

**A Community's Perspective: A qualitative study of
the social determinants of pregnancy outcomes
among African Americans in Louisville, KY**

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Background

- Funded by the Federal Office of Minority Health, U.S. Dept. for Health and Human Services
- Pilot project helped to establish the Kentucky Office of Health Equity as a significant component of Kentucky Department for Public Health
- Worked in Collaboration with the Louisville Metro Department for Health, Center for Health Equity and Wellness and Healthy Start of Louisville, (A HRSA funded program to identify and develop community-based systems approach to reducing infant mortality)

Background

- Infant Mortality: death occurring during the first year of life
- Infant Mortality Rate: the number of infant deaths per 1,000.
- Infant Mortality is one of the most important indicators reflecting social, political, health care delivery and medical outcomes in a geographic area.
- The U.S. is ranked 28th in the world for infant mortality.

Background

- Leading Causes:
 - Congenital abnormalities
 - Pre-term/low birth weight
 - Sudden Infant Death Syndrome (SIDS)
 - Problems related to complications of pregnancy
 - Respiratory distress syndrome

Preventive Measures

- Prenatal care in the first trimester
- Education
- Proper nutrition
- No smoking
- No illicit substances
- Avoid stress
- Exercise

Background

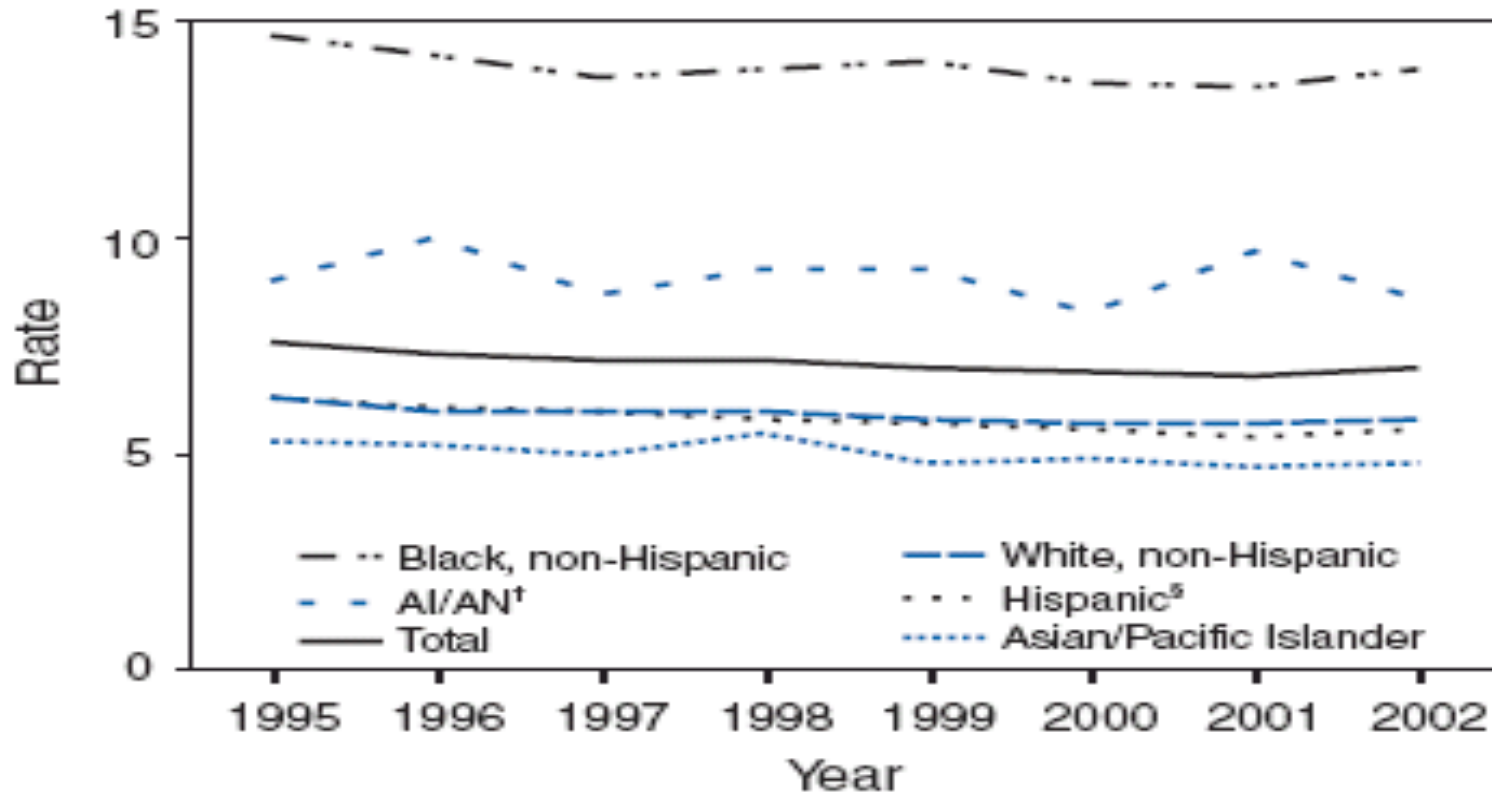
- According to the March of Dimes, KY infant mortality rates (IMR) declined by 11% from 1995-2005.
- Improvements in IMRs is associated with improvements to basic health care, access, and medical technology
- National Center for Health Statistics indicates that IMR's have declined over the past several.
 - 1960: 26.0 per 1,000 live births.
 - 2000: 6.9 per 1,000 live births.
 - 2006: 6.69 per 1,000 live births.

Background

- Although, IMRs have declined over the last decade, a disparity has persisted between the non-Hispanic whites and racial and ethnic minorities, specifically among the African-American population.
- In 2000, the IMR among African-Americans was 14.1 per 1,000.
- SIDS deaths among American Indian and Alaska Natives is 2.3 times the rate of non-Hispanic whites.
- Healthy People 2010 objective to reduce IMRs to 4.5/1,000 live births.

Infant Mortality Health Disparities

FIGURE. Infant mortality rate*, by race/ethnicity of mother and year — United States, 1995–2002



* Per 1,000 live births.

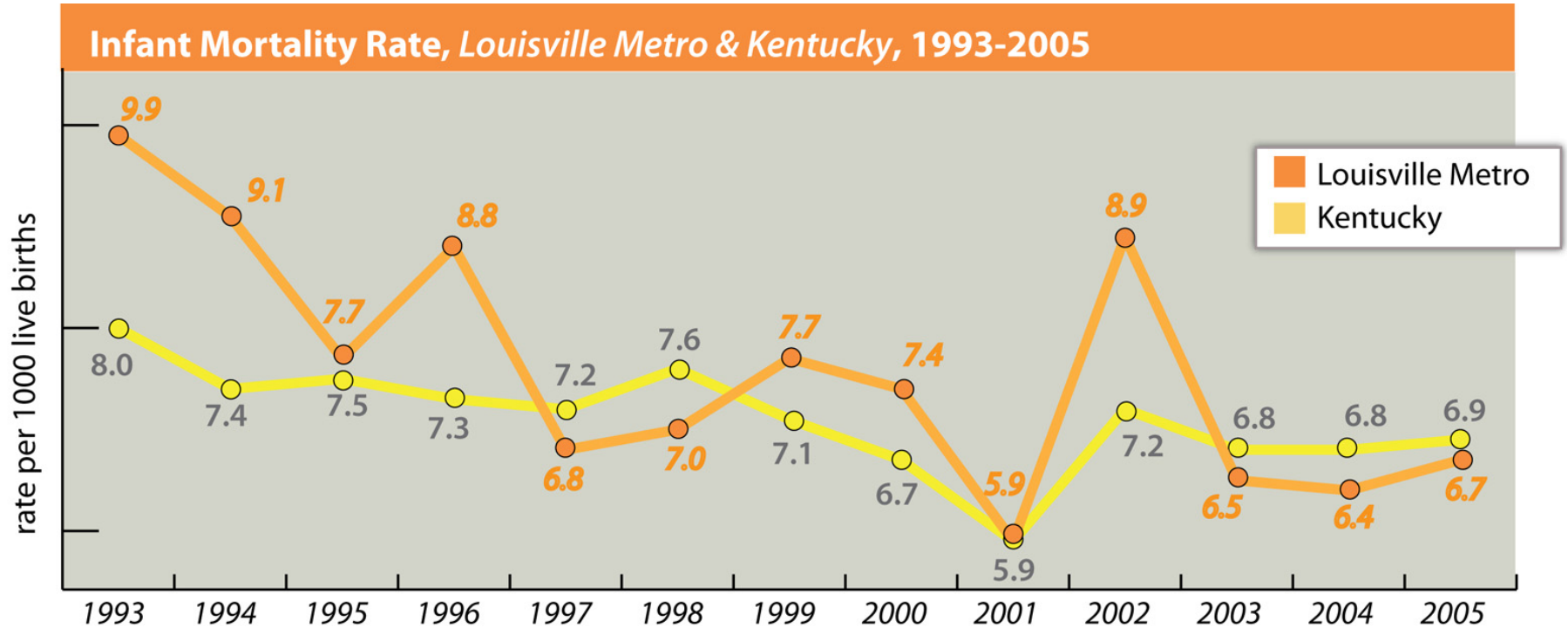
† American Indian/Alaska Native.

§ Hispanic mothers might be of any race.

Infant Mortality Health Disparities

- Numerous studies indicate that high IMRs among racial /ethnic minorities can be contributed to chronic psychosocial stress **throughout the course of life, not only during pregnancy** that may be related to racism, discrimination, exposure to environmental hazards, and poverty. (*Lu, Halfon, 2003, Maternal and Child Health Journal*); (*Schulz, Parker, & Israel, et.al, 2002, Health Education & Behavior*); (*Papacek, Collins, & Schulte, 2002, Maternal and Child Health*); (*Pestronk, & Franks, 2003, Public Health Reports*)
- African American women—of any class—who reported high levels of experience with racial discrimination were nearly five times as likely to deliver underweight babies as those who reported no experience with it. (*Unnatural Causes, 2005*)

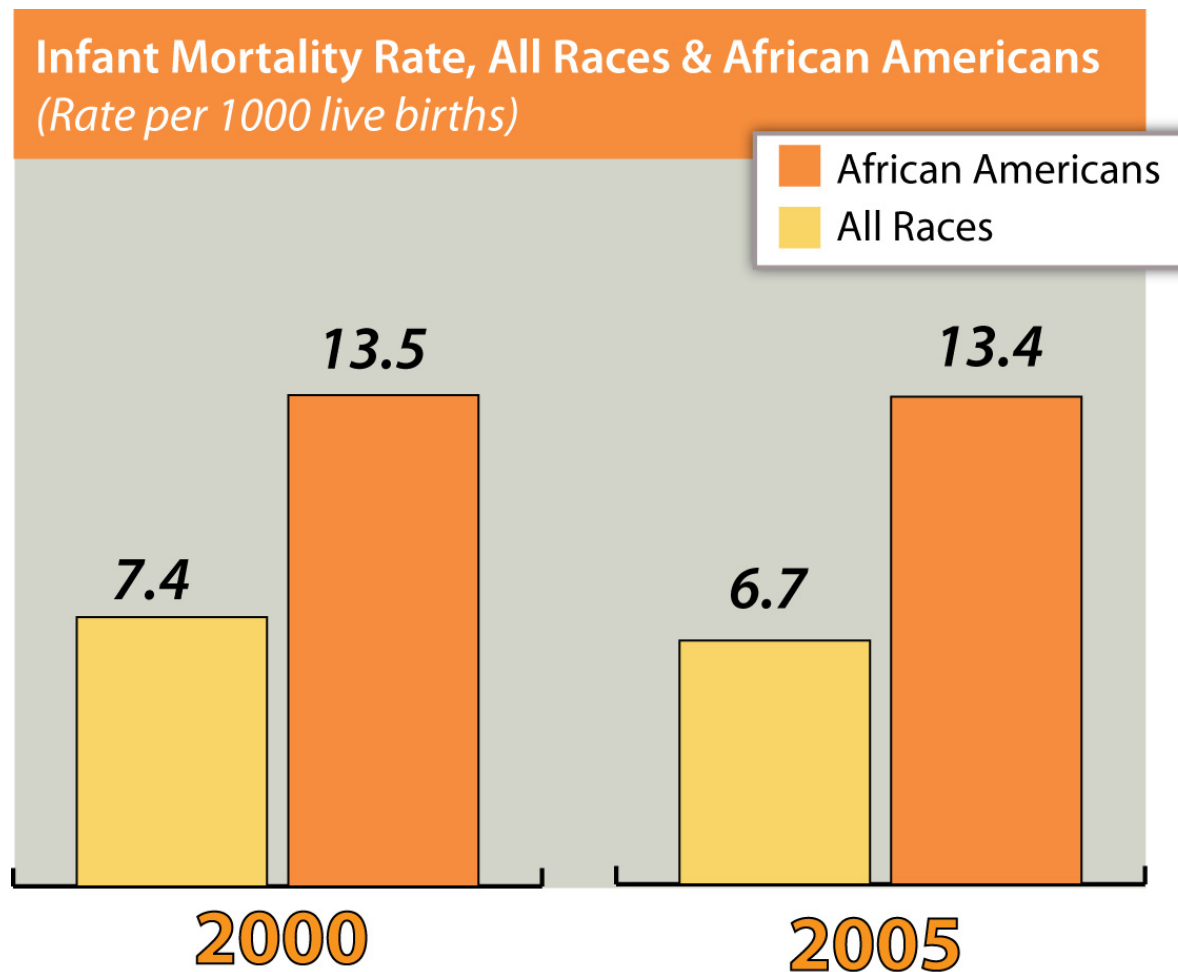
Infant Mortality Rate, Louisville Metro & KY



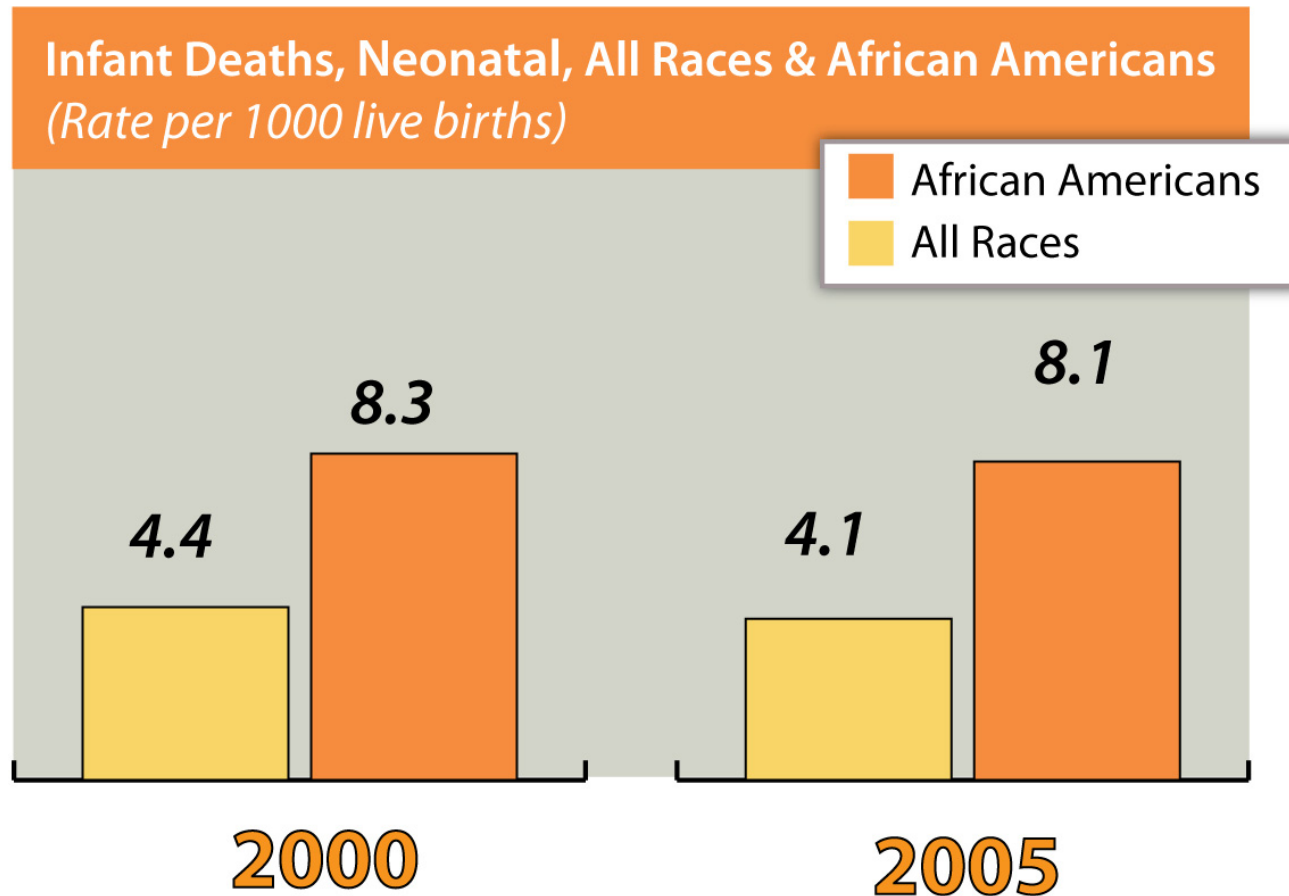
Cabinet for Health and Family Services
Health Start Louisville, Louisville Metro Public Health & Wellness



Infant Mortality Rate, All Races & African Americans, Metro Level Data



Infant Deaths, Neonatal, All Races & African Americans, Metro Level Data



Infant Mortality Rates, 2006

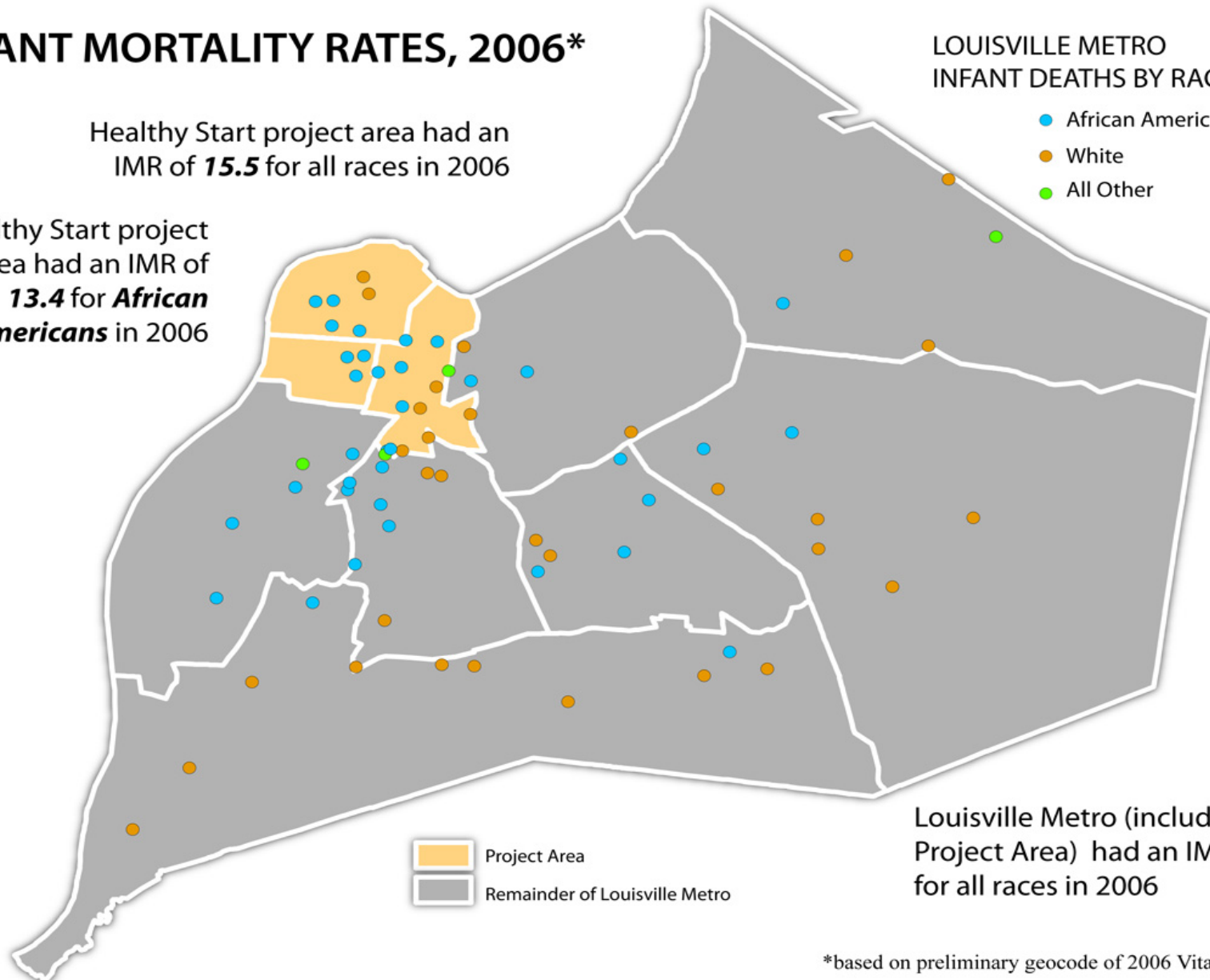
INFANT MORTALITY RATES, 2006*

Healthy Start project area had an IMR of **15.5** for all races in 2006

Healthy Start project area had an IMR of **13.4** for **African Americans** in 2006

LOUISVILLE METRO INFANT DEATHS BY RACE

- African American
- White
- All Other



- Project Area
- Remainder of Louisville Metro

Louisville Metro (including the Project Area) had an IMR of **8.1** for all races in 2006

*based on preliminary geocode of 2006 Vital statistics

Jefferson County Infant Mortality Project

- Qualitative Study to determine the social and environmental factors that contribute to a healthy/unhealthy pregnancy in an African-American community aside from individual behavior.
- Key Informant Interviews to determine the readiness of community leaders, agencies, and community members to address infant mortality.

Addressing Infant Mortality Using a Systems-Based Approach

- **Healthy Start**

- Provides adequate prenatal care
- Helps clients meet basic health needs (nutrition, housing, psychosocial support)
- Reduce barriers to access
- Enabling empowerment
- ***Guiding Principles:*** personal responsibility, multi-agency participation, community commitment and involvement, innovations in service delivery.

Addressing Infant Mortality Using a Systems-Based Approach

- **Healthy Start of Louisville**
 - Administered through and in partnership with the community councils of local Neighborhood Places in Louisville
 - The councils are comprised of residents of the areas served, so that those living in the Healthy Start areas participate in shaping services to meet the needs of each neighborhood.
 - Supported by HRSA funding through the Maternal and Child Health Bureau

Jefferson County Infant Mortality Project

- Participants were recruited using fliers and word of mouth through the Louisville Healthy Start and Neighborhood Places.
- Participants were required to be 18 years or older or a healthcare provider that serves women of childbearing age/ pregnant women.
- Participants consented to participate.
- Each participant received a \$30 gift card as an incentive.
- Key Informants participated “in-kind” and received no incentive.

Jefferson County Infant Mortality Project

- **Methods**

- **Photovoice:** a photographic technique that enables people to record and reflect their community's strengths and concerns; to promote critical dialogue and knowledge about important issues through large and small group discussions of photographs; and to reach policymakers
- Demographic Survey
- Focus Groups were recorded and transcribed

Jefferson County Infant Mortality Project

- **Methods**

- ***A Facilitator asked focus group participants open-ended questions:***

- What do you see in this picture?
 - What do you see in these neighborhoods that helps residents be healthy?
 - What do you see that creates barriers to health?
 - Out of those things that you named for a healthy neighborhood, what does that have to do with a having a healthy pregnancy or healthy infants?
 - Unhealthy pregnancy or unhealthy infants?
 - Out of what was said for a health or unhealthy neighborhood, how do you think these things relate?
 - Residential segregation
 - Poverty
 - Environmental hazards such as air pollution, water pollution, etc.
 - Violence
 - Housing
 - Transportation
 - Inadequate social services
 - Access to healthcare

Jefferson County Infant Mortality Project

- **Methods**
 - ***Focus Groups***
 - Research team incl. 3 members reviewed the independently to indentify patterns related to research questions; find emerging themes
 - Codebook was developed
 - Conducted interrator reliability
 - ***Key Informant Interviews***
 - Community Readiness Assessment Interview developed by the Tri-Ethnic Center for Prevention Research
 - Used to facilitate community-based change
 - Community specific
 - Build cooperation among systems and individuals
 - Assists in creating a road map for community development
 - All responses were recorded and transcribed
 - Scored interviews on six dimensions of: existing community efforts; community knowledge of efforts; leadership; community climate; community knowledge about the issue; resources related to the issue.

Jefferson County Infant Mortality Project

- **Results (Focus Groups)**
 - (10) focus groups were conducted
 - N=131 participants (93% female; 9% male)
 - *Race/Ethnicity*
 - N=104, 79% were African-American
 - N=23, 17% were Caucasian/White
 - N=4, 3% were Other
 - Avg. age 36.4 years
 - Avg. age at first pregnancy, 18.2 years

Jefferson County Infant Mortality Project

- **Results**

- N=47, 36% currently smoked; N=84, 64% did not
- N=13, 11% had never been pregnant
- Prior Pregnancies:
 - 81% had been pregnant once
 - 56% had been pregnant twice
 - 34% had been pregnant three times
 - 20% had been pregnant at least four times

Jefferson County Infant Mortality Project:

- **Smoking during Pregnancy**
 - N =17, 15% 1st pregnancy
 - N=9, 9%, 2nd pregnancy
 - N=6, 7%, 3rd pregnancy
 - N=3, 4%, 4th pregnancy
- **Prenatal Care**
 - N=106, 94% 1st pregnancy
 - N=82, 81% 2nd pregnancy
 - N=58, 64% 3rd pregnancy
 - N= 28, 35% 4th pregnancy

Jefferson County Infant Mortality Project: Emerging Themes

- Bias
- Community action
- Education
- Environmental hazards
- Food access
- Food – access - healthy
- Food – access - unhealthy
- Healthcare access - neg
- Healthcare access - pro
- Healthcare providers
- Housing bad
- Housing good
- Local assets - neg
- Local assets – pro
- Marketing & product promotion good
- Marketing and product promotion – bad.
- Mental Health
- Mistrust
- Neighborhood appearance – bad
- Neighborhood appearance –good
- Parenting
- Personal responsibility –
- Physical fitness opportunities
- Poverty
- Resource Allocation, Poor
- Safety
- Social Support System
- Social Services
- Spirituality
- Substance use & abuse



Priority Area

- **Safety**

- Most frequently discussed topic.
- Participants believed neighborhood safety contributed a healthy pregnancy.
- A safe neighborhood to them was one that was free of debris, vacant and abandoned houses and had safe playgrounds.
- Participants agreed that a safe neighborhood contributed to a stress-free environment for pregnant women.
- *“Basically, this is what I’m saying, the healthy community; just keep the drug dealers off the streets,we’ve got kids out, we don’t know what’s going on, you know what I’m saying.... There’s just too much going out here; you can’t trust everything. There’s too much going on..... your child should be able to go outside and play anywhere and be safe.”-Focus Group Participant*

Priority Area

- **Poverty:** Participants believed poverty greatly contributed to overall health. Most perceived that poverty causes doctors and nurses to treat them differently than those who have more money.
 - *“They’re not getting the proper care they need because you can’t afford insurance or you know you’re poor so you can’t go out and you know get your prenatal care, you can’t buy vitamins....or groceries.”*
 - *I didn’t even go to the doctor, I didn’t even go, you know....How are you going to pay for things?”*

Priority Area

- **Neighborhood Appearance and Environmental Hazards**

- Participants perceived that a bad neighborhood appearance is likely to produce crime, disease, rodents, environmental toxins, and hopelessness among the residents.
- Expressed concern about trash in the allies, drug needles on the ground, liquor stores on the corner bringing down their home property values.
- Cutting the grass and picking up trash were proposed solutions.
- *“So, so if she walks out of her door and she breathes in all, because we can’t smell what’s on this picture but we can imagine what it must smell like because look at what it looks like; there’s trash, there’s cups, there’s brokenness and I could go on and on and on. However, another woman who walks outside her door, who has beautiful landscape, she’s got beautiful trees and violets and roses and stuff growing; you know we breathe that stuff in, it’s photosynthesis. So when that woman walks outside, if she doesn’t have those factors, then she immediately is able to, her baby, that baby is in her womb, immediately has an advantage over that woman, not to mention all of the mental stress, all the mental things that this woman has to process who walks outside and looks at this versus the woman who’s over here who does not have that.”-Focus Group Participant*

Priority Area

- Housing
 - Viewed the abundance of abandoned housing as environmental hazards.
 - The threat of increasing homeless persons in abandoned housing enhanced stress about violence and strangers in the neighborhood.
 - *“[If] you’re pregnant and even if you’re not pregnant [anymore] and just had the baby,it helps [housing], it kind of motivates you more; you have a place now and you’re not living [with someone]. -Focus Group Participant*

Priority Areas

- **Local Assets:** critical to quality of life because they provided needed resources, social support, safe havens, education and services. **Positive assets** were identified as condoms, job placement, prenatal vitamins, churches, good neighborhood appearance, public libraries, sanitation, daycare, thrift stores. **Negative assets** were identified as grocery stores with limited food selection.
- **Social Services:** Participants felt that some service organizations discouraged family unity, stating that once the father becomes involved in the family and appears to provide additional income, families are easily dropped from health services programs.

“Better collaboration with the resources that are available”-

Focus Group Participant

Cabinet for Health and Family Services



Priority Areas

- **Teenage Pregnancy and Parenting:** Participants believed teen pregnancy occurred as a result of low self-esteem and the lack of a dominant male figure. Perceived resources as being available. Believed that a structured home environment was a significant factor in prevention.
- **Health Access:** Participants believed that a convenient location to receive healthcare was good for people, especially if they are afraid to go to the hospital. Believed that health access was directly related to income.
- **Education:** Essential to prevention
- **Physical Fitness Opportunities:** Clean parks and safe walking trails could provide opportunities to stay healthy and encourage children to play.
- **Substance Use:** Discussed marijuana, and that many do not believe that it is a dangerous drug because you don't see the effects immediately. However, they did believe that "weed" killed brain cells.

Jefferson County Infant Mortality Project

- N= 4 Key Informants
- 3 were female, 1 male
- All participants were long time residents of Louisville ranging from 18 – 40 years of residence.
- Existing efforts: HANDS, FIMR, Passport Mommy and Me

Jefferson County Infant Mortality Project

Dimension	Score (1-9)	Stage of Readiness
Existing Community Efforts	5.625	Preparation
Community Knowledge of the Efforts	3.0	Vague Awareness
Leadership	5.1875	Preparation
Community Climate	2.875	Denial/Resistance
Community Knowledge About the Issue	3.0	Vague Awareness

Jefferson County Infant Mortality Project

- Key Informants indicated that the Louisville community including businesses and volunteers are not involved in current efforts.
- Interviews suggested that the community was in the preplanning stage of addressing infant mortality.
- Believed that there were resources, but there were barriers to receiving services.
- Increased media exposure to enhance awareness.

Jefferson County Infant Mortality Project

- Limitations
 - Not Generalizable
 - No causality
 - Self-reported responses
 - Key Informants were employed by the human services sector

Recommendations

- Work with partners such as the police department, sanitation, housing, parks and recreation, and transportation to work to address community concerns.
- Cultural Competency
- Educate decision makers and civic leaders about community issues.
- Expand the project
- Enhance community readiness
- Increase awareness
- Increase availability of community-specific data
- Educate civic leaders about disparities

Current Activities

- Center for Health Equity is working with Advocates and Policy Analysts to sift through transcribed data and priority areas to develop policy briefs.
- Expansion of the project
- Continued Healthy Start funding from HRSA.