A Most Pressing issue: The Racial Divide in the Health and Wellbeing of Minority Women and Children in the State of Ohio

Op Ed by

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We in the State of Ohio are blessed to live in part of this great Nation's bread basket. Fertile fields bring forth fresh fruits, vegetables, and grains that allow many of us to furnish our dinner tables with healthy meals that sustain our families. Healthy, fertile land brings forth healthy fruit. In many, ways my brief discussion of infant mortality and the health of minority women is no different. If you leave this essay with nothing more than "healthy land brings forth healthy fruit" you are at the tipping point of understanding the travesty of our infant mortality crisis and its implications for our Beloved State. Healthier women give birth to healthier children. Infant mortality both locally and nationally ***is still a most pressing issue.***

The definition of infant mortality is the number of all live-born infants per 1,000 who die within the first year of life. Infant mortality is a measure of the health of a society and speaks volumes for its future.[1] The most precious product of a society is its children as they lay the groundwork for the future electorate, work -force, and tax base. In the past Ohio has ranked as one of the worst states for the death of babies in the first year of life for infants of all races [2] and **50th** out of 50 states for African American babies.[3] According to the Ohio Department of Health infant death rates have decreased from 2011 to 2013 however they remain higher than the national

[1] http://www.cdc.gov

[2] Ohio Department of Health Web Site

[3] Columbus Dispatch Sunday Sept 14, 2014

average by 23%[4]. The previous sentences crystallize our ***most pressing issue***. The health and wellbeing of our electorate and our State depend on our ability to recognize the health disparities based on race that result in poor fetal and infant outcomes Let us look at the numbers more closely. The rate of infant death for Black Ohioans is double that for White Ohioans at 13.9 and 6.4 respectively as of 2012.[5] In 2013 the numbers slightly improved for white infants but remained dismal for Black infants at 6.0 and 13.8 respectively.[6] It is the **average** of these two numbers that determines Ohio's national ranking. The collective efforts of intervention need to be spread across all races but clearly some concentrated effort needs to be placed on minority communities that are severely lagging behind. It is the age old conundrum of justice versus equality. Equality is to equally distribute resources to all. Justice, on the other hand, is to insure that the appropriate resources are given to those based on need. Essentially, until we address the issues in the communities that are failing, Ohio will never be able to rank with those states that are meeting and exceeding national standards for overall infant mortality. We have no choice but to dig in, and focus on communities that are fragile and address head on the racial health disparities that exist.

There is an emotional connection that many of us feel regarding our national ranking for the deaths of Black babies in the first year of life .[7] For some, there is simply shame at such a dismissal spot for our Beloved Ohio. For others of us who have worked with underserved

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[4] Ohio Commission on Minority Health Medical Expert White Paper Series :Achieving Equity and Eliminating Infant Mortality Disparities within Racial and Ethnic Populations: From Data to Action,Vol 1 Release date Sept 18,2015

[5] Ohio Department of Health Web Site/ Ohio Collaborative to Prevent Infant Mortality

[6] Ohio Commission on Minority Health White Paper see foot note 4

[7] Columbus Dispatch Sunday edition Sept. 14, 2014

populations and Ohioans of color this current situation has been a long time in the making. It has been a “simmering pot” for decades that is starting to boil over.

Unlike national disasters, such as storms or hurricanes, infant mortality is an utterly traceable social marker. A weakened public school system, resulting in poor job opportunities for its graduates, healthcare services far from home, a lack of emphasis on preventative health, and the surge in obesity are all factors. Prematurity, low birth weight, birth defects, and infant sleep related deaths (SIDS) are major contributors as well. Babies also die of neglect, injuries, and disease. In addition poor physical and mental health, tobacco, alcohol, and drug use, having pregnancies too close together, and limited breastfeeding among women of reproductive age lead to increased infant mortality rates.[8] Many of these issues are concentrated in minority communities due to lack of access, lack of health education, and racial bias. No one wants to believe we discriminate against babies, however, when the Mother is discriminated against we do indeed. Remember ***from healthy land comes healthy fruit***. The mental health and wellbeing of the Mother determines the environment in which the fetus develops, and the environment in which the baby upon delivery fails or thrives. If you don't have healthy communities, the offspring of the said community cannot be healthy. In the words of Dr. Patricia Temple Gabbe …

> “Infant deaths are at the heart of our inadequate health care system. Why should any infant die because their mother had no health insurance before she became pregnant, had little access to treat anemia, depression, asthma, diabetes or hypertension, or to safely space her last pregnancy? Infant deaths are preventable if we realign our priorities and our financial incentives.”[9]

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[8] Ohio Department of State Web Site

[9] Patricia Temple Gabbe MD MPH Infant Mortality Task Force Member Clinical professor of pediatrics Ohio State University and Nationwide Childrens Hospital Senior Medical Director OSUMHCS Preventing Infant Mortality in Ohio: Task Force Report November 2009

So What do We do ?

Some upon reflection of the answer to this question declare that We, as a society, help those who are less fortunate by providing medical care via our tax dollars in the form of public assistance and Medicaid. However, as a "soldier on the ground" serving this population what I can impart is that the number of providers available is limited. Not all women's health professionals take Mothers with Medicaid due to reimbursement. In addition, for many of these women it does take a village, and the medical provider is just one piece of the puzzle. Social workers, health educators, transportation, translators are all important components and in most private OB/GYN offices this array of services is not present.

I would be remiss if I did not address racism as a contributing factor to the infant mortality crisis. A crisis in which there is a blatant racial divide. Racism is a serpent whose head we as a country are struggling to sever and we as a State continue to fight with vehemence. The reality is there is *institutionalized racism,* that prevents equal access to goods and services and healthcare regardless of socioeconomic status. How else can we explain why a Black female Ohioan with five or more years of college is more likely to have a premature delivery than poor a Caucasian woman with only a high- school education or less? [10] There is also *personally mediated racism*, which occurs when we judge our fellow Ohioans based on our assumptions about them because of the color of their skin, their zip code, how they talk or the language they speak, and ultimately if we, as providers, want them in our waiting rooms. Finally, the worst part of racism is *internalized racism,* this subtype changes how a individual sees themselves and their perceived value to society. Internalized racism is the result of individuals accepting

[10] Ohio Department of Health Web site Physician fact sheet Infant Mortality Collaborative

negative messages about themselves and living down to those expectations. [11] Many of the aforementioned issues are surmountable but we need to acknowledge them all in order to remedy what is an otherwise debilitating situation.

All is not lost, there are some bright spots in this otherwise overwhelming issue of infant mortality. There are clinics that do coalesce all of the previously mentioned services, we just need more of them. In addition there is an emerging active discussion in the medical community about infant mortality, health disparities, and social /racial determinants of health. The medical community is slowly setting medical standards for induction of labor of fetuses prior to their due date to decrease the number of iatrogenic preterm births. One of the cornerstones of the battle against infant mortality was the initiation of presumptive coverage via Medicaid, for those women who become pregnant but are within 200% of the US poverty line. There is some question of how the delivery of these benefits may change in the future but the hope is that it will not change drastically. To decrease the health benefits for women teetering on the poverty line, or to make access to these benefits a convoluted process at this point in our States infant health crisis would be ill advised. Finally, we need to increase the racial diversity of the healthcare force to be more reflective of the community it serves. Some may read this last statement with a lack of understanding but it is simply true. In most cases, minority health providers are invested in the health of minority communities. We are making headway in the battle for our babies but we have more work to do.

[11] Levels of Racism: A Theoretic Framework and A Gardener's Tale, Camara Phyllis Jones, MD, MPH, PhD(Am J Public Health. 2000; 90:1212-1215).

In closing, we are especially lucky to live in what I deem to be a great State. We should all be inspired to work towards making all of Ohio's citizens and their offspring healthy and whole. All of our babies deserve an equal chance and this is our ***most pressing issue***.