of all the hopes and dreams that their loved ones put into them. As you see the brightness in their eyes and their healthy plumpness, one may assume that all is well in their worlds. Unfortunately, in the state of Wisconsin, and more specifically in the city of Milwaukee, far too many African American infants are not fortunate enough to reach their first birthday. It seems as if these infants are crying out to the community, but few seem to hear, care or respond to their urgent moaning for brighter days. There is an often referred to African proverb that states, "It takes a village to raise a child." Where is the village? Where is the broad community outcry and attention on infant deaths? Within the public health community there is the belief that the state of the most fragile amongst us is an indication of the overall status of our society. With infants being the most fragile amongst us and their survival rates being so threatened, our society in general is not healthy!

*The time for action is now!*

Despite the fact that the number of infant deaths of Whites in Wisconsin continue to decrease, the numbers continue to remain at unacceptably high rates for African Americans. This is not a new phenomena; unfortunately Black infants have died at over three times the rate of White babies in Wisconsin for decades. This longstanding health disparity is often talked about within the public health community, studies are done, work groups are formed, conferences are held; but all of this has been done to no avail as the discouraging data persists.

*The time for action is now!*

In recent years, Black infants in Milwaukee are not just losing their lives due to traditional health problems, but there has been an increase in infant homicides and negligence cases as well. This is a disturbing reality in our community that has to be addressed collectively by every segment of our society. Brighter days for our infants will not occur until women, men, families, health care providers, government services, politicians, law enforcement and others work together with the determined will to stop the unnecessary deaths.

*The time for action is now!*

Reducing infant mortality does not just include looking at ways to ensure infants get required well-baby visits, have proper nutrition, have safe sleeping environments, etc... but it must also include making sure pregnant women are supported in our community. Of all the infants that die before their first birthday, two-thirds of those deaths occur before the infant even leaves the hospital. Prematurity and low birthweights are prevailing factors behind these occurrences. Women have to be empowered to have healthy pregnancies.

*The time for action is now!*

As we learn from the information that is in this publication, high incidence of African American infant deaths occur not only in Wisconsin, but throughout the United States. This is an issue that prevails within the population, oftentimes despite the absence of poverty, advanced education, access to care, healthy living habits and other recommended factors. Recent research has shown that the toll of racism over the course of a lifetime, and through generations, creates risks for African Americans that are contributing causes to pre-term births and low birthweights, leading infant mortality factors.

*We as a society must, and can, do better!* The time for action is now! If we truly believe that children are our future, we must fully welcome them into this world and provide them a society in which they can thrive.



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## *Persistent Peril: Why African American babies have the highest infant mortality rate in the developed world by Ziba Kashef*

Sophie Womack, 48, was surprised when in 1985 her first child, Brandi, was born three weeks shy of her due date and six ounces below normal birth weight. The Detroit mother had received timely prenatal care and was in good health throughout her pregnancy. Yet her baby was premature. Then, two years later, Sophie's second child, Ashley, also entered the world too small and too early. "In spite of the fact that I ate well and otherwise was healthy, I still had two relatively small children," she recalls.

This pattern seemed particularly odd since Sophie was a neonatologist, a type of doctor who specializes in the development of newborns. As a physician, she knew a great deal about how to prepare for pregnancy and childbirth. She just didn't fit the profile of a mom of low birth weight children: She wasn't too young. She wasn't poor. She was educated and had medical care. Yet Sophie had one key risk factor that seemed to cancel out all the positives: She was black.

African American women have long had higher rates than whites of low-birth weight and preterm babies, the leading causes of infant mortality or death in the first year of life. This fact does not seem extraordinary considering the long list of other well-documented health disparities, including life expectancy and various disease incidence rates. But a recent study published in the *Journal of the American Medical Association* reported that one particular disparity—the gap in black-white baby deaths—has not just persisted but actually grown in recent years despite federal efforts to eliminate the difference. As the journal authors noted, that long-standing inequality is not readily explained by a mother's age, education or income.

While many ob/gyns and health experts point to causes like the timing of prenatal care or unequal health insurance access, others are asking broader questions about race, racism, and health. These more complex questions may begin to explain why in a country with one of the most advanced health care systems in the world black babies remain the most vulnerable, and such racial health disparities simply refuse to go away.

**Medical mystery** An infant's survival and long-term health is influenced by many factors, including the mother's age, health status and behavior during pregnancy. The

two most significant determinants of a young baby's health and development, however, are birth weight and gestational age at birth. Infants born at or before 37 weeks, or under 2,500 grams (5 lbs., 8 oz.), are at greater risk of medical problems, disability, and death before their first birthday. Compared with women from various ethnic groups in the United States (Hawaiian, American Indian, Puerto Rican, Filipino, Mexican, Cuban, Japanese, Chinese and non-Hispanic white), black mothers have the highest percentage of low birth weight and preterm births. In 2000, more than one in ten black infants was born too small and nearly one in five was born before the ideal time.

This disparity has long been the case. Historically, while African-American moms have been stereotyped as "fertile Myrtles," they've had consistently poorer birth outcomes, including more low birth weight babies, very low birth weight (at or less than 3 lbs. 5 oz.) babies and infant mortality. In 2000, the rate of infant death for blacks stood at 13.6 per 1,000 live births—double the rate for the general population, and almost triple the rate for whites. (Even the group with the next highest infant mortality rate—Hawaiians with a 9 per 1,000 baby death rate—fare far better than blacks.)

However, the usual explanations for the disparity—income, education, late prenatal care—don't come close to identifying why even professional, middle-class black mothers like Sophie continue to experience the two to threefold higher risk of having a small baby than white moms. Research has debunked the notion that socioeconomic status and related factors are the source of the problem. Consider these facts:

- College- and graduate-school educated black mothers have a higher infant mortality rate than white moms who didn't finish high school
- Black women who get prenatal care in the first trimester have double the infant mortality rate of white mothers with first-trimester care
- Black women with similar levels of prenatal care as Hispanic women

(generally less educated and with lower incomes than blacks) have higher rates of low birth weight, preterm deliveries, and infant mortality.

According to Dr. Michael Lu, assistant professor of obstetrics and gynecology and public health at UCLA, researchers have found that even when they control for such varied factors as poverty, housing, employment, medical risk, abuse, social support and so on, 90 percent of the differences in birth weight between black and white moms remains unaccounted for. "Most studies have looked at black-white differences during pregnancy, for example, differences in prenatal care utilization or maternal behavior," he says. "What we're finding is that these differences really explain very little of the disparities in birth outcomes."

Even genetics fail to provide answers. To test the hypothesis, Dr. James W. Collins, Jr., associate professor of pediatrics at Northwestern University Medical School, compared birth outcomes of African American and Africa-born mothers in Illinois over a 15-year period. He assumed if there was something about African genes that caused poor birth outcomes, the statistics for African-born women might actually be worse. But Collins and his colleagues found that the babies of African-born women had birth weights similar to those of white American women and higher than those of black American women.

**A different paradigm** To probe the underlying cause of excess black infant mortality some experts are beginning to look beyond individual women's risk factors at the time of pregnancy to a more complete, long-term perspective on women's health. "Healthy women beget healthy children," says Lu. "So when you start to talk about the health of the mother, you have to really look at her life course experiences, and some of that actually depends on the health of *her* mother."

It's known, for example, that a child is more likely to be born low birth weight if her mother was also born that way. If the cause is not a shared gene, perhaps it's a shared experience. For instance, the immune system begins to develop in utero and matures over time. During certain critical periods of development, Dr. Lu points out, the immune system can be adversely

## Guest Commentary

**Earnestine Willis, MD, MPH, Professor, Department of Pediatrics, Medical College of Wisconsin**

**Emmanuel Ngui, DrPH, Assistant Professor, Department of Pediatrics, Medical College of Wisconsin**

### *Community Call to Action!*

Recent news of multiple infant deaths in the City of Milwaukee have attracted much media attention and stimulated community stakeholders' discussion. While we applaud this attention, these deaths highlight decades of a persisting "epidemic" for lack of a better term in our community. These tragic losses in human potential mask a larger number of babies who die each year in this city, but do not receive much media attention or public outcry. Infant deaths are a major social and public health problem in our community and especially within the African-American community. These deaths reflect the wellbeing and vitality of our community and should move us to action. As a community, we CARE! We need to wake up and begin to address this problem.

We need to be aware and informed about the individual and community risk taking behaviors that endanger the health and wellbeing of our children. This includes, among other issues, increasing community awareness of unsafe sleeping arrangements (e.g. co-sleeping) and the risks of smothering and entrapment they pose.

We need to mobilize our collective resources to reduce infant deaths in Milwaukee. Every child born in this metropolitan area needs to go home to a safe environment. We need to examine our support systems for families and children and identify areas that need to be improved. Milwaukee and other communities in Wisconsin need to be concerned and engaged in increasing awareness, funding, and providing resources and support to address poverty, accessibility to quality services, living conditions of young families, etc. and to be actively engaged in finding solutions through community actions and policy development.

### **Persist Peril** (continued from page 2)

affected by certain experiences and exposures, such as repeated infections or undue stress. These exposures may pattern the immune system in a particular way that sets the stage for increased risk to poor health and poor birth outcomes. A mother with less than optimal immune response may give birth to a baby with less than optimal immune response and so on.

Chronic emotional stress results from many factors, including physically demanding jobs and a lack of control in the workplace, single parenthood, and financial worries—all problems experienced disproportionately by women of color. Discrimination is also a documented source of harmful stress. One study found that women who gave birth to very low birth weight babies were more likely to have experienced racial discrimination than women who had normal weight babies.

Sophie Womack acknowledges that the related issues of discrimination and stress may explain, in part, why even she and many of her fellow black physician friends all gave birth to small babies despite their education and higher incomes. "As a black woman going into the field of medicine and stepping out into the world, we're constantly trying to accomplish and do well because we're afraid if we don't do well that we may be discriminated against," she says. "I'm sure that plays some role in the amount of stress that we have during the time that we're in training and trying to develop our careers. It's just not very easy. And those things do factor into what happens in our pregnancies."

While women of color and their health advocates can't undo centuries of discrimination or the stress it causes, they can begin to recognize the complexity of the problem. "For about 20 years, our model of prenatal care says if only we can give women universal access to early and adequate prenatal care, if we get them to the doctor's office, if we can enhance quality of prenatal care that they get, somehow we improve the birth outcomes," says Dr. Lu. "But to expect that one visit once a month to once a week, in less than nine months, to reverse all the cumulative disadvantages and inequities over their life course is probably expecting too much of prenatal care."

**Closing the gap** To counter low birth weight, prematurity, and infant mortality among blacks and other women of color, the health care system must go beyond narrow messages about prenatal vitamins and visits. Doctors can talk to women about preconceptional health and the importance of identifying and treating medical conditions, such as hypertension and diabetes, prior to pregnancy. The medical community also needs to confront the now-proven pattern of bias in medical care. While the Institute of Medicine uncovered discrimination in such areas as cardiac care, less well-publicized studies have found discrepancies in prenatal care and high-risk obstetrics. White mothers in preterm labor and white newborns with life-threatening conditions such as respiratory distress syndrome by and large receive better care.

Public health providers can take a cue from successful programs, such as the Black Infant Health Program (BIH). Based in San Diego, BIH helps women with whole-life issues such as applying for health insurance, accessing transportation to their doctor's office, and finding drug treatment programs. From the time a woman enters the program and through the first year after birth, she can expect home visits from nurses and services such as support groups. By assisting women with a range of issues, including housing, child custody, marital and work problems, the program has seen a small but demonstrable increase in the birth weight and viability of black newborns in San Diego.

Another key area is culture. Research by Dr. Collins and others has shown that while some foreign-born women (specifically African and Mexican women) have babies with better birth weights, the birth outcomes of *their* daughters show a decline. The same is true of Native American women who leave reservations. While women of color in the U.S. may gain from certain aspects of living in mainstream American society, they may also miss out on some of the protective effects of culture and close familial and community ties that serve as a buffer to stress and racial discrimination.

(Source: ColorLines Magazine/Race Wire, Feb. 2003)

## Perinatal Health/Infant Mortality Terms

**Access to Care:** The ability to receive appropriate health care either by being able to see a provider (providers present in the community), ability to get to a provider (transportation, hours of clinic operation), or ability to pay for care (presence/absence of insurance or Medicaid/Medicare).

**Adequate Prenatal Care:** Getting care early in a pregnancy, as well as seeing a healthcare provider regularly. Most experts suggest seeing a doctor about once each month for the first six months of pregnancy, every two weeks for the seventh and eighth month of pregnancy, and then every week until the baby is born. These criteria may be different and visits more frequent if the mother is over 35 or at high risk because of health problems. Adequacy also refers to ensuring that the provider's care and content of the prenatal care visit is appropriate for the pregnancy.



**Birth Defects:** Any medical condition that is present at birth. Congenital conditions can be referred to as diseases, defects, disorders, anomalies, or simply genetic differences. These conditions can be as a result of faulty development, infection, heredity, or injury.

**Birth Rate:** A birth rate is calculated by dividing the number of live births in a population in a year by the midyear resident population. Birth rates are expressed as the number of live births per 1,000 population.

**Birth Weight:** The weight of the infant at the time of birth, usually expressed in grams.

**Breastfeeding:** To feed a baby mother's milk from the breast or a bottle if necessary.

**Causes of Death:** The underlying cause is defined by the World Health Organization (WHO) as the disease or injury that initiated the chain of events leading directly to death, or the circumstances of the accident or violence, which produced the fatal injury.

**External Causation:** Refers to a category of death which includes motor vehicle accidents, mechanical or positional asphyxiations, smoke inhalation or

drowning.

**Family Planning:** A program to regulate the number and spacing of children in a family through the practice of contraception or other methods of birth control.

**Fetal Death:** A fetal death or stillbirth is "a fetus which does not breathe, or show other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of the voluntary muscles." By Wisconsin statute, a stillbirth of at least 20 weeks gestation or 350 grams must be reported.

**Fetal Death Rate:** A fetal death rate is the number of fetal deaths with stated or presumed gestation of 20 weeks or more divided by the sum of live births plus fetal deaths, per 1,000 live births plus fetal deaths.

**Folic Acid:** A man-made form of folate found in supplements and added to fortified foods. It is a B vitamin used in the body to make new cells. If a woman has enough folic acid in her body before she is pregnant, it can help lower the risks of major birth defects of her baby's brain and spine.

**Full-term:** Describes the length of a pregnancy that is between 37-41 weeks.

**Gestation:** The period of gestation is defined as beginning with the first day of the last normal menstrual period and ending with the day of birth or day of termination of pregnancy.

**Gestational Diabetes:** Diabetes that occurs during pregnancy.

**Health Indicator:** A measure that reflects the state of health of persons in a defined population, e.g., the infant mortality rate.

**Inadequate Prenatal Care:** Inadequate prenatal care can fall anywhere in the range of not receiving prenatal care prior to giving birth, receiving prenatal care late in a pregnancy, or receiving prenatal care that does not properly address the medical needs of the mother and/or child.

**Infant:** a child less than one year of age.

**Infant Death:** A child death occurring before a child's first birthday if the child was born alive, without regard to gestational age or weight.

**Infant Mortality Rate (IMR):** Infant mortality is defined as the number of infants who are born alive, but die before one year of age.

**Interconception:** Refers to the time period between pregnancies.

**Lifespan Approach:** An approach to healthcare that takes into account the health of a woman from birth to death and incorporates aspects of physical and social well-being. This approach also looks at cultural and social values of the patient as well as the affect socioeconomic status has on that patient's health.

**Low Birth Weight (LBW):** Refers to birthweight of less than 2,500 grams (5.5 pounds).

**Maternal Death:** The death of a women while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

**Morbidity:** Illness or disease. Morbidity rate is calculated by dividing the number of illnesses or disease cases in a year by the resident population.

**Mortality Rate:** A measure of the frequency of occurrence of death in a defined population during a specified interval of time.

**Mortality Rate, Age Adjusted:** A mortality rate statistically modified to eliminate the affect of different age distributions in the different populations.

**Mortality Rate, Age Specific:** A mortality rate limited to a particular age group. The numerator is the number of deaths in that age group; the denominator is the number of persons in that age group in the population.

**Mortality Rate, Crude:** Mortality rate (or death rate) is calculated by dividing the number of deaths in a population in a year by the resident population.

### 10 Steps to Having a Healthier Baby



Infant mortality rates for African Americans are more than double that of the United States as a whole. That's more than 7,500 infant deaths per year. The following 10 steps are helpful to ensure the health of your baby.

#### For mom:

- ◆ Get a checkup to identify high blood pressure, diabetes, asthma, seizures and thyroid disease.
- ◆ Make and keep your prenatal care appointments.
- ◆ Take prenatal vitamins with folic acid everyday.
- ◆ Don't smoke, drink or do drugs. They will harm you and your baby.

- ◆ Eat a healthy diet, with plenty of fruits and vegetables, drink plenty of water and maintain a healthy weight.

#### For baby:

- ◆ Put your baby to sleep on her/his back EVERY TIME to prevent Sudden Infant Death Syndrome (SIDS).
- ◆ Avoid using soft objects, stuffed toys, loose bedding and blankets in the crib
- ◆ Give your baby breast milk. Breast is best!
- ◆ Keep your baby's shots current and keep your well-baby appointments
- ◆ Follow your health care provider's recommendations.

This information is from the U.S Department of Health & Human Services Office of Minority Health's *A Healthy Baby Begins with You* campaign. You can go to [www.omhrc.gov](http://www.omhrc.gov) to obtain more information or call 1-800-444-6472.

## Perinatal Health/Infant Mortality Terms (continued from page 4)

**Mortality Rate, Infant:** A ratio expressing the number of deaths among children under one year of age reported during a given time period divided by the number of births reported during the same time period. The infant mortality rate is usually expressed per 1,000 live births.

**Mortality Rate, Neonatal:** A ratio expressing the number of deaths among children from birth up to but not including 28 days of age divided by the number of live births reported during the same time period. The neonatal mortality rate is usually expressed per 1,000 live births.

**Mortality Rate, Postnatal:** A ratio expressing the number of deaths among children from 28 days up to but not including 1 year of age during a given time period divided by the number of live births reported during the same time period. The postneonatal mortality rate is usually expressed per 1,000 live births.

**Neonatal Mortality:** Death of a live born infant before the infant becomes 28 days old.

**Perinatal:** Of, relating to, or being the period around childbirth, especially the five months before and one month after birth.

**Perinatal Insults:** Refers to a category of

death where the infant is born full term and cause of death is a complication of labor and delivery or as a result of a maternal condition.

**Postpartum:** The postpartum period can span anywhere from 3 months to the first year after birth.

**Preconception:** Generally, referred to as the time before a woman becomes pregnant. Focuses on the health and well-being of a woman before she gets pregnant.

**Prenatal Care (PNC):** Prenatal care is medical care provided to a pregnant woman to prevent complications and decrease the incidence of maternal and prenatal mortality.

**Preterm Births:** A situation when infants are born before 37 weeks of gestation.

**Prone Sleep Position:** When an infant is put to sleep on his/her stomach.

**Rate:** A measure of the frequency of some event in a defined population of a specified time. In a rate, the numerator is a subset of the denominator. The rate is expressed per 100, 1,000, 10,000 or 100,000.

**Stillbirth:** When a fetus dies during birth, or when the fetus dies during the late stages of pregnancy when it would have been otherwise expected to survive.

### **Sudden Infant Death Syndrome (SIDS):**

Refers to the sudden death of an infant where no cause of death can be found, and after an autopsy a death scene investigation.

### **Sudden Unexpected Death in Infancy (SUDI):**

Refers to the sudden unexpected death of an infant where no cause of death can be found after an autopsy and death scene investigation with one or more additional factor(s) present; such as bed-sharing or prone sleep position.

**Supine Sleep Position:** When an infant is put to sleep on his/her back.

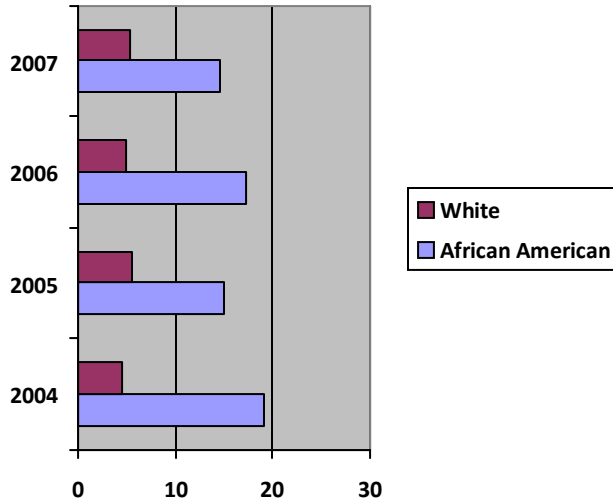
**Very Low Birth Weight (VLBW):** Refers to a birthweight of less than 1500 grams (3.3 pounds)

**Women of Reproductive Age:** (or women of childbearing age): Refers to all women aged 15 to 49 years.

(Sources: Milwaukee Fetal Infant Mortality Review Report to the City of Milwaukee, Illinois Department of Human Services Maternal & Infant Mortality Summit Glossary, UNFPA Reproductive Health in Refugee Situations Appendix Three Glossary of Terms, Vanderburgh County, Indiana Fetal Infant Mortality Review Glossary of Terms, Hawaii Health Data Warehouse HHDW Glossary and Government of Mauritius Glossary of Health Statistical Terms)

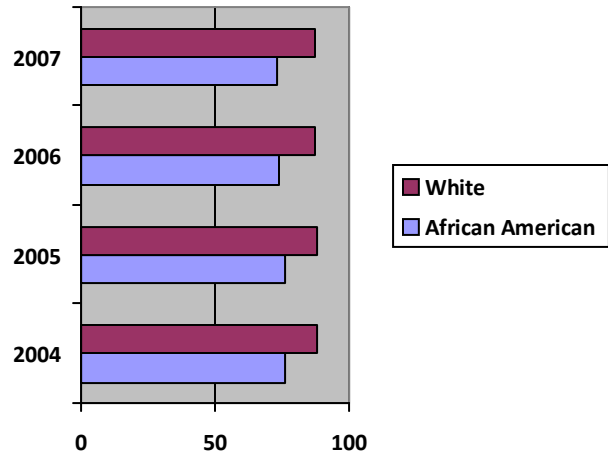
## Infant Mortality Data

Wisconsin Infant Mortality (Deaths per 1,000 live births)



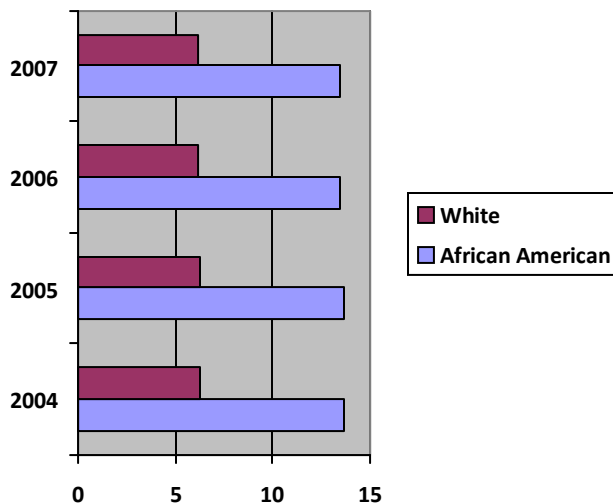
2004: African American 19.2; White 4.5  
 2005: African American 15.0; White 5.6  
 2006: African American 17.2; White 6.4  
 2007: African American 14.5; White 5.3

Wisconsin Prenatal Care (% of births in which prenatal care started in the first trimester of pregnancy)



2004: African American 76; White 88  
 2005: African American 76; White 88  
 2006: African American 74; White 87  
 2007: African American 73; White 87

Wisconsin Low Birthweight (%/Less than 2,500 grams or 5.5 pounds)



2004: African American 13.7, White 6.3  
 2005: African American 13.7, White 6.3  
 2006: African American 13.5, White 6.2  
 2007: African American 13.5; White 6.2

Source: Wisconsin Division of Public Health - Health Counts in Wisconsin: Infant Health 2004, 2005, 2006, 2007





### ***In an Average Week in Wisconsin***

- ◆ 1,365 babies are born
- ◆ 116 babies are born to teen mothers (ages 15-19)
- ◆ 323 babies are delivered by cesarean section
- ◆ 156 babies are born preterm
- ◆ 96 babies are born low birthweight
- ◆ 9 babies die before their first birthday

(source: March of Dimes)

## **Sudden Infant Death Syndrome (SIDS) Quiz**

- 1) SIDS is most likely to occur between the ages of one to six months.  
A. True                      B. False
- 2) Parents can lower the risk of SIDS by placing babies on their stomach to sleep.  
A. True                      B. False
- 3) White infants are more prone to SIDS.  
A. True                      B. False
- 4) SIDS is caused by shots, medicines and vaccines.  
A. True                      B. False
- 5) Smoking does not put your baby at an increased risk for SIDS.  
A. True                      B. False
- 6) Breastfeeding your baby can help protect against SIDS.  
A. True                      B. False

**\*\*Answers to the quiz are on page 12.\*\***

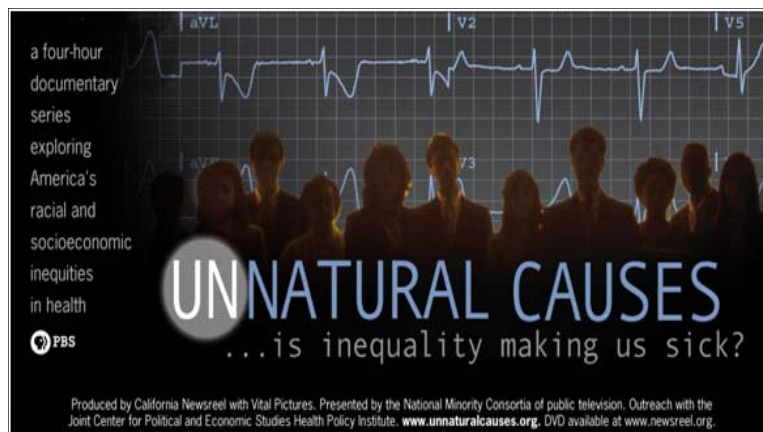
(Source: SIDS Awareness Month Quiz, [www.omhrc.gov](http://www.omhrc.gov))

### **When the Bough Breaks**

A segment in the PBS series titled *Unnatural Causes...is inequality making us sick?*

Segment Description:

Why do infant mortality rates among African Americans remain more than twice as high as among white Americans? Although birth outcomes are generally better for those with higher education and income, Black women with college degrees are still more likely to give birth prematurely than white women who haven't even finished high school. Researchers are circling in on a provocative explanation: the chronic stress of racism can become embedded in the body, taking a heavy toll of African American families on children even before they leave the womb.



To learn more about this documentary, you can log onto [www.unnaturalcauses.org](http://www.unnaturalcauses.org) or rent it from your local library.

## Black Men Can Help Reduce the High Number of Infant Deaths

Black babies in Milwaukee die three times as much as white infants. In an average week in WI, 9 babies die before reaching their first birthday. It is a shame to our community when any infant dies, but this reality is especially sad in the Black community where the numbers are so alarmingly high. Unfortunately, there are little signs of much needed improvement any time soon in this area. The pain of an infant loss impacts not only the woman, but also the fathers of the infants, members of her family, and the community as a whole.



One area for change that little attention is given to is the role the men play in the health of their children. Infant mortality, the death of a baby who is born alive but then dies during their first year of life, is not just an issue of concern for pregnant women and mothers of infants. Fathers can play a valuable role in making sure their infants survive past their first birthday.

Here are a few key points regarding infant deaths that men should be aware of:

### Mothers whose infant died:

- ◆ 45.2% had experienced a previous early infant loss
- ◆ 31.6% had a diagnosed infection (dental or sexually transmitted infection)
- ◆ 23.4% had either self-reported or documented mental health problems during pregnancy
- ◆ 12% had no prenatal care
- ◆ 11.2% had been physically or emotionally abused
- ◆ 4.4% were homeless

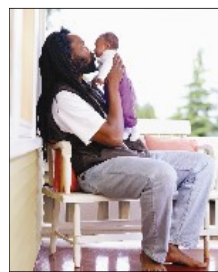
### Infants who died after hospital discharge:

- ◆ 55.5 % were exposed to secondhand smoke
- ◆ 46% were sharing a bed or other sleeping area with a parent or caregiver when they died
- ◆ 25% Had no well baby care (and were at least 4 weeks old)

Men can make sure their infants are healthy and make it past their first birthday by foremost making sure they themselves are healthy. When a man lives his daily life with the mindset and practice of healthy habits, they are more likely to have a healthier body than others. When men have healthy bodies they then help to improve infant mortality rates by reducing some of the genetic risk factors that infants can inherit. Also, when a man lives a healthy lifestyle, he is more likely to make responsible choices as to when he will father a child, help to make sure the expectant mother has a healthy pregnancy and provide proper care and resources for the infant.

Here are a few tips for men so they can play a more active role in the prevention of infant deaths:

- ◆ Make sure pregnant women get regular pre-natal care
- ◆ Make sure pregnant women eat properly
- ◆ Reduce the stress level of pregnant women
- ◆ Protect pregnant women from physical and verbal abuse
- ◆ Reducing the number of STD's and other infections
- ◆ Help pregnant women have full-term pregnancies so that babies are not born preterm (too soon)
- ◆ Make sure infants have safe sleeping environments (no chance of being suffocated by someone or bedding materials)
- ◆ Don't expose pregnant women or infants to tobacco smoke
- ◆ Discourage pregnant women from drinking, smoking or using other illicit drugs
- ◆ Make sure infants receive proper medical care and immunizations
- ◆ Make sure infants have care-minded child-care providers
- ◆ Encourage the spacing of two years between pregnancies



Mothers play a major role in the development of healthy infants and there are many societal factors that contribute to infant deaths, but the positive involvement of men in reference to infant mortality can help to lessen the devastating toll this problem is creating in our homes, families and community. These tips can be done without changing any legislation or health policies, thus they can be accomplished quicker.

*"Of all of the forms of injustices, injustices in health care is the most shocking and inhumane."*

-Dr. Martin Luther King Jr.

## Breastfeeding Can Help Improve Infant Health

The breastfeeding of infants was once a time honored tradition within the African American community. Recent generations have been more inclined to bottle-feed their infants out of convenience and other reasons. At a time when African American babies are dying at such alarming rates, breastfeeding becoming the norm in the community can help to improve the health of the infants. This can only occur when women who are expecting children and mothers of infants are given proper education on the value of breastfeeding and society as a whole supports women's rights to breastfeed. The benefits of breastfeeding:

### For infants

- ◆ Recent studies show that babies who are exclusively breastfed for 6 months are less likely to develop ear infections, diarrhea, and respiratory illnesses. They may also be less likely to develop childhood obesity.
- ◆ Breast milk has just the right amount of fat, sugar, water, and protein that is needed for a baby's growth.
- ◆ Most babies find breast milk easier to digest than formula.
- ◆ Most babies are not allergic to the protein in breast milk because it is a baby's natural food.
- ◆ Premature babies are healthier when they are breastfed.



### For mom

- ◆ It delays the return of the menstrual cycle
- ◆ Breastfeeding mothers return to their pre-pregnancy weight faster
- ◆ It helps the uterus to get back to its original size more quickly and lessens any bleeding you may have after giving birth
- ◆ It reduces the chances of getting ovarian and pre-menopausal breast cancer
- ◆ It creates a strong mother/child bond
- ◆ Breastfeeding mothers have more self-esteem

### For dad

- ◆ It saves time and it's free - it can save the family budget hundreds of dollars
- ◆ You can enjoy the beauty of breastfeeding by simply sitting with mom and baby to enjoy the special mood that breastfeeding creates
- ◆ You can still help to care for your baby by giving him/her a bottle of pumped breast milk

### For society

- ◆ It saves on healthcare costs

- ◆ It adds to a more productive workforce since breastfeeding moms often need less time off to care for sick babies
- ◆ It creates a healthier society!

### **\*\*\*Breastfeeding Laws\*\*\***

Many employers are NOT aware of state laws that say they have to allow mothers to breastfeed on the job. Under these laws, employers are required to set up a space for moms to breastfeed and/or allow paid/unpaid time for breastfeeding employees. To check breastfeeding laws by state, go to <http://lalecheleauge.org/LawBills.html> or call 1-800-994-9662.

(Source: An Easy Guide to Breastfeeding for African American Women, U.S. Department of Health and Human Services Office of Women's Health)

### **Wisconsin Law:**

**Wis. Stat. § 944.17(3), § 944.20(2) and § 948.10(2) (1995)** provide that breastfeeding mothers are not in violation of criminal statutes of indecent or obscene exposure. (AB 154)

### **\*\*\*Profile of Milwaukee Breastfeeding Group\*\*\***

The African American Breastfeeding Network (AABN) of Milwaukee was formed in August 2008. The mission of the Network is to promote breastfeeding as a natural and the best way to provide nourishment for babies and young children. AABN's core projects are: Sista2Sista Chat, Sista2Sista Home Visitation, Father Support Phone Counseling, Pumpin' It Out Project, Mocha Notes, and Breastfeeding Awareness Community Presentations. For more information, call 414-264-3441 or email the AABN at [AABN@gmail.com](mailto:AABN@gmail.com).

<i>Infant Mortality Rate, Deaths per 1000 Live Births</i>			
<i>International Comparison</i>			
Country	Rate	Country	Rate
Singapore	2	Bahrain	7
Japan	3	Chile	7
Czech Republic	4	Cuba	7
France	4	Bahamas	8
Germany	4	Paraguay	10
Australia	5	Costa Rica	11
Canada	5	El Salvador	11
Israel	5	Mexico	13
Switzerland	5	Panama	14
United Kingdom	5	Uruguay	14
Jamaica	6	Barbados	14
<b>White American</b>	<b>6</b>	<b>Black Americans</b>	<b>14</b>

Source: Dying While Black, Vernellia Randall, J.D. 2006

## Elimination of Racial and Ethnic Disparities in Birth Outcomes in Wisconsin

### Richard Allan Aronson, MD, MPH

*Founder and Director, Humane Worlds Center for Maternal and Child Health & former Chief Medical Officer for Family and Community Health, Division of Public Health, Wisconsin Department of Health and Family Services*



Infant mortality is defined as the death of a baby during the first year of life. It is a critical indicator of the overall health of a community or society. Although Wisconsin is a leader among states for its low white infant mortality rate (number of infant deaths per 1,000 live births), the infant mortality rate for African Americans in Wisconsin is the highest in the nation. While American Indian infant mortality in Wisconsin has declined by more than half over the past 20 years, the rate of black infant deaths has remained at the same level. In 2004, a total of 420 Wisconsin infants died during their first year of life. Of these, 245 were white, and 125 were African American. If African American infant mortality were reduced to the white infant mortality level, 96 of the 125 black deaths would have been prevented. The primary contributor to this gap is the high rate of prematurity and low birth weight among black babies.

Since infant mortality is a sentinel indicator of a community's overall well being, the factors that contribute to racial and ethnic birth outcome disparities relate to all sectors of society. The neighborhoods in Wisconsin with the highest rates of black infant mortality are characterized by hyper-segregation, unemployment, economic hardship, and inadequate housing. Systems that serve children and families in these communities are often fragmented, burdensome, culturally and linguistically disrespectful, and deficit-based.

Racial and ethnic disparities in access to and quality of health care in the United States have been extensively documented. An Institute of Medicine (IOM) Report, *Unequal Treatment*, found that people of color tend to receive a lower quality of healthcare than whites, even when access-related factors, such as patients' insurance status and income, are controlled for. Women of color often perceive that their health concerns are dismissed and that they are not treated with respect and dignity. Research also shows that birth outcome disparities transcend social and economic class, and that race is an independent risk factor for prematurity and low birth weight. Further, an emerging body of research suggests that chronic stress from racial discrimination and other traumatic events throughout a woman's life has intergenerational biological consequences that put her and her own children at risk for adverse birth outcomes.

Although defining its exact role and responsibility is beyond the scope of this article and will require thoughtful and collaborative dialogue, the University of Wisconsin School of Medicine and Public Health has an opportunity to become a leader in responding to this challenge. Through the Special Initiative of the Wisconsin Partnership Program, it can finance and support culturally competent and best practice

interventions that have the potential to directly improve birth outcomes among disparate populations, and, in particular, among African Americans. This initiative should:

1) Include service, research, and educational components;

2) Incorporate the life course model and other bodies of research described in this article;

3) Honor, respect, and include families and communities in all phases;

4) Tap into strengths and resiliency not only among those immediately affected and their communities but also among providers, and health care systems and organizations;

5) Demonstrate the courage to address the influence of racism and advance much needed research on racial and ethnic disparities;

6) Challenge people from all walks of life and all kinds of agencies and funders to rise to the occasion and put this issue front and center on their agenda;

7) Integrate with existing efforts; and

8) Inform and inspire a new generation of leaders to carry on this work into the future.

The specific recommendations are the following:

A. Improve the health and safety of African American women, and their families, over their entire life span.

1. Provide a model system of interconception care for African American women with prior adverse birth outcomes, and their families.

2. Provide a model system of preconception care for African American women who have had a prior adverse birth outcome.

3. Improve a model quality of prenatal care for African American women.

B. Promote cultural and linguistic competence in health care provision.

C. Maximize cooperation among diverse agencies and stakeholders.

D. Support and strengthen existing infrastructure.

E. Advance research and higher continuing medical education in ending racial and ethnic birth outcome disparities.

Finally, this article touches only briefly on the critical and essential need for leveraging other matching resources from private foundations and other partners so as to significantly increase the amount and value of the Partnership's investment.

To effect a sustainable end to racial and ethnic birth outcome disparities requires all stakeholders to contribute their resources in a heightened way. Such an effort is neither easy nor comfortable. It is a long term process that challenges individual and organizational biases, promotes opportunities for shared learning, and respects and strengthens the voices of all, especially those of the babies, mothers, families, and communities directly affected. The University of Wisconsin School of Medicine and Public Health can provide a model through a process that develops a Request for Proposals in a way that ends up financing and supporting efforts that have built-in community-based evaluation, flexibility to change course as fiscal, federal, political or public issues arise, and assurance of commitment through the long haul.

## Elimination of Racial and Ethnic Disparities in Birth Outcomes in Wisconsin

(continued from page 10)

There is no single inoculation to catalyze the level of collaboration needed to save babies' lives. But there is an opportunity here, at this moment, for all stakeholders to humbly acknowledge and move beyond deep-seated and emotional experiences that shape their judgments and actions. Throughout it all, by keeping a shared vision of health equity at the heart of the work, significant progress in eliminating disparities is within our reach. The courage to accept and welcome participation at all degrees of expertise, combined with the need to pursue data and science in a field of study that requires a new framework, will determine whether it happens.

### Statement of Rights under the newborn's and mother's health protection act

The Newborns' and Mothers' Health Protection Act (the Newborns' Act) provides protections for mothers and their newborn children relating to the length of their hospital stays following childbirth.

Group health plans that are subject to the Newborns' Act may not restrict benefits for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. However, the attending provider may decide, after consulting with the mother, to discharge the mother and/or her newborn child earlier.

Many states have enacted their own version of the Newborns' Act for insured coverage. In these states, State law can govern in lieu of the Federal requirements.

**What group health plans must comply with the Newborns' Act?** If a plan offers benefits for hospital stays in connection with childbirth, the Newborns' Act applies if the coverage is "self-insured" by an employment-based plan.

If the coverage is provided by an insurance company or HMO (an "insured" plan), and your State has a law regulating coverage for newborns and mothers that meets specific criteria, then State law, rather than the Newborns' Act, applies. If this is the case, the State law may differ slightly from the Newborns' Act requirements, so it is important to know which law applies to the coverage offered by your plan.

For those plans with coverage that is insured by an insurance company or HMO, contact your State insurance department for the most current information on the State laws that pertain to hospital length of stay in connection with childbirth.

For those plans covered by the Federal law, the following questions apply:

**When does the 48-hour (or 96-hour) period start?** If a woman delivers her baby in the hospital, the 48-hour period (or 96-hour period) starts at the time of delivery. As an example: if a woman goes into labor and is admitted to the hospital at 10 p.m. on June 11, but gives birth by vaginal delivery at 6 a.m. on June 12, the 48-hour period begins at 6 a.m. on June 12.

However, if the woman delivers outside the hospital and is later admitted to the hospital in connection with childbirth (as determined by the attending provider), the period begins at the time of the

hospital admission. For example, if a woman gives birth at home by vaginal delivery, but begins bleeding excessively in connection with childbirth and is admitted to the hospital, the 48-hour period starts at the time of admission.

Who is the attending provider? An attending provider is an individual licensed under State law who is directly responsible for providing maternity or pediatric care to a mother or newborn child. A nurse midwife or a physician assistant may be an attending provider if licensed in the State to provide maternity or pediatric care in connection with childbirth. A health plan, hospital, insurance company, or HMO, however, would not be an attending provider. The attending provider cannot receive incentives or disincentives to discharge the mother or her child earlier than 48 hours (or 96 hours).

**May a group health plan require an individual to get permission (sometimes called prior authorization or precertification based upon medical necessity) for a 48-hour or 96-hour hospital stay?**

A plan cannot deny a mother or her newborn child coverage for a 48-hour stay (or 96-hour stay) because the plan claims that the mother or her attending provider has failed to show that the 48-hour stay (or 96-hour stay) is medically necessary.

However, plans generally can require an individual to notify the plan of the pregnancy in advance of an admission in order to use certain providers or facilities or to reduce the individual's out-of-pocket costs.

**Under the Newborns' Act, may group health plans impose deductibles or other cost-sharing provisions for hospital stays in connection with childbirth?** Yes, but only if the deductible, coinsurance, or other cost-sharing for the latter part of a 48-hour (or 96-hour) stay is not greater than that imposed for the earlier part of the stay. For example, with respect to a 48-hour stay, a group health plan is permitted to cover only 80 percent of the cost of the hospital stay.

However, a plan covering 80 percent of the cost of the first 24 hours could not reduce coverage to 50 percent for the second 24 hours.

**Does the Newborns' Act require a plan to offer maternity benefits?** No. The Newborns' Act does not require plans to provide coverage for hospital stays in connection with childbirth. However, other legal requirements, including Title VII of the Civil Rights Act of 1964, may require this type of coverage. Questions regarding Title VII should be directed to the Equal Employment Opportunity Commission. See the agency's Web site at [www.eeoc.gov](http://www.eeoc.gov).

**Are group health plans required to tell participants and beneficiaries about the Newborns' Act and any applicable State law protections?** A group health plan that provides maternity or newborn infant coverage must include in its SPD a statement describing the Federal or State law requirements applicable to the plan (or any health insurance coverage offered under the plan) relating to hospital length of stay in connection with childbirth for the mother or newborn child. If the Federal Newborns' Act law applies in some areas in which the plan operates and State laws apply in others, the SPD must describe the Federal and State law requirements that apply in each area covered by the plan.



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**WE ARE ON THE WEB @**  
**WWW.BHCW.ORG**

**SIDS Quiz Results** (from page 7)

- |      |      |      |
|------|------|------|
| 1) A | 2) B | 3) B |
| 4) B | 5) B | 6) A |

**Contributing Factors to Infant Mortality**

An infant's survival and long-term health is influenced by many factors, including the mother's age, health status and behavior during and after pregnancy.

Health researchers have identified the following nine risk factors that contribute to infant mortality:

- ◆ Late Prenatal Care
- ◆ Smoking
- ◆ Substance Abuse
- ◆ Poor Nutrition
- ◆ Obesity
- ◆ High Stress
- ◆ Domestic Violence
- ◆ Low Maternal Weight Gain
- ◆ Pre-term Labor



(Source: A Healthy Baby Begins with You brochure, www.omhrc.gov)

The Milwaukee Healthy Beginnings Project (MHBP), a project of Black Health Coalition of Wisconsin, Inc., is focused on reducing infant mortality in Milwaukee's African American community. If you would like to get involved with MHBP please contact the program coordinator, Rachel Morgan, by phone at 414-933-0064 Ext. 215 or by email at rmorgan@bhcw.org. MHBP has a community consortium that meets bi-annually, a consumer issues committee that meet quarterly and other meetings to address infant mortality and engage the community in improving the health of infants.

**Tips on How to Safely Co-Sleep with an Infant**



If families follow these steps, you are helping to prevent many risk factors for Sudden Infant Death Syndrome (SIDS) and infant mortality.

- ◆ DON'T sleep with your baby on a sofa, couch, chair, or waterbed.
- ◆ Lay your infant on its back. The back to sleep position has been considered the best sleeping position for infants. If you lay the infant on its side, do not use anything to prop the infant up and be sure not to have any loose bedding, pillows, or stuffed animals around. The baby's arm, which is closest to the bed, should be placed forward to stop him or her from rolling onto their stomach.
- ◆ If you are on medication that makes you drowsy, sleep hard, or are extremely tired, be sure to position yourself and your baby at a reasonable distance apart to help avoid the chance of mistakenly laying on or smothering their infant.
- ◆ Be careful with the type of bedding or sleeping materials you use. Fluffy pillows, stuffed animals, plastics, and loose bedding can suffocate an infant and should not be used where babies sleep. Your baby should sleep on a firm flat surface which is covered by a tight fitted sheet.
- ◆ When breastfeeding while co-sleeping, be sure to monitor your baby's eating intervals.
- ◆ If you or your partner have been drinking alcohol or using illegal drugs, DON'T HAVE YOUR BABY SLEEPING WITH YOU!!! PARENTS CAN FACE SERIOUS CRIMINAL CHARGES IF THEIR BABY DIES WHILE THEY ARE UNDER THE INFLUENCE OF ALOCHOL OR AN ILLEGAL SUBSTANCE.
- ◆ Bed sharing should never be a practice with non-caregivers. Non-caregivers will not have the same maternal or paternal instinct that is important in keeping the baby out of danger during sleep. Children older than two years should not sleep with infants.
- ◆ DON'T SMOKE AROUND YOUR BABY. Prenatal smoking and secondhand smoke affects the normal breathing of an infant and can cause respiratory failure. DON'T bed share if you are a smoker.
- ◆ AVOID OVERHEATING YOUR BABY. Your baby should be lightly clothed for sleep, and the bedroom temperature should be kept comfortable for a lightly clothed adult. Over bundling should be avoided, and the baby should not feel hot to the touch.