

**FLORIDA RACIAL AND ETHNIC APPROACHES  
TO COMMUNITY HEALTH (REACH)  
OF HILLSBOROUGH COUNTY:  
AN EXAMINATION OF  
AFRICAN AMERICAN INFANT MORTALITY**

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# PURPOSE STATEMENT FOR FLORIDA REACH

- Florida REACH is deeply committed to eliminating the racial disparity between African American and White infant mortality rates.
- Florida REACH believes that all infants deserve the same opportunities to live and thrive, to be born free from infections and impairments, and to live long, healthy lives.
- Florida REACH is a community-driven process and seeks real interventions that address the needs of African American families in eliminating this disparity.

## ACKNOWLEDGMENT

REACH Hillsborough was effective in conducting the needs assessment and developing a community action plan thanks to the hard work of members of the **Taskforce to Heal Racial and Ethnic Disparities (THRED)**.

Without you we would not have reached our community or heard their voices.

Thank you.

AS

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**JUNE 2000**

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# EXECUTIVE SUMMARY

The Florida Racial and Ethnic Approaches to Community Health 2010 (REACH) Project is focused on reducing the disparity between African American and White infant mortality rates. This project proposes to examine the root causes of the disparities in infant mortality in both Gadsden and Hillsborough counties, where infant mortality rates for African Americans are the highest for the state of Florida.

There are two phases of this effort. The first phase includes:

- 1) Utilizing existing data and conducting a community-specific needs assessment (including focus groups and surveys) to more closely examine the disparity from the perspectives of families within the community;
- 2) Outlining the beginnings of a community education campaign with the goal of increasing awareness and utilization of prenatal and postnatal services available to families;
- 3) Developing a Community Action Plan with intervention strategies that will reduce (and eventually, eliminate) the racial disparity between African American and White infant mortality. The second phase will be the implementation and evaluation of the strategies created in the Phase I Community Action Plan.

In Hillsborough County, we have determined to focus our efforts on the population with the highest infant mortality rates: unmarried African American women, ages 18 to 34 with at least a high school education. Within that population, women with both high school and post-high school education will be addressed during the needs assessment. REACH will focus its effort on African American women living throughout Hillsborough County.

The anticipated impact of REACH in Hillsborough County will be significant. This is a community-driven effort that brings together community residents, service providers and state and local officials to strategize for new solutions to eliminate the disparity. The guiding force of REACH is the creation of a decision-making body named Taskforce to Heal Racial and Ethnic Disparities (THRED). This governing body, made of long time residents and employees of Hillsborough County, makes decisions about the local actions of REACH and determines what strategies would be included in the Community Action Plan.

The goal of the evaluation is to measure the Phase I Community Action Plan strategies and action steps for appropriateness, quality, completeness, and utility. This process will involve utilizing a variety of data and information sources, needed to track progress toward the Phase I goals and to provide information to identified decision-makers.

The expected outcome of this project is to reduce the number of infant deaths to African American women in Hillsborough County. REACH proposes to examine root causes of the disparity and to develop a Community Action Plan, which will incorporate community-based interventions aimed at reducing or eliminating the root causes of this disparity. It is our intention to focus our efforts on interventions determined by the community to be most effective for reducing infant mortality rates for African American families.



# I. INTRODUCTION

What we do to improve maternal and child health will determine America's future. The best marker of a healthy society is our success as a nation in saving the lives of babies. Significant progress has been made over the course of the past century in assuring better health outcomes for mothers and children. In fact, rates of infant, child, and maternal mortality have declined substantially in the last hundred years.

Although infant mortality (IM) continues to decline, the rate of decline in infant mortality in the United States has slowed over the past decade. The United States ranked 26th among developed countries in infant mortality in 1998 despite the fact that it spends 15% of its gross domestic product on health care, more than any other nation (UNICEF, 1998). Data confirms that the infant mortality rate (IMR) is on a progressive downward trend, however, the health care system has not been successful in closing the gap in IMRs with other developed countries. The IMR in the US has declined steadily since 1933 however, it has consistently been higher than for many other industrialized countries. In 1988 the US ranked 23<sup>rd</sup> in the world conversely, in 1960 it ranked 12<sup>th</sup>. Nationally, the infant mortality rate for children born into families with incomes above the poverty level is 8.3 per 1,000 live births while for those below it is 13.5 per 1,000 live births in 1994 (CDC, 1998).

Infant mortality rates as a whole are declining nationwide; however, they continue to remain high among minority populations and in large urban areas in the United States. The high infant mortality and morbidity rate of African American infants in the US is well documented. Black infants are two to three times more likely to be born with a low birthweight and to die during the first months of life (Calvo, Jackson, Hansford, Woodman, 1998). While the rate of infant mortality has decreased in the last 30 years due to advances in medical technologies, the gap between White and Black infant mortality has not narrowed. The differences in race-specific IM, low birthweight, and very low birthweight between Blacks and Whites have steadily increased from 1980 to 1991 (Calvo et. al., 1998).

New threats to children's health such as racial and ethnic disparities are evident and have not improved over time. For a number of reasons that have yet to be identified, the health and vitality of Americans vary due to race, culture, language, gender, age, employment rates, socio-economic status and income, to name a few. These disparities in health outcomes exist across the nation, and are as prevalent in infant mortality rates within the state of Florida as they are anywhere.

These disparities also show differences in medical seeking behavior and knowledge about good health practices. The racial gap in infant mortality appears to be the result of economic inequalities such as poverty, lack of employment opportunities due to insufficient levels of education, inaccessibility to health care, and lack of basic need resources. Given that the above mentioned group contributes a disproportionate number of infant deaths, implementing programs targeted to meet their specific needs could be an effective way to reduce the racial disparity gap in infant mortality rates.

Families with incomes above the poverty level showed an IMR of 8.3 per 1000 live births while those below the poverty level showed an IMR of 13.5 per 1000 live births (CDC, 1998). Maternal education has been associated with infant mortality, African American women

who had greater than a high school education showed a significant drop in infant mortality. Disparities between racial groups are also evident in those seeking medical treatment. Various problems have been identified that prevent routine prenatal care attendance, such as personal costs including out-of-pocket expenses and loss of personal time. These problems in attending care are magnified in poor, high-risk pregnant women who need to attend care more frequently.

Within the state of Florida, racial disparities in infant death rates are among the most striking. African-American infants are twice as likely to die as are White infants. This rate increases to 2.6 to 1 in Hillsborough County. The state and county health department, as well as local agencies, including Healthy Start Coalition of Hillsborough County, Inc., the Lawton and Rhea Chiles Center, and the Department of Health have worked for many years to decrease infant mortality rates. In 1991, when Healthy Start Coalition first began its work to reduce infant mortality, death rates were 9.7 per 1,000 for White infants and 19.2 for non-White infants (the majority of which are Black infant deaths). In 1998, infant death rates in Hillsborough were 6.5 for Whites and 11.5 for non-Whites. Such organizations are having a dramatic effect in decreasing overall infant mortality rates.

The problem, however, is not in seeing a reduction of rates overall. The problem is that the disparity between rates has not decreased. In 1991, the disparity between African American and White infant death rates was 1.98 to 1. By 1998, this rate has not changed. The rates of infant death have decreased, but the gap between African American and White infant deaths remain as large as ever.

Health professionals have struggled with this and other disparity rates for years. Why, when the quality of healthcare and medical technology in the United States are the best in the world, are African Americans suffering disproportionately higher incidents of illness than White? Why, when infant mortality rates are decreasing overall for both African Americans and Whites in Hillsborough County, are African American infants dying more often than Whites? Some contemplate that the disparity is solely attributable to differences in socioeconomic status; by balancing services available across economic lines, racial disparities in health would be eliminated. Others believe that teen mothers are to blame for high infant mortality rates, in addition to not having completed high school, low wages, and lacking knowledge about how to care for their infants. Despite the recent gains in reducing infant deaths, infant mortality remains a serious and tragic problem that can be solved only if stakeholder community leaders, businesses, health care professionals, and policymakers work together to find answers. In response to this need, several agencies and local organizations resolved to work towards finding a solution.

## **BACKGROUND OF REACH**

The rate of decline in infant mortality during 1950-1991 differed significantly for African American and White infants. White infant mortality rates declined by 3.23% per year compared to 2.89% annually for African American infants. In the 1950s, the IMR was 43.9 per 1000 live births for African Americans compared to 26.8 per 1000 births for Whites. During the past decade, the mortality rate in the United States decreased from 11.0 to 8.2 per one thousand live births for White infants, and from 21.4 to 17.2 per one thousand live births for Black infants. Despite advances made over the century in terms of

better infant mortality rates there is a continuing trend of disparity between different races and ethnic groups that is evident from the 1900s and into the 21<sup>st</sup> century.

In February 1998, Black History Month, President Clinton announced a new initiative. In his radio address he committed the nation to an ambitious goal: to eliminate the disparities in areas of health experienced by racial and ethnic minority populations by the year 2010 while continuing the progress made in improving the overall health of the American people. This effort has been entitled “The Initiative to Eliminate Racial and Ethnic Disparities in Health.” The Department of Health and Human Services is leading this effort to eliminate certain disparities in health access and outcomes of racial and ethnic minorities.

Quality health care has been made more accessible and affordable for many Americans. More emphasis has been placed on prevention and there has been marked improvement overall in the nation’s health since 1993 (Hill, 1999). Obstetricians and gynecologists who provide health care to women must, however, recognize that many Americans do not share in this overall progress in obtaining quality health care. When looked at closely one would find that race and ethnicity can result in less than desired health care outcomes (Hill, 1999).

Racial differences in the IMR remain a major national and public health concern. Although all race groups in 1998 have experienced declines in IMR, the relative differences in rates between Black and White newborns, expressed as the ratio of Black to White IMRs, increased from 2.0 in 1980 to 2.4 in 1990 (CDC, 1998). The ratio remained unchanged at 2.4 from 1990-1998. While the recent decline is very encouraging, racial disparities in IMR represent continued challenges for researchers and health care providers alike. There are several theories to explain why the differences in health status exists, all of which reflect problems seen in groups that battle poverty, lack of social resources and inadequate education. The poor, powerless and under-served contribute a disproportionate percentage of infant deaths. An effective method for reducing infant mortality must be targeted to meet their specific needs.

Racial and Ethnic Approaches to Community Health (REACH) 2010 is a Centers for Disease Control initiative to determine the root causes of racial disparities in health and to create alternative strategies to addressing these issues. Thirty-two projects were funded nationwide to examine one of six health disparity areas: cardiovascular disease and stroke, diabetes, HIV/AIDS, immunizations, breast and cervical cancer, and infant mortality. Florida REACH is focused on the disparity between African American and White infant mortality rates in two counties: Gadsden (rural) and Hillsborough (urban).

The collaborative is comprised of seven organizations statewide: Florida Department of Health, Florida A&M University, Florida State University, Gadsden Citizens for Healthy Babies, the Lawton and Rhea Chiles Center, Central Hillsborough Healthy Start, and Healthy Start Coalition of Hillsborough County. Each county has a community task force that guides the decisions made for the project in each community. Taskforce to Heal Racial and Ethnic Disparities (THRED), the REACH task force in Hillsborough County, is central to the efforts of this project.

The systematic assessment of the health status of children enables health professionals to determine the impact of past and present health interventions in prevention programs. Program planners and policymakers identify trends by examining and comparing information from one data collection year to the next. The first phase of REACH includes three distinct goals. The first goal was to utilize existing data and conduct a community-specific needs assessment (including focus groups and surveys) to more closely examine the disparity from the perspectives of families within the community. The second goal was to outline the beginnings of a

community education campaign with the goal of increasing awareness and utilization of prenatal and postnatal services available to families. The third goal is to develop a Community Action Plan with intervention strategies that will reduce (and eventually, eliminate) the racial disparity between African American and White infant mortality. Phase II of REACH, if funded, will be the implementation of the strategies created in the Phase I Community Action Plan.

## II. METHODOLOGY

### COMMUNITY INVOLVEMENT IN REACH

REACH Hillsborough is comprised of local health professionals and community residents who are committed to seeing racial disparities in health eliminated. The task force, known locally as the Taskforce to Heal Racial and Ethnic Disparities (THRED), has spearheaded the efforts of REACH in Hillsborough County. Participation in THRED includes Healthy Start Coalition, Lawton and Rhea Chiles Center, Central Hillsborough Healthy Start, College of Public Health at University of South Florida, WAGES Coalition, Hillsborough County Health Department, Head Start/Early Head Start, Children's Board of Hillsborough County, Family Enrichment Center, Veterans in Business, Greater Mount Carmel AME Church, Tampa Community Bible Church, St. John's Progressive Missionary Baptist Church, Without Walls Church, Community Development Corporation, March of Dimes, and many concerned citizens from the community.

The focus of REACH during this first year is to determine the root causes of disparity in infant mortality rates for African Americans and Whites, and it was determined that a needs assessment would be conducted to uncover the causes from a community perspective. Healthy Start Coalition conducted a period of risk analysis of vital statistics data and determined that the highest infant mortality occurred to unmarried African American women ages 18-34. All of these women graduated from high school, and 20% of this population has completed some college. This group was identified as the target population for the REACH needs assessment.

### HILLSBOROUGH REACH NEEDS ASSESSMENT

The Florida REACH collaborative, including task forces in both Gadsden and Hillsborough counties, developed a questionnaire that, each task force decided, reflected the areas of concern for each community. It was determined by THRED that a survey would be distributed to 350 African American female residents of Hillsborough. The four-page survey asks women questions pertaining to health practices, income, living environment, stress, and relationships. It also questions women's knowledge of the causes of infant mortality in the African American community.

In addition to obtaining quantitative data, the community also determined that it would be vital to obtain qualitative data from the Hillsborough community about root causes of infant mortality. The original goal was to complete ten focus groups with women countywide. It was determined that focus groups would be conducted, and a focus group guide was created with great input from THRED. Focus groups, which were conducted by staff after being trained by a professional focus group facilitator, would provide a forum for women to speak in more detail about the issues identified in the surveys. Women could speak more about their experiences with providers, health care, relationships, stressful issues in their lives, and their opinions about why infant mortality is so much more prevalent among African Americans than it is among Whites in Hillsborough County.

### *SURVEYS*

Surveys were distributed to African American women by convenience, for two reasons: 1) the project had a very short time limit, and 2) the project had limited staff involved in the

assessment process. A convenience sample was determined to be the most efficient method for conducting the assessment. Surveys were completed by African American women in various locations throughout Hillsborough County. These locations included: health centers, supermarkets, churches, health fairs, fast food restaurants, college campuses, child-care centers, and several different public and private offices.

Surveys were distributed to African American women ages 18 through 44 of various marital statuses, educational levels, income levels, professions and backgrounds. Each survey took women approximately five minutes to complete, and they were easy to distribute and collect back. Feedback from women who completed surveys was very positive. Most women were anxious to know more about the source of the survey and were interested to know when results would be made available to the public.

The most successful places for completion of surveys were at health fairs, churches and office sites. Women at work, for instance, completed the survey and turned them in to their supervisor, who held surveys until REACH staff could return to collect them. Some women stayed after church a few minutes and completed a survey. Others completed a survey at a health fair and received more information about REACH. Much support from the community was enlisted to involve supervisors and employees, students, and passers-by in an effort that would benefit the entire community.

Women who completed surveys were given the option to join a focus group discussion in their area to address the issues from the survey. While few women were available on the given date to attend the focus group scheduled within their area, many women did respond with interest after completing the survey.

## ***FOCUS GROUPS***

THRED suggested several ways for reaching the target population with focus groups. While the target population for the surveys was extended to include African women ages 18-44 and of various marital and economic backgrounds, the groups were focused on the women with the highest infant mortality rate. Namely, focus group attendees were to be unmarried African American women ages 18 through 34, who had completed at least high school.

Recruiting for, scheduling and conducting focus groups takes much time and effort to coordinate. One suggestion made was to invite women who had completed the survey to attend a focus group. A second suggestion was to advertise focus group dates locally in newspapers and with radio and television advertisements. A third suggestion was to tap into “natural groups” and invite women who fit the target population to join a focus group discussion. These natural groups include students, women who work together, attendees of a church, a support group, etc.

A combination of the above suggestions could produce the most valid results, so it was decided upon by THRED to use all three. Focus group participants would have the opportunity to self-refer after completing a survey. A note was attached to the front inviting them to leave their first name and a phone number for further contact if interested. Focus groups would be also be advertised locally, within selected office sites, on college campuses, and at health fairs.

Focus groups were scheduled for two-hour sessions at a time. Though most groups were scheduled to accommodate the time needs of the project, it became clear

during the course of the assessment that there would have to be some flexibility in the hours scheduled for the meetings. The following details required careful coordination in conducting focus groups:

1) Scheduling a meeting time that women could attend.

Though most women expressed availability in the evenings, there were many who found themselves canceling or requesting to attend a re-scheduled meeting in the future. The only problem with this was having to complete focus groups within a six-week period. Unfortunately, not all women who would have liked to attend a focus group had the opportunity to do so, due to the inability to schedule meetings and give considerable prior notice.

2) Finding locations for focus groups.

Several locations that might have been ideal for hosting a focus group required a fee to use of the facility. However, THRED members identified several locations, which could be used free of charge. These sites include church sites, where the majority of focus groups were held, and individual office site conference rooms or meeting rooms. Office meeting rooms were used when focus groups were conducted at work sites. Churches were used primarily for all other focus group meetings where participants from different backgrounds were in attendance.

3) Coordinating transportation, childcare, meals and incentives.

In our efforts to include in focus groups all interested women, THRED found it essential to meet the needs of the women. The meetings were scheduled at various locations throughout Hillsborough County, in an effort to engage women from various economic and demographic backgrounds. However, many women required additional assistance in reaching focus group locations. Transportation was arranged for several women. In addition, mothers who had no other means of childcare were provided childcare during the two-hour meetings. In addition, as many women were coming to meetings straight from work and during dinnertime, we provided dinner for mothers and children and a small gift to thank them for attending our meetings.

Though many of these expenses were not originally included in the project's budget, communities pitched in and helped in many ways. A portion of the grant received from the Children's Board enabled us to provide transportation and childcare for women attending the focus groups. Some meals were donated in many sites, either by churches or by offices.

The finalized focus group meeting schedule was as follows:

Women's Groups:

Friday, February 28	College of Public Health	4:30-7:00 pm	1 group
Tuesday, March 14	University Baptist/YMCA	6-7:30 pm	1 group
Thursday, March 16	St. John's Progressive MB Church	11:30-1 pm 1:30-3:00 pm	2 groups
Friday, March 17	Greater Mt. Carmel AME Church	1-3 pm	1 group
Monday, March 20	Central Hillsborough Healthy Start	11am-1 pm	1 group
	College Hill C.O.G.I.C.	6:00-7:30 pm	1 group
Thursday, March 23	Head Start/Early Head Start	12-2 pm	2 groups
	Tampa Urban League	6-8 pm	2 groups
Friday, March 24	SAMI	8:30-10am 10:30-12 pm	2 groups
Thursday, March 30	Rosa Valdez Learning Center	6-8 pm	1 group

Men's Groups:

Tuesday, April 18	REACH Office, Innovation Room	12-2 pm	1 group
Monday, May 1	Greater Mt. Carmel AME Church	6-8 pm	1 group

REACH really provided Hillsborough with a unique opportunity to come together and pitch in for the health of mothers and infants. The result was important data findings from surveys and focus groups, as well as a sense of unity and ownership for addressing infant mortality causes in the African American community.

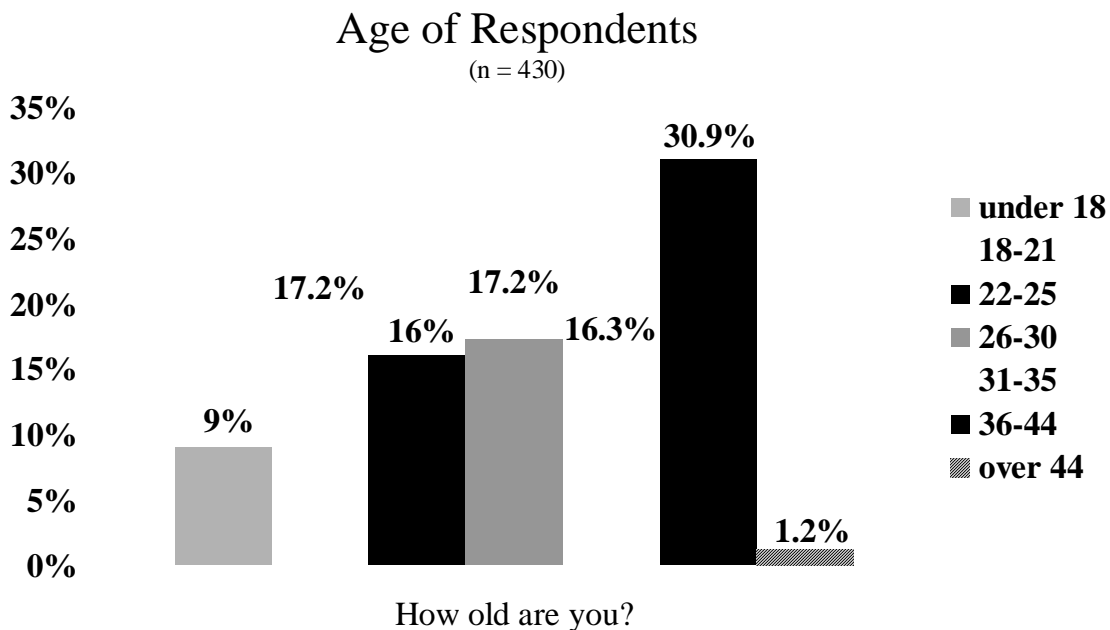
### III. RESULTS

The results of the assessment are amazing. And while some of the information is new and unexpected to many health professionals, members of the African American community are less surprised by the findings.

Approximately 430 surveys were collected from African American women representing a wide cross-demographic region of Hillsborough County. Women’s ages range from 18-44, and education levels range from less than 12<sup>th</sup> grade through professional degree.

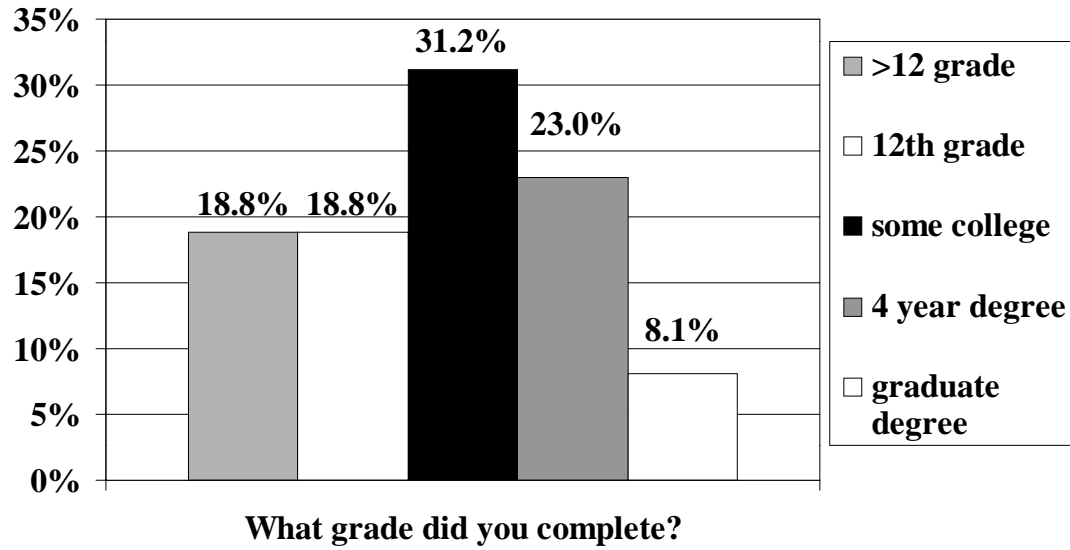
The original goal was to complete ten focus groups with women. Twelve focus groups were completed with women. In addition, THRED found it vital to receive information from men in addition to the information from women. Thus, two additional focus groups were scheduled in April with men. Fourteen focus groups were completed altogether.

Data summary sheets were created that capture the results of the assessment findings in four distinct categories. Based on the periods of risk model, we determined that the factors that contribute to infant mortality, which were most prevalent among the survey respondents would be listed. Much information was collected that supports the following known factors that contribute to infant mortality: infections (douching practices), general state of women’s health, stress, and socio-economic status. THRED received from REACH staff data summary sheets with the following results from the assessment. The data was obtained from REACH survey results, as well as from comments made by focus group participants.



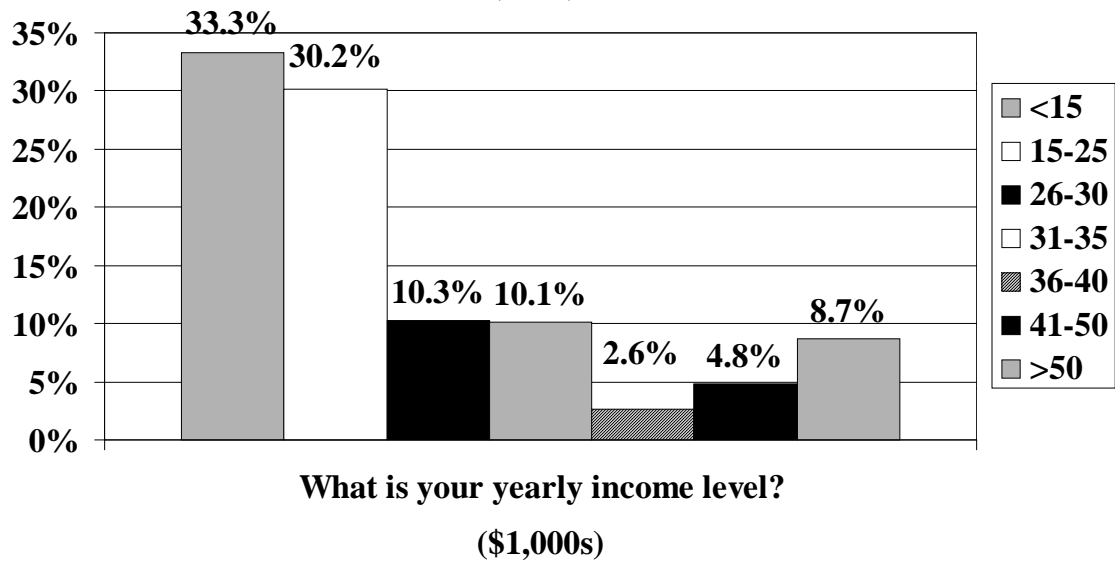
## Education Level

(n=430)



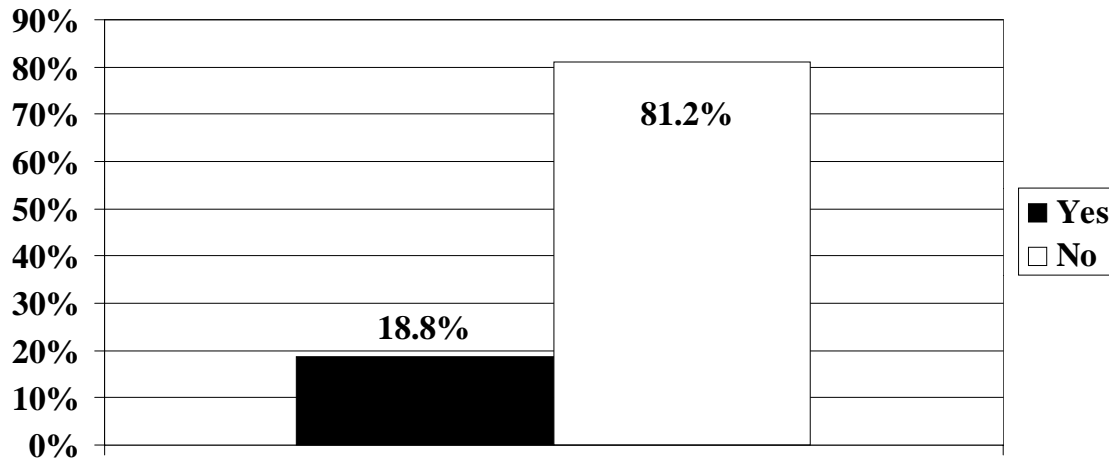
## Income

(n=378)



## Baby Born Too Soon/Low Birth Weight

(n=389)



**Have you ever had a baby that was born too soon or weighed less than 5 pounds?**

## INFECTIONS

Data indicated that the primary cause of infections is douching. Data from the Hillsborough County REACH Surveys revealed that almost half of Black women in Hillsborough County (47.7%) use a douche at least once per month:

Question: About how often would you say you use a douche?

Responses were as follows:	Percentage	Number (n=415)
a. Once a month:	21.2%	88 women
b. 2 times a month:	19.8%	82
c. 4 times a month:	6.7%	28
d. Once in a while:	24.6%	102
e. Never:	27.7%	115

Quotes from focus group participants:

“What did [your mom] tell you about douching?”

*She said to keep your body clean.*

“What made you think you should douche?”

*'Cause I was living that lifestyle . . . was keeping my body clean.*

*It keeps women having vaginal discharges and give 'em yeast. So I use douches only periodically.*

Of note, according to the Office of Minority Health Resource Center, higher rates of urogenital infections among African American women appear to make significant contributions to racial disparities in pre-term births, according to a study published in the March/April 1996 issue of the *Public Health Reports*. The study consisted of review of the medical literature on the prevalence of infections in African American and White women. Results showed that bacterial vaginosis is an established risk factor for pre-term births, and that higher rates of bacterial vaginosis in African American women may account for nearly 30% of the racial gap in pre-term births. Treatment of urogenital infections before and during pregnancy, the author concludes, offers hope for closing the racial gap in pre-term births.

A study published in the August issue of the *Archives of Pediatric and Adolescent Medicine* recommends that teenage girls and young women refrain from douching, which as practice may increase the risk of:

- bacterial vaginosis
- pelvic inflammatory disease
- tubal pregnancy
- alteration of vaginal flora, which may encourage the overgrowth of organisms that cause disease

Although douching has not been definitely linked to these disorders, the researchers note the practice also has no demonstrated benefit.

## **GENERAL STATE OF WOMEN'S HEALTH: HEALTH CARE SYSTEM AND PROVIDERS**

In regard to the health care system and providers, the Hillsborough County REACH Surveys revealed that over 30% of respondents rely on the advice of someone besides their doctor for general health, and that over 20% rely on the advice of someone other than their doctor for having healthy babies. Additionally, 32% of the respondents reported feeling that they were treated without respect by providers. Data from the surveys and focus groups are summarized below:

Number of Pregnancies (n=429)	Live Births		
Once	No live births	19 women	(4.4%)
Twice	One or less	26 women	(6%)
Three times	Two or less	30 women	(7%)
Four times or more	Three or less	30 women	(7%)

**Total who reported having been pregnant: 338 women (78.8%)**

**Total who reported having a loss: 105 women (24.5 %)**

Question: Have you ever had a baby that was born too soon or weighed less than 5 pounds?

Response: (n=389)	yes	73 women	18.8%
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Question: Who is the person you go to *most* often to get advice about your general health?

Top responses were:	Doctor	292 women	68.9%
	Mother	70 women	16.5%
	Friends	21 women	18.6%
	Grandmother	9 women	2.1%

Question: Whose advice would you trust *most* about what to do in order to have a healthy baby?

Top responses were:	Doctor	330 women	78%
	Mother	63 women	14.9%
	Grandmother	12 women	2.8%

When asked why, if at all, women felt treated disrespectfully by providers, the top three responses were due to:

Your Race	66 women	15.3%
Type of Health Insurance	55 women	12.8%
Your Sex	21 women	4.9%

Question: How old were you when you had your first pregnancy?

Responses:	Less than 15 years old	4.7%
	15-17 years old	22.8%
	18-21 years old	28.0%
	Older than 21	23.8%
	I've never been pregnant	20.7%

Quotes from focus group participants:

*I had an experience with the doctor where he spoke with the nurse to have her let me know that my Medicaid hadn't come in yet and he wouldn't be able to do my sonogram. And I felt hurt because he's outside the door telling her that she would have to come in and let me know that they have to put me off . . . . (providers)*

*This was at the emergency room. I was in the back, and I kept going up to the doctor saying what happened; they had did a RSV test on [my friend] and it was positive and he had the results sitting right there. I'm like, 'ok,*

*can I get the results?’ but he’s just sitting right there in front of me, ignoring me, talking to a nurse. Just sitting there. (providers)*

“How comfortable do you think that your clients are?”

*They’re not, cause they don’t ask questions . . . and the doctor don’t tell ‘em nothing.” (providers)*

*And if you get that impression from your doctor that you’re bothering him, you’re not going to call him. (providers)*

*My mother’s like they don’t care because if you’re on Medicaid. If you’re on Medicaid or any kind of assistance for medical procedures they don’t really care. (providers)*

*I used to work for a doctor’s office and what we had to do is book so many Medicaid for like a 1:00 appointment cause what if you had those two Medicaid and they didn’t show up. They had to get their total in for Medicaid, you know? And it’s like you had to over book for a 1:00 appointment. There’s like five of you sitting out there and you just don’t know you’re booked for the same doctor cause you’re on Medicaid. (providers)*

*I think that some of these doctors need to become more sensitive to our culture, all cultures, because some of the things they say is just, they don’t know, you know . . . we do things for a certain reason, you know? All cultures have their own little thing. (providers)*

“How do you think mobile health care was accepted?”

*They were always in the neighborhood and it build a better relationship because you was familiar with the nurses and it wasn’t as scary as it is to go to a doctor or a nurse the first time.” (healthcare)*

*And I just remember like, conversations from my mother and my aunt . . . “oh I don’t like to go to the doctor’s because they treat Black people bad that got Medicaid, like they ain’t nobody” or whatever. And when I got sick and my aunt’s like, “I’m going to take you to the doctor,” I just got scared because I remember them saying this stuff and I was like, oh, I don’t want to go . . . I was scared, because my aunts . . . saying “you got Medicaid, they’re going to treat you like dogs you’re going to get something and die.” (insurance/provider)*

## **STRESS**

Of the women surveyed, only 8% had any knowledge that stress was related to prematurity. Some factors determined by the REACH team that contribute to stress include discrimination and disrespect, poor interpersonal relationships, and difficult living situations.

Quote from focus group participant:

*It seems like the stress level for Black women doubles that of the stress level for any other race. I just think that we have a lot more stresses to deal with.*

## **DISCRIMINATION/DISRESPECT**

Approximately 79% of the women said they have experienced discrimination, primarily at work (38%) and in stores (49%), as well as other places including the doctor's office, school, and the bank.

32% of the women surveyed said that they felt disrespected by health care workers. Most of the women reported that they felt disrespected due to their race (15%) and the type of insurance they have (12.8%). This overall feeling was quite apparent in the focus groups.

Quotes from focus group participants:

*I had to tell a few [nurses] off because I didn't think they gave me respect that they were giving the White patients on the floor. Even the White patient next to me. That baby was born exposed to drugs, I think, was treated better by the nurse than I was.*

*Yeah, as soon as they show that gold card, it's like oh Lord, we ain't gonna get paid, and that's probably the reason a lot people do that because doctors really don't know what kind of insurance you have . . . it's the people at the front [who] know that and that's probably why you get treated bad . . .*

*They're like, "you know, uhm, I know you're in pain, but do you have your Medicaid number, your Medicaid card" or something like that. And now if you do, then they treat you differently than if you don't have one.*

## **RELATIONSHIP WITH BABY'S FATHER**

Approximately 24% of the women reported that their relationship with their children's father made them feel stressed and not supported.

38.3% of the women reported that they received little or no financial support from their children's father.

Quotes from focus group participants:

*Because me and my significant other because we are so young and we are both trying to start out in life, it put like a lot of stress on the relationship.*

## ***LIVING CONDITIONS***

Approximately 18% of the women reported that their current living situation is best described as being stressed.

Question: How much stress in your life has been caused by your experience with racism?

Response:	A lot of stress	6.1%
	Some stress	31.9%
	Very little stress	33.9%
	No stress	28.1%

Question: Do you feel that you have gotten the emotional support you needed during your pregnancies?

Response:	Yes	52.7%
	No	10.7%
	Somewhat	15.9%
	I've never been pregnant	20.7%

Question: Do you feel sure that you can get whatever you need to have a safe, healthy pregnancies?

Response:	Yes	84.8%
	No	6.6%
	Somewhat	8.5%

## **SOCIO-ECONOMICS**

According to the Hillsborough County REACH Surveys, the following was revealed:

- Approximately 19% of the women surveyed had less than a high school education.
- Approximately 68% of the women were unmarried.
- 38.3% of the women reported that they received little or no financial support from their children's father.
- 54.5% of the children's fathers are unemployed.

- 69.8% of the children's fathers have less than a high school education.
- 28.4% of the women reported that they were unemployed.
- 63.5% of the women surveyed earned less than \$25,000 per year. 67.5% of women earning less than \$25,000 have at least one child at home and 74.2% are unmarried.

Quotes from focus group participants:

*Sometimes we don't have it made and can't be home to do things; sometimes we have to get up, financially and hit the pavement running; some that might be able to jump into their cars, but others they might have to walk four block and take two buses.*

*My mother's like they don't care because you're on Medicaid. If you're on Medicaid or any kind of assistance for medical procedures, they don't really care.*

*Ain't nobody gonna give you no hand out. But, if you want it you got to go get it. Cause I don't want to be number 20. I had to learn that the hard way though. Before I was moved to Temple Park me and my kids we stayed in a shelter and then ate at my Mom's . . . . You know two women in the same house you know just don't get along. After a while, you see I got three kids and my Mom's only got a two-bedroom in her house . . . and my Mom, she is very clean. I pray before when I was staying at my Momma's. I said Lord, just let me get a place just let me get a place you know, of my own and then I would want to get to go to college so I can get the best for my kids.*

*In a way I think welfare holds you down because say you get a check and then decide to go and get a little part-time job, you know, part-time . . . it doesn't matter, then cut the little money off that need then you really need that money . . . .*



## IV. CONCLUSION

The Taskforce to Heal Racial and Ethnic Disparities came together on May 19, 2000 to analyze and interpret the results of the needs assessment. The information gathered during the needs assessment provides a glimpse into the perspectives of African Americans countywide. The needs of the community were expressed clearly. Because both surveys and focus groups were anonymous, men and women said that they felt comfortable being honest in their responses to questions. It was based on this information from the needs assessment that THRED created the REACH Hillsborough Community Action Plan to address the disparity in infant mortality rates.

THRED devised strategies and action steps within each strategy as a plan of action to reduce the disparity. Each strategy is based within the results of the data and is included because the group felt that each strategy would be the most effective at reducing the disparity. The action plan is still in final stages, and includes the following methods:

### REACH HILLSBOROUGH COUNTY COMMUNITY ACTION PLAN:

**Health Problem:** African American infant mortality rate  
**Cause of Death:** Prematurity  
**Period of Risk:** Maternal health

- 1. Contributing Factor:** Lack of provider and community knowledge about the impact of stress on women’s health.  
**Target:** Providers and community residents  
**Strategy:** Increase awareness among providers and community on the impact of stress on women’s health, and promote methods for stress reduction.

Action Step	Responsible Party
Encourage and support positive pregnancy outcomes of at- risk individuals through educating women on coping techniques to reduce impact of stress on women’s health.	Mental health providers and group facilitators
Develop provider workgroups that address MCH issues and teach providers about the impact of stress, using the peer educating approach.	Healthy Start Coalition
Promote interaction and trust between women and their medical providers in an effort to minimize stress and fear between providers and consumers.	Perinatal Central Hillsborough Healthy Start (CHHS); State Healthy Start; Churches; Chiles Center

**2. Contributing Factor:** Lack of community knowledge about the importance of good maternal health prior to and during pregnancy.

**Target:** Community knowledge

**Strategy:** Increase community knowledge on the importance of good maternal health prior to and during pregnancy.

<b>Action Step</b>	<b>Responsible Party</b>
Develop nutritional advocacy campaign/education for mothers, fathers, youth and informal providers (mothers, grandmothers, etc).	FAMU (lead); Churches; Hillsborough County; Schools
Schedule health events through selected schools, workplaces, and community health fairs to provide nutritional advocacy and the importance of good pre-conceptual health on pregnancy outcomes.	Agency providers; experienced youth volunteers; Head Start; CHHS; REACH Staff
Collaborate with men's groups to disseminate educational materials.	Agency providers; experienced youth volunteers; men's groups, such as: Vaughn Beal - Greater Mt. Carmel, Villard Houston, Veterans in Business, 100 Black Men, Urban League, Churches (all male groups)

- 3. Contributing Factor:** Lack of knowledge on the part of providers, insurance companies, and consumers about infections and risk factors associated with prematurity and infant mortality.
- Target:** Providers; insurance companies; and Consumer knowledge, attitudes, behavior
- Strategy:** Educate providers, insurance companies, and consumers about infections and risk factors associated with prematurity and infant mortality.

Action Step	Responsible Party
<p><b>Develop provider education campaign on Bacterial Vaginosis (BV) and oral health</b></p> <ul style="list-style-type: none"> <li>+ Include ACOG/CDC standards</li> <li>+ Include Continuing Medical Education credits</li> <li>+ Utilize medical boards to provide education</li> <li>+ Research/utilize existing literature, education programs</li> <li>+ Tap into pharmaceutical companies</li> <li>+ Develop presentation campaign</li> <li>+ Gather Baseline data on and health from consumers and providers on oral health</li> <li>+ Pilot Fem Cards</li> </ul>	<p>REACH; FAMU; Pharmaceutical Rep. (3M); doctors; AHEC; HS Coalition</p>
<p><b>Develop education campaign for insurance companies</b></p> <ul style="list-style-type: none"> <li>+ Bring medical school into Research BV in black women</li> <li>+ Engage College of Public Health in research and publishing</li> <li>+ Engage consultant on cost benefit of screening</li> <li>+ Develop presentation to insurance companies</li> <li>+ Educate consumer on various types of insurance</li> <li>+ Work with high volume employers on information regarding what to request in insurance plans</li> </ul>	<p>Representatives from insurance industry; Cooper Surgical (Fem Cards); Regional HMO group; Community; USF Medical School</p>
<p><b>Develop consumer education campaign</b></p> <ul style="list-style-type: none"> <li>+ Develop material include info on douching, medicine side effects, OTC medicines</li> <li>+ Utilize consumer focus groups in development of materials</li> <li>+ Disseminate through OB offices; public clinics; community health care providers, i.e.: drug stores</li> <li>+ Speakers bureau: high school; churches; girls/boys clubs; media</li> <li>+ Partner with school system to work with nurses to educate girls</li> <li>+ Educating providers to link consumers with literacy programs to reduce IM</li> </ul>	<p>Social Marketing Institute; Central Hillsborough Healthy Start; Kim Harper, FAMU</p>
<p><b>Explore and develop use of mobile medical van to disseminate education materials to the community</b></p> <ul style="list-style-type: none"> <li>+ Conduct fact finding to further develop strategy/action step</li> <li>+ Involve HMOs in planning process</li> </ul>	<p>Sydel Barnes, MD (Without Walls Church); Charles Mahan, MD; HMO; REACH Staff</p>

- 4. Contributing Factor:** Lack of culturally sensitive health care providers.  
**Target:** Provider knowledge  
**Strategy:** Establish and promote culturally sensitive standards for health providers.

Action Step	Responsible Party
Develop public campaign for promoting friendly, culturally sensitive health care providers.	Chiles Center; Central Healthy Start
Promote cultural competence within the professional medical schools and public health curriculum.	Chiles Center; Central Healthy Start; Healthy Start Coalition
Use the mobile health care approach to take culturally sensitive services to the community.	Sydel Barnes, MD; REACH Staff
Use providers to educate their peers on cultural competence.	Central Healthy Start; Healthy Start Coalition
Identify "friendly" providers and create a resource list to promulgate awareness of culturally sensitive providers to the community.	REACH Staff; Central Healthy Start; Healthy Start Coalition
Advocate for flexibility in hours in provider offices and clinics.	REACH Staff
Review black infant deaths and VLBW births, using FIMR/ACOG guidelines, to identify issues.	Healthy Start Coalition of Hillsborough

## V. FUNDING: THE FUTURE OF REACH

REACH of both Gadsden and Hillsborough counties are in the process of applying for funding for Phase II. The Centers for Disease Control are planning to fund twenty of the thirty-two currently funded REACH projects nationwide. Each project can be funded for a maximum of \$1 million per year, to be renewed up to four years. The projects that are funded are expected to implement the new strategies and reduce the health disparity.

Continuation of REACH efforts in Hillsborough County is contingent upon funding obtained to implement the strategies outlined in the community action plan. In addition to CDC-sponsored REACH funding, other grantors locally have been involved with REACH's efforts and may provide additional sources of funding to partners to implement strategies. Some of these sources may include the Children's Board, March of Dimes, and the Racial and Ethnic Disparities Bill. REACH will know whether it has been funded by the CDC to continue its efforts by late September 2000.

The first phase provided a wonderful opportunity to empower the community to determine the root causes of disparity in infant mortality. REACH Hillsborough has been successful during this first phase. A community-specific needs assessment has been developed by members of the African American community; data has been collected and analyzed; and a community-developed, community-centered action plan has been created to address the needs of the African American community. Few projects have allowed the leadership to come directly from the community. REACH is innovative, unconventional, and a bit risky. Perhaps the heart of the project, which is to create change through a changed system, is the answer that will make the difference in impacting infant mortality.

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