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PREFACE

This report was prepared by The Bronx Health Link staff, including Joann Casado, Executive Director, and Robert Lederer, Researcher and Policy Analyst. We wish to acknowledge the important contributions of Judy Wessler, Executive Director of the Commission of the Public’s Health System.

The development and distribution of this document was made possible by funding from the New York City Council Infant Mortality Reduction Initiative and the New York City Department of Health and Mental Hygiene (NYCDOHMH).
FORWARD

This Equity Report offers a new look at the old, stubborn problems of infant mortality, low birth weight, pre-term births, teen pregnancies, and related issues that face the women and families of our borough. Past editions of our annual reports on maternal and infant health have carefully documented the data and demographics concerning these problems and have touched upon some of the factors involved in each. For instance, the 2008 Community Health Profile explored the influences of racism, education, health literacy, providers’ communication skills, language barriers, poverty, and inequitable access to medical care on maternal and child health as a whole. To obtain a copy, email lpabon@bronxhealthlink.org or call us at 718-590-2648.

This year’s report goes deeper to analyze the gamut of contributing factors to each phenomenon, and most importantly, offers recommendations for action to make further progress in combating the problems and specifically, in achieving health equity. The idea is to get past just the usual discussion of the data and move us to the point where we can start organizing the community to address these health issues - it is a move from mere intellectual discussions to actual community action plans where we infuse our work and help others with advocating for better health conditions and outcomes for our community - where the rubber hits the road. (However, we have also summarized much relevant data in a series of graphs and charts on maternal and infant health in the Bronx in Appendix A.)

Focusing on Health Equity

We chose to organize this report around the theme of equity because over and over, both the professional literature and the human experience reported to us by Bronx women say the same thing: Every aspect of maternal and infant health is drastically affected by gross disparities based on race, ethnicity, nationality, and income, all of which are determined by systems and policies beyond the control of individuals – and all of which can be corrected. The Centers for Disease Control and Prevention has defined health equity as “a situation in which, regardless of individual behavior, individuals have access to equal opportunities for positive health outcomes.” What our report documents is that, for Bronx women who give birth, the reality instead is systemic health inequity, which the Center for Health Equity has defined as “a subset of health inequalities or disparities involving circumstances that may be controlled by a policy, system, or institution so that the disparity is avoidable.”

To capture the overall impact of these inequities, we open each section with an “Equity Index” that provides the most recent data on the problem in question for the Bronx, New York City as a whole, New York State as a whole, and Manhattan’s Upper East Side. The latter was chosen due its status as the wealthiest district in New York City, and thus the stark contrast it provides in most health outcomes. In almost every case, these numbers tell the story vividly: The Bronx – with greater proportions of women giving birth who are living in poverty (68% on Medicaid), of color (94%), and immigrants...
than any of the other cited geographic areas – has unacceptable levels of suffering and death among its women and infants, in stark contrast to wealthier and whiter areas.

Finally, where applicable, we have included the “Healthy People 2010 Goals” developed several years ago by the U.S. Department of Health and Human Services in consultation with many state and local governmental and nongovernmental organizations. According to HHS, “Healthy People 2010” goals seek “to help individuals of all ages increase life expectancy and improve their quality of life” and “eliminate health disparities among different segments of the population.” As such, the goals provide a measuring rod for how far the Bronx has to go to achieve health equity.

Among the themes that recur throughout this report are that Black and Latina women have much higher rates of almost every health problem connected to pregnancy than do white women, and (where data is available) that immigrant women often, though not always, suffer worse outcomes than non-immigrants. The report summarizes some of the inequities in health care delivery and a range of stresses that underlie these trends, and the way many of these influences lock in health problems in the mother-to-be long before conception. As the producers of the award-winning PBS documentary on health inequality titled “Unnatural Causes” have summarized: “Study after study has outlined the ways in which a woman's health, diet and stress level during pregnancy affects her newborn's life chances: everything from neurological and emotional development to the likelihood of adult obesity. Proper nutrition, prenatal care, and exercise are important, but class, racism, loving relationships and place can also affect pregnant women.” The issue of health insurance coverage (or the lack of it) is central to health equity, so we have included two sections analyzing the impact of the Bronx’s high levels of people who receive Medicaid and those who are uninsured. (Note: Because the issues of child health are closely related to those covered here, we have included in the appendix the Bronx Health Link’s Policy Development Document containing facts and recommendations on three major children’s health issues in the Bronx -- asthma, mental health and obesity. This was prepared as our contribution to the overall report of the citywide Child Health Initiative.)

Not included in this document is the very important role of environmental exposures, which disproportionately affect people of color, in damaging maternal and infant health. Next January, The Bronx Health Link will issue a special report on these issues – which include air pollution, cigarette smoke, pesticides, chemicals in household and personal care products, lead and mercury – and the role of environmental racism in heightening their impact.

Despite the poor health indicators documented in this report, there are thousands of women, babies and families who survive and succeed in the borough. Their resilience in the face of endemic barriers is to be lauded. We believe that the assets of the individuals, families and the communities create a will to survive in spite of poverty, racism, and discrimination -- a fortitude that transcends even the statistics cited herein. It is this spirit of survival, of endurance, that creates the hope that the men, women and children of the
Bronx will use their individual drive, the strength of their families, and the determination of the community to address, struggle against and finally overcome the threats to their existence, and ultimately to achieve a state of well-being and health.

**Recommendations for Action**

We have drawn upon those inspiring experiences – gathered through years of surveys, focus groups, workshops, conferences, and one-on-one discussions with consumers and providers in the Bronx – in assembling a set of recommendations for action to make progress on these seemingly intractable problems. One recent meeting that contributed proposals for broad healthcare reform that are included here was the Bronx Community Health Care Discussion for the Obama-Biden Transition Team. All of these ideas have been supplemented by a broad range of sources -- including medical professional organizations, governmental health agencies, elected officials, and most important, other community-based service and advocacy organizations – which have done creative thinking toward solutions. While some of the proposals are far-reaching and politically challenging, and may take years to achieve, others are more modest and could be adopted quickly -- if community, medical, and most of all political institutions have the will to do so.

We have organized this report as a series of sections about the component issues of maternal and child health. Each section is formatted to stand alone – including some repetition of applicable recommendations from other sections – as a tool for use by policy analysts and community advocates in their areas of specialization.

A few recommendations apply to many problems covered in the report and so constitute common themes of needed institutional change:

- Adopt a national, universal, single-payer health care financing system, such as that embodied in the House bill, HR 676, covering all U.S. residents, including both documented and undocumented immigrants; coverage of all medical services, mental health, dental and optical care, prescription medications, and such preventive services as screening tests, nutritional counseling, and case management; with identical rules and procedures for all states and cities, and a uniform set of administrative forms.

- In the absence of a single-payer system, incorporate expanded eligibility for Medicaid into any health care reform program, and expand access to private coverage for the remaining uninsured population.

- Expand access to public and private insurance programs so as to achieve universal coverage of women of childbearing age (15- 44).

- Increase and ensure the active role of women in the formulation and execution of health promotion, education and care programs. They can participate in this process either as members of Community Advisory Boards or as Board members. In addition, the ongoing
use of community-based participatory research can engage the community in the development and implementation of programs and services.

- Fully involve communities in decisions concerning the distribution of health resources and the formulation and execution of health promotion, education and care programs.

- Provide women with options for receiving maternity care. Among those options should be birthing centers wherein women design and determine the content of care and health care providers serve as consultants to childbearing women.

- Build a financial and programmatic infrastructure to provide women with preventive health care, including preconception and interconception care, to make prenatal care far more effective in improving women’s health and birth outcomes. First priority should go to women who have experienced premature births and/or suffered the death of an infant.

- Promote the Medical Home model to ensure that women have access to quality and reliable interconception health care.

- Expand funding for the Community Health Worker Program to increase the reach of culturally competent outreach and education efforts about eligibility for the Prenatal Care Assistance Program (PCAP) and the importance of prenatal care to more underserved pregnant women. Efforts should target overall populations (i.e., not just women of reproductive age) that are most disconnected from care, such as undocumented immigrants, teenagers, and the working poor with incomes above the Medicaid-eligible level.

- Expand funding for the Healthy Families New York Home Visiting Program to provide prenatal and postnatal education and services to more underserved women, including teenagers.

- Provide funding for additional community-based prenatal and postpartum clinics in underserved areas.

- Provide funding for all facilities providing prenatal and postpartum care to hire multilingual, culturally competent staff and translators and to make available multilingual printed materials.

- Secure workplace support for pregnant and postpartum mothers, including: affordable health insurance; paid maternity leave; onsite child care; flexible hours and home work; mothers' rooms (private areas to pump breast milk); and separate paid infant feeding breaks in addition to other breaks.

- Support and enhance access to healthy foods and products to address the issue of obesity as a factor affecting maternal and infant health: Provide tax incentives, subsidies and other incentives to encourage grocers, restaurants, farmers markets to do business in
communities hardest hit by infant mortality and to induce fast-food restaurants and stores to sell healthy produce.

In closing, we are issuing this report as an urgent call to action and as a tool for others to use to advance these goals. Health inequities can be reversed, and equity can be achieved. We owe it to the women and children of the Bronx who are most severely underserved to do nothing less. We invite all individuals, organizations, and governmental officials who want to reverse these atrocious conditions to join us in this work.

Joann Casado
Robert Lederer
September, 2009
ABOUT THE BRONX HEALTH LINK, INC.
The Bronx Health Link, Inc. (TBHL), is a unique collaboration created in 1998 by Bronx-Lebanon Hospital Center, Montefiore Medical Center, Our Lady of Mercy Medical Center, and St. Barnabas Hospital—and the office of the Bronx Borough President. The shared vision was to build an organization that addresses community concerns by creating linkages between the different providers, organizations, coalitions and stakeholders that serve Bronx communities. The goal of TBHL is to create a platform for the involvement of residents and other stakeholders in public health planning, programming and decision-making, TBHL currently works with over 150 community organizations and providers. While TBHL serves the entire borough, the focus is on low income neighborhoods with the highest risk poor health outcomes, many located in the 16th Congressional District, the poorest Congressional District in the entire United States.

The Bronx Health Link, Inc. is an organization that serves as a clearinghouse for the members of the health and human service delivery system of the Bronx. In this capacity, we reach over 700 members and agencies that actively participate in an electronic mailing list and numerous workgroups, advisory boards and task forces. We also coordinate the Perinatal Information Network and thus work extensively with the community and health care providers with the aim of improving birth outcomes, prenatal care and the reproductive health of women in the Bronx. The Bronx Health Link works with many community partners to improve the overall health of Bronx women, children and families.

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Infant Mortality

**Equity Index**

*Measure: Infant mortality rate – the number of deaths of infants one year old or younger per 1,000 live births annually*

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**Issue:**

The persistence of infant mortality rates in the Bronx higher than any other NYC borough is an unacceptable reality that demonstrates serious gaps in the health and human service safety net. Meanwhile both the Bronx and citywide rates remain significantly higher than the Healthy People 2010 Goal.

In New York City in 2007, the leading causes of infant deaths were congenital malformation/deformation (birth defects), short gestation/low birth weight, and cardiovascular disorders. Birth defects mainly resulted from genetic disorders, cardiovascular and lung malformations, and neural tube defects. It is significant 74% of the infants who died had low birth weight, and the lower the weight, the higher the death rate. Also, infants who are multiples (twins, triplets, etc.) died at five times the rate of single infants because they are often born preterm.

**Facts:**

**Trends:** Nationally, after a dramatic decline throughout the 20th century, infant mortality rates leveled off beginning around 2000, and the U.S.’s ranking internationally has worsened in recent decades. In New York City, the rate has declined significantly in recent years, going from 11.6 in 1990 to 7.0 in 1997 to 5.4 in 2007. However, in the Bronx, the long-term decline has been substantial, going from 13.3 in 1990 to 7.9 in 1997 to 6.1 today. But along the way there has been inconsistency, with spikes as high as 8.6 in 2003 and 7.1 in 2006.

**Inequities:** Despite some improvements in recent years, drastic gaps persist in infant mortality rates between people of color and white people in the Bronx, New York City as a whole, and nationally. The NYC Department of Health and Mental Hygiene has reported, “In 2006, the infant mortality rates for Black and Puerto Rican New Yorkers were more than double those for whites and Asians – a pattern that has persisted for more than a decade.” This pattern largely continued in 2007, when the rates were 9.8 for Blacks, 6.3 for Puerto Ricans, 3.9 for whites, and 3.1 for Asians (the rate for other
Latinos was 4.3). Another report by the Health Department put the reality starkly: “If the infant mortality rate among African Americans decreased to that of Whites, nearly 200 fewer babies would die [in New York City] each year.” Most of the Black-white disparity in infant mortality stems from the high proportion of premature and low birth weight infants among Blacks. In NYC in 2007, babies born very prematurely or very low birth weight -- less than 2% of live births – accounted for almost 60% of all infant deaths.

**Contributing Factors:**

There are many factors that contribute to infant mortality and its precipitating conditions, such as low birth weight and pre-term birth. Among the most significant are the following:

- **Racial discrimination:** In recent years, research has shown that persistently high infant mortality rates among African Americans are not simply a function of higher poverty rates. As the NYC Health Department has reported, “Infants born to higher-income black women died at nearly three times the rate of those born to higher-income white women.” One expert has concluded from his research on infant mortality among Black women that a prime cause of this is the stress experienced from racial discrimination “initiates the release of stress hormones leading to preterm birth and increased susceptibility for infection.” Another research team, citing “evidence on links between gestational hypertension and adverse birth outcomes” among Black women, has proposed that racial discrimination elevates the risk of gestational hypertension. A recent study found premature births more than twice as likely to occur with Black women than white women, with depression more likely to be involved. The study’s lead author stated that the higher Black preterm birth rate might result from “weathering” or accelerated health declines due to socioeconomic and other hardships. Another factor producing inequity, as found by the Institute of Medicine, is that “many women of color receive different counseling, screening and treatment than their white counterparts.”

- **Lack of preconceptional and interconceptional care for women of childbearing age.** For years, it was widely believed that one of the keys to reducing infant mortality was increasing pregnant women’s participation in prenatal care. Yet, while that participation has increased substantially in recent decades in NYC, the infant mortality rates have only modestly declined. Increasingly, researchers are emphasizing that without preconception care, the many health and social problems and harmful behaviors (such as infections, nutritional deficiencies, tobacco/alcohol/drug use, stress, depression, and abuse, as well as chronic illnesses such as diabetes and heart disease) that contribute to poor birth outcomes cannot be easily reversed, or reversed in time to have an impact on the baby. Research has clearly shown that the early weeks after conception are critical to the baby’s development and health, yet “the first doctor’s visit (by pregnant women) typically does not occur before 6-12 weeks after conception.”

- **Lack of insurance:** Prior to pregnancy, women of reproductive age (15-44) who obtain regular medical care can detect and treat medical conditions and infections that can make
at-risk babies more likely. But in 2006, 17.4% of women of those ages in New York State were uninsured. More specifically, “women who are young, single, working part-time, or unemployed are most likely to be uninsured.”

- **Teen pregnancy:** Research has demonstrated that teens are at greater risk for delivering low-birth-weight babies, a major risk factor for infant mortality. The 34% decline in NYC teen births between 1996 and 2005 contributed to the major reduction over that period in infant mortality.

- **Nutritional deficiencies.** Considerable evidence has linked poor maternal nutrition to major causes of infant mortality, such as birth defects, preterm birth, fetal growth restriction, and maternal complications of pregnancy. For example, folate and B12 deficiencies have been linked to neural tube defects, and inadequate B vitamins, vitamin K, magnesium, copper and zinc linked to other birth defects. Deficiencies in vitamin A and other nutrients are implicated in maternal infections, which can increase risk of low birth weight.

- **Inadequate folic acid consumption:** A recent study found that folic acid supplementation for at least one year before pregnancy is linked to a 50% drop in preterm deliveries at 28-32 weeks, and a 70% drop in very early preterm deliveries at 20-28 weeks.

- **Underweight or obesity during pregnancy.** Numerous studies have found that both underweight and obesity during pregnancy are linked to a wide range of adverse health outcomes that can contribute to infant mortality.

- **Dental problems in the mother.** New evidence has emerged that pregnant women with periodontal disease have seven times the risk of giving birth to a low-birth-weight or preterm baby.

- **Infections in the mother:** Certain infections, especially those involving the uterus, may increase the risk of preterm delivery.

- **Chronic health problems in the mother:** Maternal high blood pressure, diabetes, heart, lung and kidney problems can sometimes reduce birth weight.

- **Alcohol and illicit drugs:** Consuming alcohol and some illicit drugs during pregnancy increases the risk of low birth weight.

- **Smoking:** Infants born to mothers who smoke during pregnancy are reported to be at greatly increased risk of low birth weight and preterm birth. Nationally, CDC data shows that in 2004 10% of pregnant women reported smoking, a drop from 20% in 1989.

- **External environmental exposures:** Many studies have linked low birth weight to residential environmental exposures, including air pollution, substances in drinking water, and industrial chemicals. One study that included Dominican and African
American mothers in the South Bronx found that exposure of pregnant women to pollutants from vehicle exhaust led to significantly reduced fetal growth, with more severe effects in smoking households. Also, research has found that exposure to high levels of lead during pregnancy can contribute to preterm delivery and low birth weight. In 2005 nearly 500 NYC women of reproductive age were reported to have blood lead levels in the high-risk range.

- **Domestic violence**: Research has shown that pregnant women subjected to violence are at higher risk for not only serious health damage to themselves, but also for delivering preterm and/or low-birth-weight babies. A 2006 NYC survey found that 3.2% of pregnant women citywide and 9% of Bronx women reported that they had been subjected to intimate partner violence during their last pregnancy.

- **Infections in the fetus**: Certain viral and parasitic infections, including cytomegalovirus, rubella, chickenpox and toxoplasmosis, can slow fetal growth and cause birth defects.

- **Birth defects**: Babies with certain birth defects are more likely to have their growth restricted.

- **Placental problems**: Placental problems can reduce flow of blood and nutrients to the fetus, limiting growth.

- **C-sections and induced labor**: Nationally, 92% of the increase in preterm births between 1996 and 2004 was found to be due to Cesarean sections. In 2005, 27.5% of Bronx live births were by C-section. A rising rate of early induction of labor also has played a role in up to 25% of premature births.

- **Prior history of preterm births**: Studies indicate that a women’s medical history, such as a preterm birth in a previous pregnancy, a family history of preterm birth, or if the woman was born preterm herself, are all risk factors for preterm births.

**Recommendations for Action:**

**Community Recommendations**

- Ensure that prenatal/postpartum care providers fully follow state standards and develop collaborative relationships with community-based organizations that specialize in prenatal/postpartum outreach, education and case management.

- Educate pregnant patients and train providers on the importance of dental care in preventing poor birth outcomes and improving the mother’s overall health.

- Prenatal assessment of women must include a risk assessment for preterm birth. Questions in the prenatal intake form should include familial and family history of preterm birth. Indication of either a familial or individual risk for preterm birth should
trigger intensive health promotion, stress management, nutritional counseling, care coordination, and case management, to help reduce adverse health outcomes.

- “Perinatal care providers, including WIC programs, should routinely assess psychosocial factors, including stress and social support among pregnant women and families. Those who screen positive should be referred to appropriate support services.” In addition, such providers should explore use of doulas, group prenatal care, and other forms of social support for improving maternal nutrition, and health insurance plans should support such services.

- Develop a critical mass of people to participate in “maternal matrices” by identifying, training, and employing women who have proven resilient in response to their own life trials and tribulations.

- Pass the New York State bills sponsored by Assemblymember Amy Paulin (whose bill passed the Assembly in 2008) and Senator Kemp Hannon, providing for a state-funded education and outreach campaign for both consumers and providers to “educate the public about health risks, benefits and choices with regard to birthing procedures,” including vaginal delivery, C-sections and the use of drugs during childbirth.

- Develop community-based campaigns that educate pregnant women consistently about the risks of Cesarean sections in their language of preference using principles of adult literacy, adult education and recognizes and utilizes culturally competent content.

- Create and provide encouragement including social support for men to actively participate in supporting their mates in childbearing, rearing and breastfeeding.

- Necessary actions related to workplaces include:
  - securing workplace support including: affordable health insurance; paid maternity leave; onsite child care; flexible hours and home work; mothers' rooms (private areas to pump breast milk); and separate paid infant feeding breaks in addition to other breaks
  - dissemination of available documents related to costs and benefits of breastfeeding, and the costs and risks of alternate feeding, to appropriate policymakers, employers, consumers (e.g., *The Business Case for Breastfeeding* by the U.S. Department of Health and Human Services).

- Health care providers should educate pregnant women and new mothers and other family members about the risks of SIDS and risk reduction methods in their language of preference in a manner that acknowledges and respects the culture of the community.
**Health Care Services Recommendations**

- Expand financial access to prenatal and postpartum care by increasing Medicaid eligibility for coverage from 200% to 250% of poverty and set clear and narrow exemptions from provider requirements to offer such state-reimbursed care.\(^{46}\)

- Expand state-funded postpartum care beyond the current limit of 90 days post-delivery to ensure continuity of access to health care services for women and their babies.

- Provide funding for additional community-based prenatal clinics in underserved areas.

- Require that state-reimbursed prenatal care include adequate amounts of non-medical services such as nutrition counseling and smoking cessation, and establish adequate monitoring mechanism to ensure that providers follow this and other standards.

- Guarantee all pregnant women access to dental care as part of the prenatal continuum, as per the recommendations of the New York State Health Department.\(^{47}\)

- Provide funding for all facilities providing prenatal care to hire multilingual, culturally competent staff and translators and to make available multi-lingual printed materials.\(^{48}\)

- Expand funding for the Community Health Worker Program to increase reach of culturally competent outreach and education efforts about eligibility for prenatal/postpartum coverage and the importance of prenatal care to more underserved pregnant women.\(^{49}\)

- Target overall populations (i.e., not just women of reproductive age) that are most disconnected from care, such as undocumented immigrants, teenagers, and the working poor with incomes above Medicaid-eligible level.\(^{50}\)

- Expand funding for the Healthy Families New York Home Visiting Program to provide prenatal and postpartum education and services to more underserved women.

**Systems Recommendations**

- Overall: Build a financial and programmatic infrastructure to provide women with preventive health care, including preconception and interconception care, to make prenatal care far more effective in improving women’s health and birth outcomes. First priority should go to women who have experienced premature births and/or suffered the death of an infant. Some components of this:
  
  - Expand access to public and private insurance programs to achieve universal coverage of women of childbearing age (15-44).\(^{51}\)

  - Promote the Medical Home model to ensure that women have access to quality and reliable preconception and interconception care.
• Expand public and private insurance coverage to include support for smoking
cessation programs among women of childbearing age.

• Build the capacity within the health care setting and the community to provide
nutritional counseling to women of childbearing age in order to decrease the
alarming effects of obesity.

• Provide funding for folic acid supplementation to young girls starting in school
health centers.

• Support development of statewide or regional maternity care quality improvement
collaboratives and develop statewide or regional database/reporting systems to provide
public information on performance of various providers and facilities.

• The New York State Department of Health should monitor and evaluate NYC hospitals’
compliance with the Maternity Information Act. The NYC Health and Hospitals
Corporation (HHC) should work with the NYSDOH to ensure that the city’s 12 public
hospitals that offer labor and delivery services are in compliance with the law.

• The NYC Department of Health and Mental Hygiene should make up-to-date information
about birthing statistics available and easily accessible on its website. The website
information should be presented in a user-friendly, easy-to-read format.

• To assist community members who do not have access to computers or the Web, build
the capacity of community-based agencies and providers to access this information and
provide it to women in the course of their prenatal care.

Overarching Recommendations

• Provide women with options for receiving maternity care. Among those options should
be birthing centers wherein women design and determine the content of care and health
care providers serve as consultants to childbearing women.

• Expand federal support for research to better understand:
  ▪ the causes of premature birth and low birth weight.
  ▪ strategies for prevention that improve care and outcomes for preterm and
    low-birth weight infants.
  ▪ the influences of partner support, provider encouragement, social network,
    and psychosocial factors impacting on maternal nutritional status and
    behaviors before and during pregnancy.52
  ▪ reproductive racial and ethnic disparities, including preconceptual and
    interconceptual experiences that affect birth outcomes.
  ▪ Assets within communities of color that account for positive birth
    outcomes despite adverse conditions
  ▪ Existing and needed psychosocial services for preconceptual, perinatal and
    interconceptual care.
• All research in disenfranchised communities should employ principles of community-based participatory research. All researchers should develop and implement studies that are culturally competent and sensitive. All research must involve the community as active participants, particularly in translating the findings and results of the inquiries into beneficial actions for the community.

• Support and enhance access to healthy foods and products to address the issue of obesity as a factor affecting maternal and infant health: Provide tax incentives, subsidies and other incentives to encourage grocers, restaurants, farmers markets to do business in communities hardest hit by infant mortality and to induce fast-food restaurants and stores to sell healthy produce.53

• Undertake multimedia messaging to stimulate demand for healthy nutrition.54

• Adopt a national, universal, single-payer health care financing system, such as that embodied in the House bill, HR 676, covering all U.S. residents, including both documented and undocumented immigrants; coverage of all medical services, mental health, dental and optical care, prescription medications, and such preventive services as screening tests, nutritional counseling, and case management; with identical rules and procedures for all states and cities, and a uniform set of administrative forms.

• In the absence of a single-payer system, incorporate expanded eligibility for Medicaid into any health care reform program, and expand access to private coverage for the remaining uninsured population.

• Expand access to public and private insurance programs so as to achieve universal coverage of women of childbearing age (15-44).55

• Fully involve communities in decisions concerning the distribution of health resources and the formulation and execution of health promotion, education and care programs.

• Increase and ensure the active role of women in the formulation and execution of health promotion, education and care programs. They can participate in this process either as members of Community Advisory Boards or as Board members. In addition, the ongoing use of community-based participatory research can engage the community in the development and implementation of programs and services.
Bronx Health Link

Health Equity Report

SIDS
Sudden Infant Death Syndrome (SIDS)

**Equity Index**

*Measure: Deaths of infants under one year whose death is unexplained after a thorough investigation, per 1,000 live births. (In parentheses: Actual numbers of deaths from SIDS)*

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**Issue:**

Sudden Infant Death Syndrome (SIDS) is the leading cause of death in infants from 1 month to 1 year of age, with most deaths occurring between 2 and 4 months. The death is sudden, silent and with no apparent cause. Experts agree that the risk of SIDS is much higher among infants who sleep on their stomach or side (for other contributing factors, see below).

**Facts:**

**Trends:** Nationally the SIDS rate has declined by over 50% since 1990, but decreases have been lower among Black, Latino and Native American infants. SIDS deaths in NYC declined from 51 in 1997 to 5 in 2007, and in the Bronx from 9 in 1997 to 1 in 2007. In NYC, 2007 was the fourth consecutive year in which SIDS was not one of the 10 leading causes of deaths among infants under age one. The NYC SIDS rate decreased from .4 per 1,000 live births in 2000 to .03 in 2007. However, one expert argues that much of that seeming reduction was due to a classification change from SIDS to “accidental asphyxiation,” and that other data shows that injury-caused infant deaths increased substantially during that period.

**Inequities:** Nationally, African-American and Native American infants are two to three times more likely to die from SIDS as other infants. According to a 2006 survey, 50% of Bronx mothers placed their infants on their backs to sleep, compared with 63% of Manhattan mothers. Citywide, far greater percentages of white (71%) than Black (45%) or Latina (52%) mothers did so.

**Contributing Factors:**

Researchers have identified several factors that increase the risk of dying of SIDS. 

- **Stomach (prone) or side sleeping:** Babies put on their stomachs or sides.
- **Soft sleep surfaces**: Sleeping on a waterbed, couch, sofa, or pillows, or with stuffed toys.

- **Loose bedding**: Sleeping with pillows or loose bedding such as comforters, quilts and blankets.

- **Overheating**: Too much clothing, too many blankets, or a room that is hot.

- **Smoke exposure**: Infants whose mothers smoked during pregnancy or who are exposed to cigarette smoke, or infants exposed to smoke at home or at day care.

- **Bed sharing**: Sharing a bed with anyone other than the parents or caregivers or someone under the influence of alcohol or drugs.

- **Preterm and low birth weight infants**.

**Recommendations for Action:**

**Community Recommendations**

- Health care providers should educate pregnant women and new mothers and other family members about the risks of SIDS and risk reduction methods in their language of preference, with records kept of the education.

- Health care providers should educate pregnant women and new mothers and other family members about the risks of SIDS and risk reduction methods in their language of preference, with records kept of the education.

- Ensure that prenatal/postpartum care providers fully follow state standards and develop collaborative relationships with community-based organizations that specialize in prenatal/postpartum outreach, education and case management.

- Educate pregnant patients and train providers on the importance of dental care in preventing poor birth outcomes and improving the mother’s overall health.

- Prenatal assessment of women must include a risk assessment for preterm birth. Questions in the prenatal intake form should include familial and family history of preterm birth. Indication of a either of familial or individual risk for preterm birth should trigger intensive health promotion, stress management, nutritional counseling, care coordination, and case management, to help reduce adverse health outcomes.

- “Perinatal care providers, including WIC programs, should routinely assess psychosocial factors, including stress and social support among pregnant women and families. Those who screen positive should be referred to appropriate support services.”71 In addition, such providers should explore use of doulas, group prenatal care, and other forms of
social support for improving maternal nutrition, and health insurance plans should support such services.  

- Develop a critical mass of people to participate in “maternal matrices” by identifying, training, and employing women who have proven resilient in response to their own life trials and tribulations.

- Pass the New York State bills sponsored by Assemblymember Amy Paulin (whose bill passed the Assembly in 2008) and Senator Kemp Hannon, providing for a state-funded education and outreach campaign for both consumers and providers to “educate the public about health risks, benefits and choices with regard to birthing procedures,” including vaginal delivery, C-sections and the use of drugs during childbirth.

- Develop community-based campaigns that educate pregnant women consistently about the risks of Cesarean sections in their language of preference using principles of adult literacy, adult education and recognizes and utilizes culturally competent content.

- Create and provide incentives for men to actively participate in supporting their mates in childbearing, rearing and breastfeeding.

- Necessary actions related to workplaces include:
  - securing workplace support including: affordable health insurance; paid maternity leave; onsite child care; flexible hours and home work; mothers' rooms (private areas to pump breast milk); and separate paid infant feeding breaks in addition to other breaks
  - dissemination of available documents related to costs and benefits of breastfeeding, and the costs and risks of alternate feeding, to appropriate policymakers, employers, consumers (e.g., *The Business Case for Breastfeeding* by the U.S. Department of Health and Human Services).

**Health Care Services Recommendations**

- Expand financial access to prenatal and postpartum care by increasing Medicaid eligibility for coverage from 200% to 250% of poverty and set clear and narrow exemptions from provider requirements to offer such state-reimbursed care.

- Expand state-funded postpartum care beyond the current limit of 90 days post-delivery to ensure continuity of access to health care services for women and their babies.

- Provide funding for additional community-based prenatal clinics in underserved areas.

- Require that state-reimbursed prenatal care include adequate amounts of non-medical services such as nutrition counseling and smoking cessation, and establish adequate monitoring mechanism to ensure that providers follow this and other standards
• Guarantee all pregnant women access to dental care as part of the prenatal continuum, as per the recommendations of the New York State Health Department.  

• Provide funding for all facilities providing prenatal care to hire multilingual, culturally competent staff and translators and to make available multi-lingual printed materials.

• Expand funding for the Community Health Worker Program to increase reach of culturally competent outreach and education efforts about eligibility for prenatal/postpartum coverage and the importance of prenatal care to more underserved pregnant women. Target overall populations (i.e., not just women of reproductive age) that are most disconnected from care, such as undocumented immigrants, teenagers, and the working poor with incomes above Medicaid-eligible level.

• Expand funding for the Healthy Families New York Home Visiting Program to provide prenatal and postpartum education and services to more underserved women.

**Systems Recommendations**

• Overall: Build a financial and programmatic infrastructure to provide women with preventive health care, including preconception and interconception care, to make prenatal care far more effective in improving women’s health and birth outcomes. First priority should go to women who have experienced premature births and/or suffered the death of an infant. Some components of this:
  
  o Expand access to public and private insurance programs to achieve universal coverage of women of childbearing age (15-44).

• Promote the Medical Home model to ensure that women have access to quality and reliable preconception and interconception care.

• Expand public and private insurance coverage to include support for smoking cessation programs among women of childbearing age.

• Build the capacity within the health care setting and the community to provide nutritional counseling to women of childbearing age in order to decrease the alarming effects of obesity.

• Provide funding for folic acid supplementation to young girls starting in school health centers.

• Support development of statewide or regional maternity care quality improvement collaboratives and develop statewide or regional database/reporting systems to provide public information on performance of various providers and facilities.
• The New York State Department of Health should monitor and evaluate NYC hospitals’ compliance with the Maternity Information Act. The NYC Health and Hospitals Corporation (HHC) should work with the NYSDOH to ensure that the city’s 12 public hospitals that offer labor and delivery services are in compliance with the law.

• The NYC Department of Health and Mental Hygiene should make up-to-date information about birthing statistics available and easily accessible on its website. The website information should be presented in a user-friendly, easy-to-read format.

• To assist community members who do not have access to computers or the Web, build the capacity of community-based agencies and providers to access this information and provide it to women in the course of their prenatal care.

**Overarching Recommendations**

• Provide women with options for receiving maternity care. Among those options should be birthing centers wherein women design and determine the content of care and health care providers serve as consultants to childbearing women.

• Expand federal support for research to better understand:
  - the causes of premature birth and low birth weight.
  - strategies for prevention that improve care and outcomes for preterm and low-birth weight infants.
  - the influences of partner support, provider encouragement, social network, and psychosocial factors impacting on maternal nutritional status and behaviors before and during pregnancy.\(^80\)
  - reproductive racial and ethnic disparities, including preconceptual and interconceptual experiences that affect birth outcomes.
  - Assets within communities of color that account for positive birth outcomes despite adverse conditions
  - Existing and needed psychosocial services for preconceptual, perinatal and interconceptual care.

• All research in disenfranchised communities should employ principles of community-based participatory research. All researchers should develop and implement studies that are culturally competent and sensitive. All research must involve the community as active participants, particularly in translating the findings and results of the inquiries into beneficial actions for the empowerment of the community.

• Support and enhance access to healthy foods and products to address the issue of obesity as a factor affecting maternal and infant health: Provide tax incentives, subsidies and other incentives to encourage grocers, restaurants, farmers markets to do business in communities hardest hit by infant mortality and to induce fast-food restaurants and stores to sell healthy produce.\(^81\)

• Undertake multimedia messaging to stimulate demand for healthy nutrition.\(^82\)
• Adopt a national, universal, single-payer health care financing system, such as that embodied in the House bill, HR 676, covering all U.S. residents, including both documented and undocumented immigrants; coverage of all medical services, mental health, dental and optical care, prescription medications, and such preventive services as screening tests, nutritional counseling, and case management; with identical rules and procedures for all states and cities, and a uniform set of administrative forms.

• In the absence of a single-payer system, incorporate expanded eligibility for Medicaid into any health care reform program, and expand access to private coverage for the remaining uninsured population.

• Expand access to public and private insurance programs so as to achieve universal coverage of women of childbearing age (15-44).83

• Fully involve communities in decisions concerning the distribution of health resources and the formulation and execution of health promotion, education and care programs.

• Increase and ensure the active role of women in the formulation and execution of health promotion, education and care programs. They can participate in this process either as members of Community Advisory Boards or as Board members. In addition, the ongoing use of community-based participatory research can engage the community in the development and implementation of programs and services.
Bronx Health Link

Health Equity Report

Preterm Births
Preterm Births

**Equity Index**

*Measure: Percentage of live births that occur before 37 weeks of pregnancy*

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<th>Location</th>
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**Issue:**

According to the March of Dimes, “Prematurity is the leading killer of America's newborns. The National Institutes of Health in its report, *Preterm Birth: Causes, Consequences and Prevention*, found that although the survival rates for preterm babies has greatly improved, these infants remain susceptible to many complications. Those who survive often have lifelong health problems, including respiratory problems, cerebral palsy, mental retardation, chronic lung disease, blindness and hearing loss.”

Babies born between 32 and 36 weeks, those that make up the majority of preterm births, are also at risk for health and developmental delays that will affect their health for years to come. Research has found that the earlier an infant is born, the higher the risk of neurodevelopmental problems. In addition to the issues affecting the baby, the cost of prematurity is tremendous. Nationwide, the cost of the care of a preterm baby is estimated at $26 billion per year. Much of this money is spent on medical care.89

Finally, according to the Institute of Medicine, “What seems certain is that any progress in our understanding and prevention of preterm births requires acknowledgement that it is not one disease with a single bullet. Any significant gains to be made in the study of preterm births are in the area of prevention.”

**Facts:**

**Trends:** According to the National Center for Health Statistics, more than 12% of infants born in the U.S. are premature. Over the last 25 years, the rate of preterm birth has increased from 9.1% to 12.7%, and the rate of late preterm deliveries (deliveries between 34 and 36 weeks) has also increased significantly since 2002. In some cases, doctors understand the reasons for premature delivery, but in other cases, there is no apparent reason for the early delivery. Percentages of babies born prematurely have been substantially increasing nationally and in the city over the past two decades.90
Inequities: Data evidences a persistent disparity in the number of preterm births to women of color. Nationally, African American/Black and Latino infants have a much higher risk of being born preterm than white infants.\textsuperscript{91} According to the National Center for Health Statistics, the number of preterm births to Latinas has increased in recent years, while rates for whites and Blacks have remained unchanged. Notwithstanding the unchanged rates for Black women, they have the highest preterm birth rate, at 18.5%. Bronx data for 2005 showed percentages of 10.7% for African-Americans vs. 9.8% for whites (Latino data unavailable). For Bronx mothers born outside the U.S., the highest percentages of preterm births were for Guyanese (14.5), Puerto Ricans (13.7), Ghanaians (12.5), and Jamaicans (11.9).\textsuperscript{92}

Contributing Factors:

- **Racial inequities**: Racial disparities in preterm births are driven by the differences in access and quality to health care, along with discrimination-induced stress and economic and environmental exposures.\textsuperscript{93} In a recent study, researchers looked at birth rate data collected over a 6 year period from the Coronary Artery Risk Development in Young adults study and found that Black women were twice as likely to give birth prematurely as white women and a greater likelihood of depression may play a role in that. The study’s lead author stated that the higher preterm birth rate among Black women might be the result of “weathering” or accelerated declines in health because of socioeconomic or other factors.”

- **Prior history of preterm births**: Studies indicate that a woman’s medical history, such as a preterm birth in a previous pregnancy, a family history of preterm birth, or if the woman was born preterm herself are all risk factors for preterm births.

- **Lack of insurance**: Prior to pregnancy, women of reproductive age (15-44) who obtain regular medical care can detect and treat medical conditions and infections that can make premature births more likely. But in 2006, 17.4% of women of those ages in New York State were uninsured.\textsuperscript{94}

- **Genital tract infections**: According to the March of Dimes, common infections of the genital tract -- bacterial vaginosis, chlamydia, and gonorrhea, as well as urinary tract infections -- account for up to 50% of preterm births.\textsuperscript{95}

- **Dental problems in the mother**: New evidence has emerged that pregnant women with periodontal disease have seven times the risk of giving birth to a low-birth-weight or preterm baby.\textsuperscript{96}

- **Inadequate folic acid consumption**: A recent study found that folic acid supplementation for at least one year before pregnancy is linked to a 50% drop in preterm deliveries at 28-32 weeks, and a 70% drop in very early preterm deliveries at 20-28 weeks.\textsuperscript{97}
• **Lead exposure**: Exposure to high levels of lead during pregnancy can contribute to preterm delivery and low birth weight. In 2005 nearly 500 NYC women of reproductive age were reported to have blood lead levels in the high-risk range.\textsuperscript{98}

• **C-sections and induced labor**: Nationally, 92% of the increase in preterm births between 1996 and 2004 was found to be due to Cesarean sections.\textsuperscript{99} In 2005, 27.5% of Bronx live births were by C-section. A rising rate of early induction of labor also has played a role in up to 25% of premature births.\textsuperscript{100}

• **Smoking**: Smoking during pregnancy can increase the risk of premature birth. Nationally, CDC data shows that in 2004 10% of pregnant women reported smoking, a drop from 20% in 1989.\textsuperscript{101}

• **Domestic violence**: Studies have found that pregnant women subjected to violence are far more likely to deliver preterm and/or low-birth-weight babies.

**Recommendations for Action:**

**Community Recommendations**

• Ensure that prenatal/postpartum care providers fully follow state standards and develop collaborative relationships with community-based organizations that specialize in prenatal/postpartum outreach, education and case management.

• Prenatal assessment of women must include a risk assessment for preterm birth. Questions in the prenatal intake form should include familial and family history of preterm birth. Indication of a either of familial or individual risk for preterm birth should trigger intensive health promotion, stress management, nutritional counseling, care coordination, and case management, to help reduce adverse health outcomes.

• “Perinatal care providers, including WIC programs, should routinely assess psychosocial factors, including stress and social support among pregnant women and families. Those who screen positive should be referred to appropriate support services.”\textsuperscript{102} In addition, such providers should explore use of doulas, group prenatal care, and other forms of social support for improving maternal nutrition, and health insurance plans should support such services.\textsuperscript{103}

• Create and provide incentives for men to actively participate in supporting their mates in childbearing, rearing and breastfeeding.

• Pass the New York State bills sponsored by Assemblymember Amy Paulin (whose bill passed the Assembly in 2008) and Senator Kemp Hannon, providing for a state-funded education and outreach campaign for both consumers and providers to “educate the public about health risks, benefits and choices with regard to birthing procedures,” including vaginal delivery, C-sections and the use of drugs during childbirth.\textsuperscript{104}
**Health Care Services Recommendations**

- Expand financial access to prenatal and postpartum care by increasing Medicaid eligibility for coverage from 200% to 250% of poverty and set clear and narrow exemptions from provider requirements to offer such state-reimbursed care.\(^{105}\)

- Expand state-funded postpartum care beyond the current limit of 90 days post-delivery to ensure continuity of access to health care services for women and their babies.

- Provide funding for additional community-based prenatal clinics in underserved areas.

- Require that state-reimbursed prenatal care include adequate amounts of non-medical services such as nutrition counseling and smoking cessation, and establish adequate monitoring mechanism to ensure that providers follow this and other standards.

- Guarantee all pregnant women access to dental care as part of the prenatal continuum, as per the recommendations of the New York State Health Department.\(^{106}\)

- Educate pregnant patients and train providers on the importance of dental care in preventing poor birth outcomes and improving the mother’s overall health.

- Provide funding for all facilities providing prenatal care to hire multilingual, culturally competent staff and translators and to make available multi-lingual printed materials\(^{107}\)

- Expand funding for the Community Health Worker Program to increase reach of culturally competent outreach and education efforts about eligibility for prenatal/postpartum coverage and the importance of prenatal care to more underserved pregnant women.\(^{108}\) Target overall populations (i.e., not just women of reproductive age) that are most disconnected from care, such as undocumented immigrants, teenagers, and the working poor with incomes above Medicaid-eligible level.\(^{109}\)

- Expand funding for the Healthy Families New York Home Visiting Program to provide prenatal and postpartum education and services to more underserved women.

- The New York State Department of Health should provide leadership in meeting the World Health Organization’s goal of a cesarean delivery rate of no more than 15 percent. Action taken should include an initiative that prioritizes reducing the cesarean rate, emphasizes continued research into the risks associated with the procedure, and establishes “best practice” procedures for all health care facilities and providers in NYC. Attention should be given to the continued monitoring of hospital data, and corresponding strategies and recommendations should be developed.\(^{110}\)

- Voluntarily review all C-section births that occur before 39 weeks gestation, to ensure they meet established American College of Obstetricians and Gynecologists (ACOG) guidelines regarding medical necessity of elective procedures.
**Systems Recommendations**

- Overall: Build a financial and programmatic infrastructure to provide women with preventive health care, including preconception and interconception care, to make prenatal care far more effective in improving women’s health and birth outcomes. First priority should go to women who have experienced premature births and/or suffered the death of an infant. Some components of this:
  - Expand access to public and private insurance programs to achieve universal coverage of women of childbearing age (15-44).\(^{1}\)
  - Promote the Medical Home model to ensure that women have access to quality and reliable preconception and interconception care.
  - Expand public and private insurance coverage to include support for smoking cessation programs among women of childbearing age.
  - Build the capacity within the health care setting and the community to provide nutritional counseling to women of childbearing age in order to decrease the alarming effects of obesity.
  - Provide funding for folic acid supplementation to young girls starting in school health centers.
  - The New York State Department of Health should monitor and evaluate NYC hospitals’ compliance with the Maternity Information Act. The NYC Health and Hospitals Corporation (HHC) should work with the NYSDOH to ensure that the city’s 12 public hospitals that offer labor and delivery services are in compliance with the law.
  - The NYC Department of Health and Mental Hygiene should make up-to-date information about birthing statistics available and easily accessible on its website. The website information should be presented in a user-friendly, easy-to-read format.
  - To assist community members who do not have access to computers or the Web, build the capacity of community-based agencies and providers to access this information and provide it to women in the course of their prenatal care.
**Overarching Recommendations**

- Expand federal support for research to improve understanding of the causes of preterm birth.

- Expand federal support for funding of research into strategies for prevention that improve care and outcomes for preterm infants.

- Provide women with options for receiving maternity care. Among those options should be birthing centers wherein women design and determine the content of care and health care providers serve as consultants to childbearing women.

- Adopt a national, universal, single-payer health care financing system, such as that embodied in the House bill, HR 676, covering all U.S. residents, including both documented and undocumented immigrants; coverage of all medical services, mental health, dental and optical care, prescription medications, and such preventive services as screening tests, nutritional counseling, and case management; with identical rules and procedures for all states and cities, and a uniform set of administrative forms.

- In the absence of a single-payer system, incorporate expanded eligibility for Medicaid into any health care reform program, and expand access to private coverage for the remaining uninsured population.

- Expand access to public and private insurance programs so as to achieve universal coverage of women of childbearing age (15-44).\(^{1f2}\)

- Support and enhance access to healthy foods and products to address the issue of obesity as a factor affecting maternal and infant health: Provide tax incentives, subsidies and other incentives to encourage grocers, restaurants, farmers markets to do business in communities hardest hit by infant mortality and to induce fast-food restaurants and stores to sell healthy produce.\(^{1f3}\)

- Fully involve communities in decisions concerning the distribution of health resources and the formulation and execution of health promotion, education and care programs.

- All research in disenfranchised communities should employ principles of community-based participatory research. All researchers should develop and implement studies that are culturally competent and sensitive. All research must involve the community as active participants, particularly in translating the findings and results of the inquiries into beneficial actions for the community.

- Increase and ensure the active role of women in the formulation and execution of health promotion, education and care programs. They can participate in this process either as members of Community Advisory Boards or as Board members. In addition, the ongoing use of community-based participatory research can engage the community in the development and implementation of programs and services.
Bronx Health Link

Health Equity Report

Low Birth Weight
Low Birth Weight

**Equity Index**

*Measure: Percentage of live births in which newborn weighs less than 2,500 grams (5 pounds, 8 ounces)*

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**Issue:**

Low birth weight is a major cause of infant mortality. In New York City in 2007, 74% of the infants who died had low birth weight, and the lower the weight, the higher the death rate.\(^\text{119}\)

Babies born with low birth weight are at risk for serious medical problems during infancy and later in life. The human toll of a low birth weight baby often adversely affects already strained families living in the Bronx. These families must address the special and often emotionally difficult needs of a low birth weight baby, often unstable employment situations (with little to no access to the benefits of the Family Medical Leave Act) and the stress of raising other, often young children.

Low birth weight can be due to premature birth or fetal growth restriction in full-term birth.\(^\text{120}\)

**Facts:**

**Trends:** Nationally, percentages of babies born with low birth weight have been rising steadily over the past two decades.\(^\text{121}\) The preterm rate has increased by 36 percent since the 1980’s and although there was a decline in the rate of low birth weight in 2007 (the rate of pre term birth dropped from 12.8 to 12.7), the number of babies born at 34-36 weeks of gestation was more than 540,000.

**Inequities:** Low birth weight in New York City was highest in 2007 for Black babies at 13%, followed by Latino and Asian/Pacific Islander babies, both at 8%, compared to white babies at 7%.\(^\text{122}\) In 2005 in the Bronx, mothers of certain nationalities had particularly high percentages of low-birth-weight babies: Puerto Ricans, 12%; Guyanese, 15%; Jamaicans, 13%; and Ghanaians, 12%.\(^\text{123}\)
Contributing Factors:

There are many factors affecting low birth weight (many of which also affect pre-term births). We have chosen the following to highlight the complicated nature of this problem:

- **Racial inequities**: Racial disparities in low birth weight are driven by the differences in access and quality to health care, along with discrimination-induced stress and economic and environmental exposures.\(^{124}\)

- **Socioeconomic factors**: Low income and lack of education are associated with increased risk of having a low-birthweight baby, although the underlying reasons for this are not well understood. Black women and women under 17 and over 35 years of age also are at increased risk.

- **Lack of insurance**: Prior to pregnancy, women of reproductive age (15-44) who obtain regular medical care can detect and treat conditions and infections that can make low birth weight babies more likely. But in 2006, 17.4% of women of those ages in New York State were uninsured.\(^{125}\)

- **Chronic health problems in the mother**: Maternal high blood pressure, diabetes, and heart, lung and kidney problems can sometimes reduce birth weight.\(^{126}\)

- **Inadequate maternal weight gain**: Women who don’t gain enough weight during pregnancy increase their risk of having a low-birth-weight baby.

- **Dental problems in the mother**: New evidence has emerged that pregnant women with periodontal disease have seven times the risk of giving birth to a low-birth-weight or preterm baby.\(^{127}\)

- **Infections in the mother**: Certain infections, especially those involving the uterus, may increase the risk of preterm delivery or low birth weight.\(^{128}\)

- **Alcohol and illicit drugs**: Consuming alcohol and some illicit drugs during pregnancy increases the risk of low birth weight.\(^{129}\)

- **Smoking**: Infants born to mothers who smoke during pregnancy are reported to be 65% more likely to have low birth weight.\(^{130}\) Nationally, CDC data shows that in 2004 10% of pregnant women reported smoking, a drop from 20% in 1989.\(^{131}\)

- **External environmental exposures**: Many studies have linked low birth weight to residential environmental exposures, including air pollution, substances in drinking water, and industrial chemicals.\(^{132}\) One study that included Dominican and African
American mothers in the South Bronx found that exposure of pregnant women to pollutants from vehicle exhaust led to significantly reduced fetal growth, with more severe effects in smoking households.133

- **Domestic violence:** Research has shown that pregnant women subjected to violence are at higher risk for not only serious health damage to themselves, but also for delivering underweight babies.134 A 2006 NYC survey found that 3.2% of pregnant women citywide and 9% of Bronx women reported that they had been subjected to intimate partner violence during their last pregnancy.135

- **Infections in the fetus:** Certain viral and parasitic infections, including cytomegalovirus, rubella, chickenpox and toxoplasmosis, can slow fetal growth and cause birth defects.

- **Birth defects:** Babies with certain birth defects are more likely to have their growth restricted.

- **Placental problems:** Placental problems can reduce flow of blood and nutrients to the fetus, limiting growth.

**Recommendations for Action:**

**Community Recommendations**

- Ensure that prenatal/postpartum care providers fully follow state standards and develop collaborative relationships with community-based organizations that specialize in prenatal/postpartum outreach, education and case management.

- Pass the New York State bills sponsored by Assemblymember Amy Paulin (whose bill passed the Assembly in 2008) and Senator Kemp Hannon, providing for a state-funded education and outreach campaign for both consumers and providers to “educate the public about health risks, benefits and choices with regard to birthing procedures,” including vaginal delivery, C-sections and the use of drugs during childbirth.136

- Prenatal assessment of women must include a risk assessment for preterm birth. Questions in the prenatal intake form should include familial and family history of preterm birth. Indication of a either of familial or individual risk for preterm birth should trigger intensive health promotion, stress management, nutritional counseling, care coordination, and case management, to help reduce adverse health outcomes.

- “Perinatal care providers, including WIC programs, should routinely assess psychosocial factors, including stress and social support among pregnant women and families. Those who screen positive should be referred to appropriate support services.”137 In addition, such providers should explore use of doulas, group prenatal care, and other forms of social support for improving maternal nutrition, and health insurance plans should support such services.138
• Create and provide incentives for men to actively participate in supporting their mates in childbearing, rearing and breastfeeding.

**Health Care Services Recommendations**

• Expand financial access to prenatal and postpartum care by increasing Medicaid eligibility for coverage from 200% to 250% of poverty and set clear and narrow exemptions from provider requirements to offer such state-reimbursed care. \(^{139}\)

• Expand state-funded postpartum care beyond the current limit of 90 days post-delivery to ensure continuity of access to health care services for women and their babies.

• Provide funding for additional community-based prenatal clinics in underserved areas.

• Require that state-reimbursed prenatal care include adequate amounts of non-medical services such as nutrition counseling and smoking cessation, and establish adequate monitoring mechanism to ensure that providers follow this and other standards.

• Guarantee all pregnant women access to dental care as part of the prenatal continuum, as per the recommendations of the New York State Health Department. \(^{140}\)

• Educate pregnant patients and train providers on the importance of dental care in preventing poor birth outcomes and improving the mother’s overall health.

• Provide funding for all facilities providing prenatal care to hire multilingual, culturally competent staff and translators and to make available multi-lingual printed materials. \(^{131}\)

• Expand funding for the Community Health Worker Program to increase reach of culturally competent outreach and education efforts about eligibility for prenatal/postpartum coverage and the importance of prenatal care to more underserved pregnant women. \(^{142}\) Efforts should target overall populations (i.e., not just women of reproductive age) that are most disconnected from care, such as undocumented immigrants, teenagers, and the working poor with incomes above Medicaid-eligible level. \(^{143}\)

• Expand funding for the Healthy Families New York Home Visiting Program to provide prenatal and postpartum education and services to more underserved women.

• The New York State Department of Health should provide leadership in meeting the World Health Organization’s goal of a cesarean delivery rate of no more than 15 percent. Action taken should include an initiative that prioritizes reducing the cesarean rate, emphasizes continued research into the risks associated with the procedure, and establishes “best practice” procedures for all health care facilities and providers in NYC. Attention should be given to the continued monitoring of hospital data, and corresponding strategies and recommendations should be developed. \(^{144}\)
Voluntarily review all C-section births that occur before 39 weeks gestation, to ensure they meet established American College of Obstetricians and Gynecologists (ACOG) guidelines regarding medical necessity of elective procedures.

**Systems Recommendations**

Overall: Build a financial and programmatic infrastructure to provide women with preventive health care, including preconception and interconception care, to make prenatal care far more effective in improving women’s health and birth outcomes. First priority should go to women who have experienced premature births and/or suffered the death of an infant. Some components of this:

- Expand access to public and private insurance programs to achieve universal coverage of women of childbearing age (15-44).[^1]

- Promote the Medical Home model to ensure that women have access to quality and reliable preconception and interconception care.

- Expand public and private insurance coverage to include support for smoking cessation programs among women of childbearing age.

- Build the capacity within the health care setting and the community to provide nutritional counseling to women of childbearing age in order to decrease the alarming effects of obesity.

- Provide funding for folic acid supplementation to young girls starting in school health centers.

- The New York State Department of Health should monitor and evaluate NYC hospitals’ compliance with the Maternity Information Act. The NYC Health and Hospitals Corporation (HHC) should work with the NYSDOH to ensure that the city’s 12 public hospitals that offer labor and delivery services are in compliance with the law.

- The NYC Department of Health and Mental Hygiene should make up-to-date information about birthing statistics available and easily accessible on its website. The website information should be presented in a user-friendly, easy-to-read format.

- To assist community members who do not have access to computers or the Web, build the capacity of community-based agencies and providers to access this information and provide it to women in the course of their prenatal care.

**Overarching Recommendations**

- Expand federal support for research to improve understanding of the causes of low birth weight.
• Expand federal support for funding of research into strategies for prevention that improve care and outcomes for low birth-weight infants.

• Provide women with options for receiving maternity care. Among those options should be birthing centers wherein women design and determine the content of care and health care providers serve as consultants to childbearing women.

• Institute a national, universal, single-payer health care financing system, such as that embodied in the House bill, HR 676, which covers all U.S. residents, including both documented and undocumented immigrants; coverage of all medical services, mental health, dental and optical care, prescription medications, and such preventive services as screening tests, nutritional counseling, and case management; with identical rules and procedures for all states and cities, and a uniform set of administrative forms.

• In the absence of a single-payer system, incorporate expanded eligibility for Medicaid into any health care reform program, and expand access to private coverage for the remaining uninsured population.

•Expand access to public and private insurance programs so as to achieve universal coverage of women of childbearing age (15-44).\textsuperscript{146}

• Support and enhance access to healthy foods and products to address the issue of obesity as a factor affecting maternal and infant health: Provide tax incentives, subsidies and other incentives to encourage grocers, restaurants, farmers markets to do business in communities hardest hit by infant mortality and to induce fast-food restaurants and stores to sell healthy produce.\textsuperscript{147}

• Fully involve communities in decisions concerning the distribution of health resources and the formulation and execution of health promotion, education and care programs.

• All research in disenfranchised communities should employ principles of community-based participatory research. All researchers should develop and implement studies that are culturally competent and sensitive. All research must involve the community as active participants, particularly in translating the findings and results of the inquiries into beneficial actions for the community.

• Increase and ensure the active role of women in the formulation and execution of health promotion, education and care programs. They can participate in this process either as members of Community Advisory Boards or as Board members. In addition, the ongoing use of community-based participatory research can engage the community in the development and implementation of programs and services.
**Prenatal Care**

**Equity Index**

*Measure: Percentage of total live births to women who received late or no prenatal care*

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**Issue:**

Prenatal care is key to healthy pregnancy and childbirth, and must start early to be fully effective. It includes not only health screening and care, but also education and counseling about many aspects of pregnancy and childbirth, including nutrition, physical activity, and skills in infant care. One study noted, “Early and continuous prenatal care provides women with opportunities for ongoing assessment for one of the most significant complications of pregnancy -- low birth weight.”

A policy review reported that prenatal care “saves money because it reduces the need for emergency treatment and long-term care for preventable complications. One study has estimated that every $1 cut from prenatal care…would correlate to $3.33 in postnatal care costs and $4.63 for long-term morbidity care.”

When prenatal care is delayed or sporadic, it undermines the woman’s ability to prevent health problems from deteriorating and potentially jeopardizing the health and life of both mother and infant. Such inconsistent care also makes it harder for the woman to obtain the information and skills necessary to make informed decisions and take control of her own health care.

While the value of early and consistent prenatal care has been established, in recent years a consensus has developed in the maternal/child health field that it is not sufficient to make major headway in improving negative birth outcomes. Only through longer-term programs of preconception and interconception care can those gains be achieved. However, there is minimal funding for such programs, and so many women – particularly of low-incomes – have no access.

In order to expand the access of low-income pregnant women to prenatal, delivery, and postpartum care, Medicaid legislation has required states to offer coverage of the core services to all pregnant women with incomes of up to 133% of the federal poverty level. States can receive federal matching funds for coverage of pregnant women with incomes up to and beyond 185% of the poverty level. Immigrants are generally banned from
Medicaid coverage for the first five years in the U.S., but states can cover residents without federal funds if they so choose.

In New York State, two Medicaid programs provide no-cost coverage of these services to pregnant women with incomes up to 200% of the poverty level. The Prenatal Care Assistance Programs (PCAPs) are state-approved hospitals and clinics offering the services; the Medicaid Obstetrical and Maternal Services (MOMS) Program provides these services where PCAP health centers are not located. Both programs offer routine pregnancy checkups, hospital care during pregnancy and delivery, full health care for the woman until at least two months after delivery, and full health care coverage for the baby up to one year of age.\textsuperscript{156} PCAP has been a very successful program. One of the reasons is that because of a federal court decision, pregnant women are eligible for PCAP regardless of their immigration status. Also the PCAP program has a simplified application process. Presumptive eligibility makes a pregnant women immediately eligible once her pregnancy is confirmed. A full, but shorter, application is then submitted.

New York State is currently proposing to incorporate PCAP into the Medicaid program, so that the same standards will be applied for the care of all pregnant women. Some concerns have been raised about losing the unique features of PCAP if it is incorporated and no longer a separate Medicaid program.

**Facts:**

**Trends:** Percentages of mother receiving late or no prenatal care have declined substantially over the past two decades nationally and in New York City.\textsuperscript{157} According to the National Center for Health Statistics, “These gains were linked to the expansion of Medicaid for pregnant women in the late 1980s; studies suggest that more recent changes to welfare and Medicaid policy might limit further improvements in timely care.”\textsuperscript{158}

**Inequities:** Nationally in 2006, only 5.2% of white pregnant women had late or no prenatal care, compared to 11.8% of African Americans and 12.2% of Latinas.\textsuperscript{159} In New York City in 2007, the numbers were 2.5% for whites, 8.8% for African Americans, 5.0% for Puerto Ricans, 6.7% for other Latinas, and 5.0% for Asians.\textsuperscript{160} The mothers of particular ancestries with the highest percentages were: Trinidadians (13.7), Pakistanis (12.9), Latin Americans (11.7), Haitian (11.6), and Bangladeshi (10.9).\textsuperscript{161}

**Barriers:**

Surveys of NYC women and focus groups with Bronx women have found a variety of institutional deficiencies and barriers, as well as lack of insurance coverage and inadequate programs to counter lack of knowledge about available coverage and unwarranted fears of punitive actions that prevent or delay women’s entry into prenatal care. Specifically:
Problems obtaining care

- Transportation problems: excessive distance or expense
- Providers who don’t accept Medicaid
- Difficulty securing appointments
- Limited provider hours (and lack of time off from work)
- Long waiting times and clinic overcrowding
- Language barriers (lack of translators). Resulting poor communication can be traumatic for the woman; in one New York Hospital, a non-English-speaking Latina immigrant had her pregnant aborted and was sterilized after signing an English-language consent form that she believed authorized “saving the baby.”
- Racial stereotyping, insensitive or unresponsive treatment by providers
- Lack of child care
- Institutional barriers: In one survey of women denied an appointment, 22% were told they needed to first speak with a financial director or coordinator of the PCAP, 22% were told to repeat a pregnancy test, and 20% were told to register first.

Lack of insurance coverage: The state’s prenatal care coverage program only covers women with family income up to 200% of the federal poverty level. According to the Guttmacher Institute, 18% of women of childbearing age (15-44) in New York State are uninsured. In numerous studies, researchers have found that uninsured pregnant women are less likely to receive prenatal care than women who have private insurance. In a 2002 study that examined the relationship between the timing of insurance coverage and use of prenatal care among low-income women in California, the researchers found that although only 2% of women remained uninsured throughout the pregnancy, one-fifth lacked coverage during the critical first trimester. Rates of untimely care were the highest among women who were uninsured throughout their pregnancy or whose coverage began after the first trimester; rates were lowest among women who obtained coverage during the first trimester.

Lack of knowledge of available coverage: One study found that 33% of women whose prenatal care was paid for by Medicaid or state programs delayed care because they believed they lacked the money or insurance to pay for their visits.

Lack of awareness of pregnancy during early stages, often due to unintended pregnancy. Also, women without ongoing insurance or access to family planning services may not learn they are pregnant until they are far along.

Among undocumented immigrants, fear of deportation.

Fear of penalties (such as child removal) for health habits such as drug or alcohol use, as well as inadequate drug treatment facilities that accept pregnant women.

Recommendations for Action:

Community Recommendations
• Ensure that prenatal/postpartum care providers fully follow state standards and develop collaborative relationships with community-based organizations that specialize in prenatal/postpartum outreach, education and case management.

• Prenatal assessment of women must include a risk assessment for preterm birth. Questions in the prenatal intake form should include familial and family history of preterm birth. Indication of a either of familial or individual risk for preterm birth should trigger intensive health promotion, stress management, nutritional counseling, care coordination, and case management, to help reduce adverse health outcomes.

• “Perinatal care providers, including WIC programs, should routinely assess psychosocial factors, including stress and social support among pregnant women and families. Those who screen positive should be referred to appropriate support services.” In addition, such providers should explore use of doulas, group prenatal care, and other forms of social support for improving maternal nutrition, and health insurance plans should support such services.

• Create and provide incentives for men to actively participate in supporting their mates in childbearing, rearing and breastfeeding.

• Pass the New York State bills sponsored by Assemblymember Amy Paulin (whose bill passed the Assembly in 2008) and Senator Kemp Hannon, providing for a state-funded education and outreach campaign for both consumers and providers to “educate the public about health risks, benefits and choices with regard to birthing procedures,” including vaginal delivery, C-sections and the use of drugs during childbirth.

• Necessary actions related to workplaces include:
  
  o securing workplace support including: affordable health insurance; paid maternity leave; onsite child care; flexible hours and home work; mothers' rooms (private areas to pump breast milk); and separate paid infant feeding breaks in addition to other breaks
  
  o dissemination of available documents related to costs and benefits of breastfeeding, and the costs and risks of alternate feeding, to appropriate policymakers, employers, consumers (e.g., The Business Case for Breastfeeding by the U.S. Department of Health and Human Services).

**Health Care Services Recommendations**

• Expand financial access to prenatal and postpartum care by increasing Medicaid eligibility for coverage from 200% to 250% of poverty and set clear and narrow exemptions from provider requirements to offer such state-reimbursed care.
• Expand state-funded postpartum care beyond the current limit of 90 days post-delivery to ensure continuity of access to health care services for women and their babies.

• Provide funding for additional community-based prenatal clinics in underserved areas.

• Require that state-reimbursed prenatal care include adequate amounts of non-medical services such as nutrition counseling and smoking cessation, and establish adequate monitoring mechanism to ensure that providers follow this and other standards.

• Guarantee all pregnant women access to dental care as part of the prenatal continuum, as per the recommendations of the New York State Health Department.  

• Educate pregnant patients and train providers on the importance of dental care in preventing poor birth outcomes and improving the mother’s overall health.

• Provide funding for all facilities providing prenatal care to hire multilingual, culturally competent staff and translators and to make available multi-lingual printed materials.

• Expand funding for the Community Health Worker Program to increase reach of culturally competent outreach and education efforts about eligibility for prenatal/postpartum coverage and the importance of prenatal care to more underserved pregnant women. Target overall populations (i.e., not just women of reproductive age) that are most disconnected from care, such as undocumented immigrants, teenagers, and the working poor with incomes above Medicaid-eligible level.

• Expand funding for the Healthy Families New York Home Visiting Program to provide prenatal and postpartum education and services to more underserved women.

• The New York State Department of Health should provide leadership in meeting the World Health Organization’s goal of a cesarean delivery rate of no more than 15 percent. Action taken should include an initiative that prioritizes reducing the cesarean rate, emphasizes continued research into the risks associated with the procedure, and establishes “best practice” procedures for all health care facilities and providers in NYC. Attention should be given to the continued monitoring of hospital data, and corresponding strategies and recommendations should be developed.

• Set aggressive goals for improvement in C-section practices as part of public agency contracts for Medicaid and health care agencies.

• Voluntarily review all C-section births that occur before 39 weeks gestation, to ensure they meet established American College of Obstetricians and Gynecologists (ACOG) guidelines regarding medical necessity of elective procedures.

**Systems Recommendations**
• Overall: Build a financial and programmatic infrastructure to provide women with preventive health care, including preconception and interconception care, to make prenatal care far more effective in improving women’s health and birth outcomes. First priority should go to women who have experienced premature births and/or suffered the death of an infant. Some components of this:

  o Expand access to public and private insurance programs to achieve universal coverage of women of childbearing age (15-44).  

• Promote the Medical Home model to ensure that women have access to quality and reliable preconception and interconception care.

• Expand public and private insurance coverage to include support for smoking cessation programs among women of childbearing age.

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• Provide funding for folic acid supplementation to young girls starting in school health centers.

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• To assist community members who do not have access to computers or the Web, build the capacity of community-based agencies and providers to access this information and provide it to women in the course of their prenatal care.
Overarching Recommendations

• Expand federal support for research to improve understanding of the causes of low birth weight and preterm birth.

• Expand federal support for funding of research into strategies for prevention that improve care and outcomes for low birth-weight and preterm infants.

• Fund research into aspects of birthing procedures about which more data is needed, including:
  o possible harms of C-sections, including long term effects in women and children (using comparison groups when possible)
  o factors affecting women’s choices of birthing procedures
  o data on ethnicity and socioeconomic status.
  o impact of the liability system on maternity care, and ways to limit unintended effects

• Apply research results to education about and payment policies for birthing procedures.

• Thoroughly explore mechanisms to use payment policies to reduce unnecessary C-sections, including reducing payments for overused services, increasing payments for underused services, rewarding high-performing providers and facilities, and providing incentives to women for selecting such providers and facilities.

• Support development of statewide or regional maternity care quality improvement collaboratives and develop statewide or regional database/reporting systems to provide public information on performance of various providers and facilities.

• Adopt a national, universal, single-payer health care financing system, such as that embodied in the House bill, HR 676, covering all U.S. residents, including both documented and undocumented immigrants; coverage of all medical services, mental health, dental and optical care, prescription medications, and such preventive services as screening tests, nutritional counseling, and case management; with identical rules and procedures for all states and cities, and a uniform set of administrative forms.

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• Expand access to public and private insurance programs so as to achieve universal coverage of women of childbearing age (15-44).

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• Increase and ensure the active role of women in the formulation and execution of health promotion, education and care programs. They can participate in this process either as members of Community Advisory Boards or as Board members. In addition, the ongoing use of community-based participatory research can engage the community in the development and implementation of programs and services.

• All research in disenfranchised communities should employ principles of community-based participatory research. All researchers should develop and implement studies that are culturally competent and sensitive. All research must involve the community as active participants, particularly in translating the findings and results of the inquiries into beneficial actions for the community.
Bronx Health Link

Health Equity Report

Teen Pregnancy
Teen Pregnancy

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<td>Upper East Side (2007): 185</td>
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**Issue:**

According to Advocates for Youth, “the vast majority (at least 85%) of teen pregnancies are unintended.” The rates of pregnancy, birth, sexually transmitted infections (STIs), and abortion among teenagers are considerably higher in the United States than the rates in Canada, Britain, France, Ireland, the Netherlands, Sweden, Japan, and most other developed countries. Yet, U.S. teens are less likely to use contraception or to consistently use more effective methods of contraception when compared to the teens of several other developed countries. This situation begs the question – why? Obviously, young people in those other countries have better health outcomes, less teen pregnancies and lower rates of STIs than their US counterparts, although data show that U.S. teens’ sexual behavior is similar to teens of other developed countries in terms of when they start to have sex and how often they are having it.

This paradigm is not new and worsens each year. It is within this context, that teenagers in the Bronx have been giving birth at levels far exceeding any other NYC borough, and more than twice the levels in Manhattan and Queens.

Adolescent pregnancy is associated with higher rates of illness and death for both the mother and the child. One contributor to the sometimes worse birth outcomes for teen mothers may be the lower levels of prenatal care. In the Bronx in 2007, 9.2% of the teens delivering live babies received late or no prenatal care, compared to 6.1% of women of all ages.

Babies born to adolescents are, compared to babies born to older women:

- more likely to be pre-term \(^{188}\)
- more likely to be low birth weight \(^{189}\)
- more likely to die before the age of one year - Nationally, in 2005, the most recent data available, the infant mortality rate for mothers aged 10-19 was 10.2 deaths per 1,000 live births, exceeding even the 7.8 rate among mothers over 40, a very high-risk group. \(^{190}\)
In addition, the life for the teen mother and her baby is often difficult, as many teen mothers have lower annual incomes. More than 75% of unmarried teen mothers receive welfare within five years of the birth of their first child. As the National Campaign to Prevent Teen Pregnancy has written, “…although disadvantaged backgrounds account for many of the burdens that young women shoulder, having a baby during adolescence only makes matters worse.” Specifically:

- Teenage mothers are more likely to drop out of school. Only about one-third of teen mothers obtain a high school diploma. Only 40% of teenagers who have children before age 18 go on to graduate from high school, compared to 75% of teens from similar social and economic backgrounds who do not give birth until ages 20 or 21.

- Teenage pregnancies are associated with increased rates of alcohol and substance abuse, lower educational level, and reduced earning potential in teen fathers.

- In the United States, the annual cost of teen pregnancies from lost tax revenues, public assistance, child health care, foster care, and involvement with the criminal justice system is estimated to be about $7 billion.

**Facts:**

**Trends:** As has occurred nationally, teen births in NYC have declined in the past two decades, from 10.3% of all live births in 1987 to 6.9% in 2007, a 33% drop. But in the Bronx, that decline has been more modest, from 15.1% in 1987 to 12.0% in 2007, a 20% drop.

**Inequities:** As with all aspects of maternal/child health, births to teens show drastic racial disparities. Nationally, in 2005, the proportion of young women who have babies by age 20 was 32% of Latinas, 24% of African Americans, 11% of whites, and 7% of Asians. In New York City in 2007, based on mother’s ancestry, the percentages of live births to teenagers (a different measure) were 15.4% for Puerto Ricans, 13.2% for African Americans, 11.6% for Mexicans, 11.6% for other Latinas, with the numbers for other nationalities far lower (numbers for whites were not collectively calculated). In the Bronx, for the period 2003-5 (most recent data available), the percentages of teen births were 17.8% for Puerto Ricans, 10.7% for African Americans, 5.5% for whites, and 2.7% for Asians. On the national level, the National Campaign to Prevent Teen and Unplanned Pregnancy reported in 2008, “Recent data suggests that the significant progress the nation has made in reducing teen sexual activity, improving contraceptive use among sexually active teens, and reducing the teen birth rate has stagnated or reversed – for minorities in particular.”

**Contributing Factors:**

More than 400 studies have examined the risk and protective factors for teen pregnancy – that is, those that make it more likely or less likely that the adolescent will have
unprotected sex leading to pregnancy. One exhaustive research review highlighted, among others, the following factors that can be affected by public policy (as opposed to those such as physical maturity and age which are fixed): 

**Disadvantage, disorganization and dysfunction.** Teens who live in communities, families and peer circles with these characteristics—those with higher rates of substance abuse, violence, and hunger—are more likely to begin having sex early and to have a child. The majority of studies found that teens in families with higher incomes were less likely to become pregnant or to bear children. In addition, teens who live with both parents and enjoy close relationships with them are less likely to have unprotected sex and become pregnant.

**Sexual values, attitudes and norms, and modeling of sexual behavior.** The values, attitudes and concerns about sex, condoms, contraception, pregnancy, childbearing and STIs held by the teens themselves, their peers, and their family members strongly influence their sexual behaviors.

**Connection to adults and organizations that discourage sex, unprotected sex, or early childbearing.** Studies demonstrate that connection to parents, groups or organizations (schools, places of worship, and community organizations) with such values and practices can influence teen behavior. Some studies suggest that having a mentor, participating more in community activities, and being involved in more community organizations also protect against sexual risk-taking.

**Access to sexual and reproductive health services.** Two studies have found that state funding for family planning services is related to lower teen childbirth rates. Not included in this review is another key finding by researchers that affects teen pregnancy rates:

**Contraceptive use.** One study found that 46% of pregnancy risk among U.S. high school students resulted from failure to use any method of contraception, and 54% resulted from contraceptive failure. Conversely, another analysis found that 86% of the decline in teen pregnancy between 1995 and 2002 was due to dramatic improvements in contraceptive use (including higher overall use, use of more effective methods, and use of multiple methods). The other 14% of the decline was attributed to delay in initiating sexual intercourse.

**Factors leading to lower teen birth rates in other developed countries.** Among the factors identified in one review:

- “Strong societal messages convey that childbearing should occur only in adulthood, which is considered to be when young people have completed their education, are employed and are living in stable relationships. Societal supports exist to help young people with the transition to adulthood, through vocational training, education and job
placement services, and child care. As a result, teens have positive incentives to delay childbearing.”

- “Teens in other developed countries also have greater access to contraceptives and reproductive health services than teens in the United States, and they receive comprehensive education about pregnancy and STI prevention in schools and community settings. In contrast, sex education that promotes abstinence and discourages sex and contraceptive use is common in U.S. public schools.”203 Another study offered a factor that contributes to the racial disparity in teen birth rates: It found that Black and Latino teens are significantly less likely than white teens to receive instruction about birth control methods and more likely to have been taught abstinence only, before initiating sex.204

**Recommendations for Action:**

**Community Recommendations**

- Ensure that prenatal/postpartum care providers fully follow state standards and develop collaborative relationships with community-based organizations that specialize in prenatal/postpartum outreach, education and case management.

- Pass the New York State bills sponsored by Assemblymember Amy Paulin (whose bill passed the Assembly in 2008) and Senator Kemp Hannon, providing for a state-funded education and outreach campaign for both consumers and providers to “educate the public about health risks, benefits and choices with regard to birthing procedures,” including vaginal delivery, C-sections and the use of drugs during childbirth.205

- Necessary actions related to workplaces include:
  - securing workplace support including: affordable health insurance; paid maternity leave; onsite child care; flexible hours and home work; mothers’ rooms (private areas to pump breast milk); and separate paid infant feeding breaks in addition to other breaks

**Health Care Service Recommendations**

- Expand state-funded postpartum care beyond the current limit of 90 days post-delivery to ensure continuity of access to health care services for women and their babies.

- Provide funding for additional community-based prenatal clinics in underserved areas.

- Expand funding for the Community Health Worker Program to increase reach of culturally competent outreach and education efforts about eligibility for prenatal/postpartum coverage and the importance of prenatal care to more underserved pregnant women.206 Efforts should target overall populations (i.e., not just women of reproductive age) that are most disconnected from care, such as undocumented
immigrants, teenagers, and the working poor with incomes above Medicaid-eligible level.207

- Build a financial and programmatic infrastructure to provide women with preventive health care, including preconception and interconception care, to supplement prenatal care and make it far more effective in improving women’s health and birth outcomes. Specifically:
  - Expand access to public and private insurance programs to achieve universal coverage of women of childbearing age (15-44).208
  - Promote the Medical Home model to ensure that women have access to quality and reliable preconception and interconception care.
  - Expand public and private insurance coverage to include support for smoking cessation programs among women of childbearing age.
  - Build the capacity within the health care setting and the community to provide nutritional counseling to women of childbearing age in order to decrease the alarming effects of obesity.
  - Provide funding for folic acid supplementation to young girls starting in school health centers.

**Systems Recommendations**

- **Sex education.** Pass the federal Responsible Education About Life (REAL) Act, which supports state sex education programs following principles that include teaching young people skills for responsible sexual decision-making, including but not limited to abstinence.209

- **Affordable family planning services.** Include pregnancy prevention in any plan for health care reform. This would include funds for affordable family planning counseling, services and coverage of the full range of contraceptive options programs for the uninsured and underinsured, through expanded eligibility for Medicaid, Title X, and the State Children’s Insurance Program (SCHIP).210

- **Funding for hard-hit communities.** Focus investment in family planning programs in communities with the highest rates of teen pregnancies – particularly Black and Latino communities. This would include targeted funding for community-based interventions, school-based projects and multimedia educational campaigns.211

- **Expanded access to Emergency Contraception.** Emergency Contraception (EC) can block conception if taken within 120 hours of intercourse. Pass the NYS bill that would expand access to women and men who are 17 and under.212
• **Pharmacy access to birth control.** Enact policies prohibiting pharmacists from refusing (for “moral” or other reasons) to fill legal, valid prescriptions for birth control or EC.  

• **Teens’ right to choose reproductive care.** Oppose any measures seeking to require parental notification or permission for teenagers’ access to abortion, contraception or any other reproductive services.

• **Programs on responsibilities of men.** Fund programs to emphasize responsibilities of men in preventing unplanned teen pregnancies, including responsible fatherhood, workforce development programs, and re-entry programs.

• **Public health campaign using digital and social media.** Fund an innovative public health campaign to help young adults focus clearly and intensely on pregnancy prevention and planning, with a heavy emphasis on digital and social media.

• **Research on effective programs.** Fund research aimed at developing a range of effective, high-quality strategies, including programs for underserved populations with high pregnancy rates including youth in foster care and communities of color.

• **Research on racial disparities.** Fund research into reasons for racial disparities in teen pregnancy and birth rates.

**Overarching Recommendations**

• Adopt a national, universal, single-payer health care financing system, such as that embodied in the House bill, HR 676, covering all U.S. residents, including both documented and undocumented immigrants; coverage of all medical services, mental health, dental and optical care, prescription medications, and such preventive services as screening tests, nutritional counseling, and case management; with identical rules and procedures for all states and cities, and a uniform set of administrative forms.

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• Expand access to public and private insurance programs to achieve universal coverage of women of childbearing age (15-44).

• Fully involve communities in decisions concerning the distribution of health resources and the formulation and execution of health promotion, education and care programs.

• Increase and ensure the active role of women in the formulation and execution of health promotion, education and care programs. They can participate in this process either as members of Community Advisory Boards or as Board members. In addition, the ongoing use of community-based participatory research can engage the community in the development and implementation of programs and services.
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Bronx Health Link

Health Equity Report

Breastfeeding
Breastfeeding

Equity Index

Measure: Percentage of women who breastfed their most recent child

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* Except for NYC
** 3 months.
*** In early postpartum period

Issue:

Breastfeeding is more than just about nourishment for the infant; it is a significant step towards good health and development of the baby and the mother. Doctors agree that any amount of breastfeeding -- even during just the first few weeks -- offers the baby a host of health and developmental benefits. Numerous studies have shown that breastfeeding correlates with lower levels of infant diarrhea, ear infections, pneumonia, meningitis, and infant mortality, and later in life, diabetes, obesity, asthma, leukemia, lymphoma and other illnesses. In addition, nursing mothers have various health benefits in the postpartum period and lower risks of later diabetes, breast and ovarian cancer, and osteoporosis.\textsuperscript{222} Exclusive breastfeeding (i.e., without using infant formula) is now the standard recommended for at least the first six months of life.

However, despite the clear benefits to both mother and child, breastfeeding is not the routine for women who are poor, work in economically marginalized jobs, and do not have the social support available to women in other social classes. Progress is being made slowly, but there must be a shift in how we view and address breastfeeding, how we offer support and how we advocate for change. Breastfeeding is a powerful issue; approaches to increase the number of women who engage in it must be non-judgmental and compassionate. We must appreciate that in deciding to breastfeed, mothers must counter the effects of years of mass media coverage and cultural practices that supported bottle feeding, the sexual objectification of the breast and a labor market system that does not take into account the demands of motherhood. There must be a new view of work which appreciates the whole woman and not just her labor and contributions to the means of production.

Breastfeeding is a public health necessity and is a vital aspect of reproductive health. Women must have the right to breastfeed freely and without constraint and there must be support for a shift in the paradigm where breastfeeding is viewed as a "lifestyle choice" to
a paradigm in which it is a "human right". This shift will ensure the social, economic and political conditions necessary to promote success in increasing the number of women who initiate and continue breastfeeding for the duration that is optimal for the mother and her baby. Arrangements must be made to support women in the workforce and this may include legislation that provides adequate maternity leave, nursing breaks, affordable child care and other strategies that allows for a work place that values and respects the contributions of the female workforce.

**Facts:**

**Trends:** Percentages of mother who breastfeed have increased steadily over the past decade and a half nationally and in New York City, but compliance with the recommendation on exclusive breastfeeding remains more elusive. Women report understanding the benefits of breastfeeding but issues such as lack of familial and community support, an inability to breastfeed or pump at the workplace and other issues serve as barriers to long term breastfeeding in many cases.

**Inequities:** In NYC, according to 2006 survey data, 86% of white mothers reported having ever breastfed vs. 87% of Latinas and 80% of Blacks. Of those who had exclusively breastfed for 8 weeks or more, the figures were 42% of white mothers, 32% of Latinas and 24% of Blacks.223 Other studies have found that immigrant mothers of whatever ethnicity have much higher rates of breastfeeding than U.S.-born mothers.224

**Barriers:**

Throughout pregnancy, women hear that "breast is best." The U.S. Healthy People 2010 target is to increase the proportion of mothers who choose to breastfeed their babies for at least six months to 50 percent. The American Academy of Pediatrics (AAP) recommends that mothers breastfeed for at least 12 months. In a policy statement, the AAP says breastfeeding is "primary in achieving optimal infant and child health, growth, and development." Yet, many mothers initiate breastfeeding only to stop before the recommended time.

Breastfeeding for some women is not as easy as it looks. Many who have tried discuss the problems with sore nipples and mastitis, an inflammation of the mammary glands, as impediments to successful and prolonged breastfeeding. In addition, some babies may also be given pacifiers and formula in their early days seems to deter long-term breastfeeding.

The pressure of returning to work is another issue. Most industrialized nations guarantee maternity leave for up to 16 weeks at 75 percent to 100 percent of pay; however in the U.S., a mother gets 12 weeks of unpaid leave without the risk of losing her job. Other barriers to breastfeeding in the workplace include a perception of a disruption in job performance, lack of privacy for the mother, problems with insurance regulations and
difficulty finding a daycare facility close to the mother’s workplace, according to a study published in *The Journal of Pediatrics.*

Among the factors preventing wider practice of breastfeeding, the Baby Friendly Hospital Initiative wrote, “a woman’s ability to feel self confident and secure with her decision to breastfeed is challenged by her family and friends, the media, and health care providers.”

Among the obstacles are:

- **Family, peer and cultural attitudes and beliefs that lead to lack of social support,** including for teenagers, poor body image.

- **Inadequate breastfeeding education and support:** lack of access to breastfeeding counselors both in prenatal and postpartum periods, including home visits.

- **Health care providers’ misinformation and lack of guidance and encouragement.**

- **Undermining hospital policies,** such as early hospital discharge.

- **Commercial promotion of infant formula** through distribution of hospital discharge packs with free samples, coupons, and media ads. Numerous studies have found lower breastfeeding rates among women who received formula samples in hospital discharge packs.

- **Media portrayal of bottle feeding as the norm.**

- **Barriers for employed mothers:** lack of break time and clean surfaces for baby; policies forbidding babies on job; inadequate facilities for storing and pumping breastmilk.

- **High expense of breast pumps.**

**Recommendations for Action:**

**Community Recommendations**

- Engage in a broad-based breastfeeding promotional education campaign (targeting the public, students, clinicians, employers, unions and policymakers).

- Raise public awareness of infant formula companies' marketing strategies and the content of formula.

- Increase all women's access to economic resources and opportunities to achieve reproductive goals based on unbiased information.
• Lobby national commissions on women and status of women groups to include breastfeeding in their action plans.

• Boycott products whose advertising on TV and in magazines uses women's breasts as promotional tools.

• Welcome breastfeeding mothers at meetings and seminars by providing child care facilities and a place to breastfeed.

• Ask local elected official to endorse World Breastfeeding Week and to include breastfeeding messages in their speeches.

• Create and provide incentives for men to actively participate in supporting their mates in childbearing, rearing and breastfeeding.

• Necessary actions related to workplaces include:
  o securing workplace support including: affordable health insurance; paid maternity leave; onsite child care; flexible hours and home work; mothers' rooms (private areas to pump breast milk); and separate paid infant feeding breaks in addition to other breaks
  o dissemination of available documents related to costs and benefits of breastfeeding, and the costs and risks of alternate feeding, to appropriate policymakers, employers, consumers (e.g., The Business Case for Breastfeeding by the U.S. Department of Health and Human Services).

• Ensure that prenatal/postpartum care providers fully follow state standards and develop collaborative relationships with community-based organizations that specialize in prenatal/postpartum outreach, education and case management.

Health Care Service Recommendations

• Expand free prenatal education programs to include information on breastfeeding at every prenatal encounter.

• Expand free postpartum home support programs to all women and include immediate breastfeeding support.

• Ensure that postpartum women receiving government assistance have access to breastfeeding counselors.

• Increase WIC funding for peer counseling so that all participants have access to a qualified breastfeeding peer counselor.
• Implement a standardized, national certification program for breastfeeding peer counseling to ensure quality of care

• Develop coordination and co-location between WIC breastfeeding counseling programs and hospitals and other medical services to reach more women during prenatal and postpartum periods.

• Improve women's access to midwifery care and other sources of woman-centered, holistic, integrative models of care.

**Systems Recommendations**

• Support implementation of The Breastfeeding Bill of Rights bill sponsored by Senator Liz Krueger that:
  
  o guarantees a mother’s rights: to be informed of and refuse drugs that will dry up her milk; to have baby with the mother immediately after birth and 24 hours a day; and to breastfeed in any location where she is otherwise authorized to be, whether or not her nipple is covered; and requiring a toll-free complaint line for mothers to call if the guidelines aren't followed.

  o requires maternal healthcare facilities to provide breastfeeding information, both written and oral, and medical advice and support to pregnant women and new mothers; and prohibiting those facilities from giving pregnant women and new mothers commercial information, coupons and samples of infant formula, which are intended to discourage breastfeeding, unless specifically required by the mother.

• Increase funding for agencies providing breastfeeding counseling to comply with training standards of World Health Organization

• Require reporting of outcome data from breastfeeding peer counselor programs and offer technical assistance to programs not achieving improved outcomes.

• Seek passage of currently proposed national legislation such as the Breastfeeding Promotion Act, the Global Childhood Survival Act and the Emergency Contraceptive Education Act.

• Work toward the development and passage of legislation to reduce aggressive and misleading infant formula industry marketing, to regulate and support growth of donor milk banking.

• Support the expansion of the Family and Medical Leave Act to address all maternal/child needs.
Overarching Recommendations

- Hospitals should improve breastfeeding policies to the standard set by the World Health Organization’s Baby-Friendly Hospital Initiative\textsuperscript{231} (none currently designated as such in the Bronx), which includes:
  - Maintain a written breastfeeding policy that is routinely communicated to all health care staff.
  - Train all health care staff in skills necessary to implement this policy.
  - Inform all pregnant women about the benefits and management of breastfeeding.
  - Help mothers initiate breastfeeding within one hour of birth.
  - Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants.
  - Give infants no food or drink other than breastmilk, unless medically indicated.
  - Practice “rooming in”—allow mothers and infants to remain together 24 hours a day.
  - Encourage unrestricted breastfeeding.
  - Give no pacifiers or artificial nipples to breastfeeding infants.
  - Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

- Hospitals should adopt policies to notify associated WIC programs of births in order to improve continuity of breastfeeding support.

- As a member of the global community, we must work toward the US ratification of United Nations Convention on the Rights of the Child and the Convention to Eliminate Discrimination Against Women.

- Adopt a national, universal, single-payer health care financing system, such as that embodied in the House bill, HR 676, covering all U.S. residents, including both documented and undocumented immigrants; coverage of all medical services, mental health, dental and optical care, prescription medications, and such preventive services as screening tests, nutritional counseling, and case management; with identical rules and procedures for all states and cities, and a uniform set of administrative forms.

- In the absence of a single-payer system, incorporate expanded eligibility for Medicaid into any health care reform program, and expand access to private coverage for the remaining uninsured population.

- Expand access to public and private insurance programs so as to achieve universal coverage of women of childbearing age (15-44)\textsuperscript{252}.

- Support and enhance access to healthy foods and products to address the issue of obesity as a factor affecting maternal and infant health: Provide tax incentives, subsidies and
other incentives to encourage grocers, restaurants, farmers markets to do business in communities hardest hit by infant mortality and to induce fast-food restaurants and stores to sell healthy produce.\textsuperscript{233}

- Fully involve communities in decisions concerning the distribution of health resources and the formulation and execution of health promotion, education and care programs.

- Increase and ensure the active role of women in the formulation and execution of health promotion, education and care programs. They can participate in this process either as members of Community Advisory Boards or as Board members. In addition, the ongoing use of community-based participatory research can engage the community in the development and implementation of programs and services.
Bronx Health Link

Health Equity Report

Cesarean Sections
Cesarean Sections

**Equity Index**

*Measure: Percentage of annual live births that occur by Cesarean section*

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*For first-time births; the goal for women with prior C-sections is 63%.

**Issue:**

Cesarean section (C-section) is an invasive surgical procedure in which a baby is delivered through the mother’s abdomen and uterus. It is designed for situations when natural childbirth may be hazardous. Yet today C-section is one of the most common surgeries -- performed at levels far above those considered by the World Health Organization and other medical authorities as justifiable.238 A review published in *Lancet* concluded that rates above 15% of live births do “more harm than good.”239 Experts agree that some childbirths are appropriate candidates for the risks of C-sections, but those risks are substantial:

- For the mother: incidence of maternal death two and a half times that of vaginal delivery; increased risk of infection, injury to other organs, and infertility, anesthesia complications; and difficulty with breastfeeding (because recovery can be lengthy and painful); heightened risk of a future ectopic pregnancy or placenta previa (placenta growing in the cervix, causing life-threatening vaginal bleeding).

- For the baby: risks of accidental surgical cut and short- and long-term breathing problems; weakened bonds with mother due to denial of breastfeeding; and, when results in preterm birth, the resulting heightened health risks. Nationally, 92% of the increase in preterm births between 1996 and 2004 was found to be due to C-sections.240

The March of Dimes has stated that it is “concerned that some early deliveries may occur without good medical justification and may be done at the request of the mother or based on an inappropriate recommendation from the doctor.”

A 2006 report by the NYC Public Advocate noted: “Advocates and doctors have raised concerns that many women who deliver by Cesarean section are not provided with complete and accurate information regarding risks and recovery time and that women’s
choice of birthing method is constrained by doctors’ interest in more lucrative and less
time-consuming births. In a national survey of women who gave birth in U.S. hospitals in
2005, 25% of those who had a C-section reported having experienced pressure from a
health professional to have this procedure.” In addition, many women are discouraged
from having vaginal births after a Cesarean (VBAC), despite recent studies showing that
women who have had prior Cesareans face no greater risk of uterine rupture than those
who have had only vaginal deliveries.

The New York State Maternity Information Act (MIA) requires all hospitals to provide
women patients with a pamphlet containing statistics about its rates of C-sections and
other childbirth procedures. As the NYC Public Advocate Betsy Gotbaum has noted:
“The information required by the MIA is a useful resource for women when choosing the
hospital at which they would like to give birth.” Under pressure from Ms. Gotbaum’s
office, all 44 NYC hospitals finally began providing such pamphlets and the NYS Health
Department established a web portal with easily accessible data
(http://www.nyhealth.gov/statistics/facilities/hospital/maternity/). But such data is still
not available on the website of the NYC Department of Health and Mental Hygiene.

Facts:

Trends: Nationally and locally, the rate of C-sections has been dramatically increasing in
recent decades (when first measured in 1965, the U.S. rate was 4.5% of live births; in
2006 it was 31.1%). In the Bronx, the rate has gone up from 22.7% of live births in
1997 to 24.9% in 2003 to 30.0% in 2007. Rates at Bronx hospitals in 2007 ranged
from 19-32%.

Inequities: The few studies with limited data on the ethnicities of U.S. women obtaining
C-sections have had contradictory results. One study found that Black and Latina women
had a higher likelihood of obtaining C-sections than white women. Another found no
difference among ethnic groups of women who have had induced labor. A third study
found that Latinas were less likely to have C-sections than women from other ethnic
groups. Yet another study found that among women who already had children, “highly
acculturated” Latinas had a higher likelihood of C-sections than “less-acculturated”
Latinas, with reverse results for first-time mothers.

Contributing Factors:

Childbirth Connection, a national research, education and policy agency on maternal
care, has concluded that the following factors underlie the rising C-section rate:

• Low priority of enhancing women’s own abilities to give birth. Doctors often fail to
encourage other methods to ease labor progress, such as watchful waiting, positioning
and movement, comfort measures, or oral nourishment, with or without support from
caregivers such as doulas. The cesarean section rate could be greatly lowered through
such care.
• **Side effects of common labor interventions.** For example, research has suggested that electronic fetal monitoring and an epidural early in labor seems to increase the likelihood of a c-section.

• **Refusal to offer the informed choice of vaginal birth.** Many health professionals and/or hospitals are unwilling to offer the informed choice of vaginal birth after cesarean (VBAC) or vaginal birth when the fetus is in a breech position.

• **Casual attitudes about surgery and cesarean sections in particular.** Many health professionals, insurance plans, hospital administrators and women themselves share an ease and comfort about these interventions.

• **Limited awareness of harms that are more likely with cesarean section.** Some doctors may not be familiar with the data, and many pregnant women are not given this information.

• **Providers' fears of malpractice claims and lawsuits.** Some physicians believe that performing a cesarean reduces their risk of being sued or losing a lawsuit, even when vaginal birth is optimal care. The NYC Public Advocate also found, “In some cases, doctors are pressured by hospital officials to perform Cesarean sections in order to avoid liability.”

• **Incentives to practice in a manner that is efficient for providers.** The flat "global fee" method of paying for childbirth does not provide any extra pay for providers who patiently support a longer vaginal birth. Average hospital charges are much greater for cesarean than vaginal birth, and may offer hospitals greater scope for profit.

Note that one oft-cited reason for increasing C-section rates – the rising ages at which women in the U.S. are giving birth, with attendant higher-risk pregnancies – has *not* been borne out by research.

**Recommendations for Action:***

**Community Recommendations**

• Pass the New York State bills sponsored by Assemblymember Amy Paulin (whose bill passed the Assembly in 2008) and Senator Kemp Hannon, providing for a state-funded education and outreach campaign for both consumers and providers to “educate the public about health risks, benefits and choices with regard to birthing procedures,” including vaginal delivery, C-sections and the use of drugs during childbirth.

• Develop community-based campaigns that educate pregnant women consistently about the risks of Cesarean sections in their language of preference using principles of adult literacy, adult education and recognizes and utilizes culturally competent content.
Health Care Services Recommendations

- The New York State Department of Health should provide leadership in meeting the World Health Organization’s goal of a cesarean delivery rate of no more than 15 percent. Action taken should include an initiative that prioritizes reducing the cesarean rate, emphasizes continued research into the risks associated with the procedure, and establishes “best practice” procedures for all health care facilities and providers in NYC. Attention should be given to the continued monitoring of hospital data, and corresponding strategies and recommendations should be developed.256

- Set aggressive goals for improvement in C-section practices as part of public agency contracts for Medicaid and health care agencies.

- Voluntarily review all C-section births that occur before 39 weeks gestation, to ensure they meet established American College of Obstetricians and Gynecologists (ACOG) guidelines regarding medical necessity of elective procedures.

Systems Recommendations

- The New York State Department of Health should monitor and evaluate NYC hospitals’ compliance with the Maternity Information Act. The NYC Health and Hospitals Corporation (HHC) should work with the NYSDOH to ensure that the city’s 12 public hospitals that offer labor and delivery services are in compliance with the law.

- The NYC Department of Health and Mental Hygiene should make up-to-date information about birthing statistics available and easily accessible on its website. The website information should be presented in a user-friendly, easy-to-read format.

- To assist community members who do not have access to computers or the Web, build the capacity of community-based agencies and providers to access this information and provide it to women in the course of their prenatal care.

Overarching Recommendations257

- Fund research into aspects of birthing procedures about which more data is needed, including:
  - possible harms of C-sections, including long term effects in women and children (using comparison groups when possible)
  - factors affecting women’s choices of birthing procedures
  - data on ethnicity and socioeconomic status.

- impact of the liability system on maternity care, and ways to limit unintended effects

- Apply research results to education about and payment policies for birthing procedures.
• Thoroughly explore mechanisms to use payment policies to reduce unnecessary C-sections, including reducing payments for overused services, increasing payments for underused services, rewarding high-performing providers and facilities, and providing incentives to women for selecting such providers and facilities.

• Support development of statewide or regional maternity care quality improvement collaboratives and develop statewide or regional database/reporting systems to provide public information on performance of various providers and facilities.

• Adopt a national, universal, single-payer health care financing system, such as that embodied in the House bill, HR 676, covering all U.S. residents, including both documented and undocumented immigrants; coverage of all medical services, mental health, dental and optical care, prescription medications, and such preventive services as screening tests, nutritional counseling, and case management; with identical rules and procedures for all states and cities, and a uniform set of administrative forms.

• In the absence of a single-payer system, incorporate expanded eligibility for Medicaid into any health care reform program, and expand access to private coverage for the remaining uninsured population.

• Expand access to public and private insurance programs so as to achieve universal coverage of women of childbearing age (15-44).  

• Fully involve communities in decisions concerning the distribution of health resources and the formulation and execution of health promotion, education and care programs.

• Increase and ensure the active role of women in the formulation and execution of health promotion, education and care programs. They can participate in this process either as members of Community Advisory Boards or as Board members. In addition, the ongoing use of community-based participatory research can engage the community in the development and implementation of programs and services.

• All research in disenfranchised communities should employ principles of community-based participatory research. All researchers should develop and implement studies that are culturally competent and sensitive. All research must involve the community as active participants, particularly in translating the findings and results of the inquiries into beneficial actions for the community.
Bronx Health Link

Health Equity Report

Maternal Morbidity and Mortality
Maternal Morbidity and Mortality

**Equity Index**

*Measure: Maternal Mortality Ratio - Deaths of women due to complications of pregnancy or childbirth within 42 days of giving birth per 100,000 live births*

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**Issue:**

In the last few years much progress has been made in lowering the infant mortality rate in NYC. The latest data indicates that in NYC the rate of IM is now at 5.4 per 100,000 yet there has not been a concomitant improvement in the rate of maternal morbidity and mortality. The death of the woman is the terminal result of a number of related issues – the existence of prior, often untreated chronic illness, the long-term effects of racism and poverty, a lack of access to quality care, to name but a few factors that taken as a singular occurrence or as a life-long issue, can result in death.

Maternal mortality is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy from any cause related to or aggravated by the pregnancy or its management. Maternal morbidity is any illness or injury caused by the pregnancy or aggravated by, or associated with, pregnancy or childbirth.

Maternal illness can manifest itself during the pregnancy and childbirth and are the result of aggravation of existing conditions or the occurrence of illness during this period in the woman’s life cycle. In either case, the woman may then develop a condition that will last for months or years and will likely have a negative impact on her health and well-being. For example, in NYC, hemorrhage has been found to be the leading cause of maternal death – approximately one-third of all cases. Nationwide, the combination of eclampsia and pre-eclampsia – both of which have hypertension as an underlying precipitating factor – is among the top three causes of maternal death. This condition can also create lifelong health problems in survivors. NYC survey data for 2004-5 showed that 8% of women who gave birth reported having high blood pressure before and/or during pregnancy.
On another level, the existence of high levels of maternal illness and mortality affect the woman, her family, her children and her community. In recognition of the seminal role of women in society, community and family, the United Nations Human Rights Council has adopted a resolution acknowledging that “preventable maternal mortality and morbidity” is a human rights issue and that efforts to protect women should be scaled up.

In New York City, and specifically in the Bronx, we must assert and promote the right of women to go through a safe and healthy pregnancy and childbirth and more important than the assertion is developing programs and services to address the issue of women dying and being infirm because of pregnancy and birth.

Facts:

Trends: After declining sharply for much of the 20th century, the national rate of maternal mortality leveled off in the mid-1980s. As the Centers for Disease Control and Prevention reports, “Some people believe that maternal deaths are a rare event. However, maternal mortality rates have not improved in recent years, and deaths continue to occur.” 265

Inequities: The racial disparities in maternal mortality are severe and striking in their extreme. Nationally, for at least 50 years, Black women have had almost four times the risk of death from pregnancy complications as have white women, regardless of age or education. 266 In New York City in 2007, the racial disparities in maternal mortality ratios are extreme in their occurrence: 5.1 for whites, 15.6 for Asians, 16.4 for Latinas other than Puerto Ricans, 19.6 for Puerto Ricans, and a whopping 68.3 for African Americans. 267

Contributing Causes:

- Racial inequities. Black women, including women of reproductive age, are more likely to have hypertension, diabetes, or obesity, any of which puts them at greater risk of death. Also, Black women are less likely to begin prenatal care in the first trimester and to receive adequate care. 268 A review of NYC maternal death records found that Black women’s lower access to care and lower quality of care were also contributing factors. 269 This is part of the broader pattern; found by the Institute of Medicine, that people of color generally receive lower quality of care, even with equal access to care and insurance coverage. 270

- Inadequate quality of medical care. Three studies have shown that at least 40% of maternal deaths could have been prevented with improved quality of care. 271 More specifically, one study found that almost all deaths due to hemorrhage and complications of chronic diseases were potentially preventable. 272 A national study found that the best-performing hospitals (those with very low rates of both maternal complications and infant mortality) have 76% fewer complications during C-section deliveries than they have at the worst-performing. For vaginal births, there are about 52% fewer complications at best-performing hospitals. 273
• **Older ages of pregnancies.** Women in the United States are becoming pregnant at older ages, and the risk of death is nearly three times greater for women aged 35–39 years than for women aged 20–24 years. The risk is nearly five times greater for women over 40.274

• **Cesarean sections.** According to a review of maternal deaths in New York, excessive bleeding is one of the primary causes of pregnancy-related death, and women who have undergone several previous c-sections are at particularly high risk of death from this condition.8

• **Obesity.** Overweight women tend to have diabetes or other health issues that can risk their health. They can also have excessive tissue or larger infants, which can make a vaginal birth more difficult and lead to more C-sections.9 Obesity is present in two-thirds of U.S. maternal deaths.275

**Recommendations for Action:**

**Community Recommendations**

• Ensure that prenatal/postpartum care providers fully follow state standards and develop collaborative relationships with community-based organizations that specialize in prenatal/postpartum outreach, education and case management.

• Educate pregnant patients and train providers on the importance of dental care in preventing poor birth outcomes and improving the mother’s overall health.

• Prenatal assessment of women must include a risk assessment for preterm birth. Questions in the prenatal intake form should include familial and family history of preterm birth. Indication of a either of familial or individual risk for preterm birth should trigger intensive health promotion, stress management, nutritional counseling, care coordination, and case management, to help reduce adverse health outcomes.

• “Perinatal care providers, including WIC programs, should routinely assess psychosocial factors, including stress and social support among pregnant women and families. Those who screen positive should be referred to appropriate support services.”276 In addition, such providers should explore use of doulas, group prenatal care, and other forms of social support for improving maternal nutrition, and health insurance plans should support such services.277

• Develop a critical mass of people to participate in “maternal matrices” by identifying, training, and employing women who have proven resilient in response to their own life trials and tribulations.

• Pass the New York State bills sponsored by Assemblymember Amy Paulin (whose bill passed the Assembly in 2008) and Senator Kemp Hannon, providing for a state-funded
education and outreach campaign for both consumers and providers to “educate the public about health risks, benefits and choices with regard to birthing procedures,” including vaginal delivery, C-sections and the use of drugs during childbirth.\textsuperscript{278}

- Develop community-based campaigns that educate pregnant women consistently about the risks of Cesarean sections in their language of preference using principles of adult literacy, adult education and recognizes and utilizes culturally competent content.

- Create and provide incentives for men to actively participate in supporting their mates in childbearing, rearing and breastfeeding.

- Necessary actions related to workplaces include:
  - securing workplace support including: affordable health insurance; paid maternity leave; onsite child care; flexible hours and home work; mothers’ rooms (private areas to pump breast milk); and separate paid infant feeding breaks in addition to other breaks
  - dissemination of available documents related to costs and benefits of breastfeeding, and the costs and risks of alternate feeding, to appropriate policymakers, employers, consumers (e.g., \textit{The Business Case for Breastfeeding} by the U.S. Department of Health and Human Services).

- Support and enhance access to healthy foods and products to address the issue of obesity as a factor affecting maternal and infant health: Provide tax incentives, subsidies and other incentives to encourage grocers, restaurants, farmers markets to do business in communities hardest hit by infant mortality and to induce fast-food restaurants and stores to sell healthy produce.\textsuperscript{279}

\textit{Health Care Services Recommendations:}

- Expand financial access to prenatal and postpartum care by increasing Medicaid eligibility for coverage from 200\% to 250\% of poverty and set clear and narrow exemptions from provider requirements to offer such state-reimbursed care.\textsuperscript{280}

- Expand state-funded postpartum care beyond the current limit of 90 days post-delivery to ensure continuity of access to health care services for women and their babies.

- Provide funding for additional community-based prenatal clinics in underserved areas.

- Require that state-reimbursed prenatal care include adequate amounts of non-medical services such as nutrition counseling and smoking cessation, and establish adequate monitoring mechanism to ensure that providers follow this and other standards.

- Guarantee all pregnant women access to dental care as part of the prenatal continuum, as per the recommendations of the New York State Health Department.\textsuperscript{281}
• Provide funding for all facilities providing prenatal care to hire multilingual, culturally competent staff and translators and to make available multi-lingual printed materials.282

• Expand funding for the Community Health Worker Program to increase reach of culturally competent outreach and education efforts about eligibility for prenatal/postpartum coverage and the importance of prenatal care to more underserved pregnant women.283 Target overall populations (i.e., not just women of reproductive age) that are most disconnected from care, such as undocumented immigrants, teenagers, and the working poor with incomes above Medicaid-eligible level.284

• Expand funding for the Healthy Families New York Home Visiting Program to provide prenatal and postpartum education and services to more underserved women.

**Systems Recommendations**

• Overall: Build a financial and programmatic infrastructure to provide women with preventive health care, including preconception and interconception care, to make prenatal care far more effective in improving women’s health and birth outcomes. First priority should go to women who have experienced premature births and/or suffered the death of an infant. Some components of this:
  
  o Expand access to public and private insurance programs to achieve universal coverage of women of childbearing age (15-44).285

• Promote the Medical Home model to ensure that women have access to quality and reliable preconception and interconception care.

• Expand public and private insurance coverage to include support for smoking cessation programs among women of childbearing age.

• Build the capacity within the health care setting and the community to provide nutritional counseling to women of childbearing age in order to decrease the alarming effects of obesity.

• Provide funding for folic acid supplementation to young girls starting in school health centers.

• Support development of statewide or regional maternity care quality improvement collaboratives and develop statewide or regional database/reporting systems to provide public information on performance of various providers and facilities.

• The New York State Department of Health should monitor and evaluate NYC hospitals’ compliance with the Maternity Information Act. The NYC Health and Hospitals Corporation (HHC) should work with the NYSDOH to ensure that the city’s 12 public hospitals that offer labor and delivery services are in compliance with the law.
• The NYC Department of Health and Mental Hygiene should make up-to-date information about birthing statistics available and easily accessible on its website. The website information should be presented in a user-friendly, easy-to-read format.

• To assist community members who do not have access to computers or the Web, build the capacity of community-based agencies and providers to access this information and provide it to women in the course of their prenatal care.

**Overarching Recommendations**

• Expand federal support for maternal morbidity and mortality-related research to improve understanding of the causes and prevention of this factor affecting birth outcomes.

• Develop strategies for prevention that improve care and outcomes for women during pregnancy and birth.

• Establish sustainable efforts at the community level to address and prevent maternal morbidity and mortality

• Address the structural issues which result in the disparate rates of maternal morbidity and mortality, specifically racism, institutional discrimination, socioeconomic segregation and poverty.

• Provide women with options for receiving maternity care. Among those options should be birthing centers wherein women design and determine the content of care and health care providers serve as consultants to childbearing women.

• Adopt a national, universal, single-payer health care financing system, such as that embodied in the House bill, HR 676, covering all U.S. residents, including both documented and undocumented immigrants; coverage of all medical services, mental health, dental and optical care, prescription medications, and such preventive services as screening tests, nutritional counseling, and case management; with identical rules and procedures for all states and cities, and a uniform set of administrative forms.

• In the absence of a single-payer system, incorporate expanded eligibility for Medicaid into any health care reform program, and expand access to private coverage for the remaining uninsured population.

• Expand access to public and private insurance programs to achieve universal coverage of women of childbearing age (15- 44).\(^{286}\)

• Fully involve communities in decisions concerning the distribution of health resources and the formulation and execution of health promotion, education and care programs.
Increase and ensure the active role of women in the formulation and execution of health promotion, education and care programs. They can participate in this process either as members of Community Advisory Boards or as Board members. In addition, the ongoing use of community-based participatory research can engage the community in the development and implementation of programs and services.
Health Care Coverage: Medicaid

Equity Index

*Measure: Percentage of live births to women on Medicaid*

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**Issue:**

Medicaid is the joint federal-state program that finances health care services for low-income individuals. It is a means-tested health insurance program and it is the largest source of federal support to the states. According to a study by the Kaiser Family Foundation and the Guttmacher Institute, Medicaid plays a critical role in financing health services for women of reproductive age (15-44): In 2006, 12% of the 7.3 million women in that category utilized Medicaid for their care, including family planning. For the poorest women, the proportion was higher: 37% of women of reproductive age with incomes below the federal poverty level ($16,600 for a family of three) were enrolled in Medicaid in 2006.

In order to expand the access of low-income pregnant women to prenatal, delivery, and postpartum care, Medicaid legislation has required states to offer coverage of the core services to all pregnant women with incomes of up to 133% of the federal poverty level. States can receive federal matching funds for coverage of pregnant women with incomes up to and beyond 185% of the poverty level. In New York State, two Medicaid programs -- Prenatal Care Assistance Programs (PCAPs) and Medicaid Obstetrical and Maternal Services (MOMS) -- provide no-cost coverage of these services to pregnant women with incomes up to 200% of the poverty level. (For more details, see Prenatal Care section of this report.)

Under New York State law, anyone enrolled in a Medicaid managed care plan is entitled to free access to family planning and reproductive health services including pregnancy testing, birth control, abortion, sterilization, various women’s medical exams, and STD testing and treatment when part of a family planning visit. Free access means that a person can get these services from any doctor or clinic he/she chooses that accepts Medicaid.
Facts:

**Trends:** According to the Kaiser Family Foundation, “Responding to greater attention on rising infant mortality and maternal health, Medicaid eligibility levels were expanded in the late 1980s and 1990s to improve access to prenatal care for low-income pregnant women and improve infant mortality rates.” As a result, in NYC, the percentage of mothers giving birth on Medicaid surged throughout this period and then stabilized over the past decade. In 2007, the Bronx had the highest percentage of any borough (67.6%).

**Inequities:** According to Bronx Health REACH, “Black and Latino New Yorkers are more than twice as likely as whites to be uninsured, or to receive Medicaid or other public insurance. As a result, people of color face more barriers to accessing high-quality care, leading to disparities in health outcomes.”

**Contributing Factors:**

- **Lack of outreach/education programs about available Medicaid and other public insurance benefits.** Many uninsured individuals who may be eligible for Medicaid or Family Health Plus (or whose children may qualify for Child Health Plus) have not been made aware of their eligibility. It is nearly impossible for uninsured New Yorkers to learn everything they need to know about their legal rights as patients, the various types of public coverage for which they may be eligible, the locations and admission criteria of the various providers around the city who offer low-cost care, and where interpretation services are available.

- **Barriers to enrollment or continued enrollment in public insurance programs.** The Bronx Working Group in Infant Morality reported: “A study sponsored by Children’s Defense Fund found that Medicaid, Child Health Plus, Family Health Plus and PCAP [Prenatal Care Assistance Program] have different eligibility levels, enrollment processes and reenrollment requirements, which make it hard for families to comply with the rules of these programs. Another study by the Commonwealth Fund found that…many eligible individuals inappropriately lost coverage from the State’s Medicaid, Family Health Plus or Child Health Plus programs because they failed to complete required documentation – not because changes in their economic or family circumstances made them ineligible for continued coverage.” (Note, however, that PCAP has a simplified application process.)

Beyond these problems, many women – especially undocumented immigrants – encounter a range of obstacles when applying for Medicaid and PCAP: long waits; inadequate documentation; rude staff; lack of Spanish-speaking staff; and lack of air conditioned offices.

In addition, a 2005 federal law requiring documentation of U.S. citizenship to qualify for Medicaid has reduced participation rates by eligible people. According to the Kaiser Commission on Medicaid and the Uninsured, the law “requires states to act in opposition
to the lessons they have learned about effective ways to enroll and retain eligible people in health coverage programs. For example, they are having to add, rather than lessen, documentation requirements, and rely less on mail-in application systems. As a result, the requirement appears to be obstructing access to health coverage by eligible U.S. citizens, and could place a considerable burden on working families in particular.  

- **Second-class medical care for Medicaid patients.** For those who do end up obtaining coverage, they often obtain worse care than those who are privately insured – a system that Bronx Health REACH, which studied these disparities in NYC health care facilities, labeled “medical apartheid.” Among their findings:

  …even within the same institutions, the uninsured, people covered by Medicaid, and sometimes, even those enrolled in Medicaid Managed Care, Family Health Plus and Child Health Plus, receive poorer quality care in different locations, at different times, and by less trained physicians than those who are privately insured – a practice that is prohibited by the Patient Bill of Rights and Medicaid Managed Care contracts…

In New York a private physician providing a comprehensive visit to a new Medicare (elderly) patient is paid six times as much as when he [or she] provides the same service to a Medicaid (poor) patient. Such discrepancies virtually ensure unequal access to care. Medicaid expenditures per recipient, when stratified by race and ethnicity, reveal further inequities…. [T]otal Medicaid payments per white recipient per year are 60% higher than those for Blacks, 140% higher than for Asians, and 15% higher than for Latinos.”

Low reimbursement rates to providers almost always translate to less time spent per patient and thus much lower quality of care.

- **Barriers to immigrants.** Immigrants are generally banned from Medicaid coverage for the first five years in the U.S., although states can cover residents without federal funds if they so choose.

**Recommendations for Action:**

**Health Care Service Recommendations**

- Expand outreach to reach out and inform those eligible for Medicaid benefits.

- Continue streamlining the application and documentation procedures (beyond the simplifications recently implemented by New York State) so that eligible people do not slip between the cracks.

- Raise eligibility levels, especially for people without dependents, since Medicaid currently reaches only a fraction of those in need.

- Repeal the five-year bar on immigrants’ ability to apply for Medicaid and requirement to document U.S. citizenship to receive benefits. Cover all immigrants, both documented and undocumented.
Systems Recommendations

- Provide consistent monitoring and enforcement of state, city and federal laws requiring hospitals to provide medical care to all, regardless of ability to pay, and to inform patients about their rights.
- Fund the training and placement of patient navigators/ombudspeople in all major medical institutions, including emergency rooms, who can provide coordination of care and advocate for patients’ rights and the full attainment of the services to which they are entitled.
- Increase Medicaid reimbursement rates for providers.

Overarching Recommendations

- **Adopt a national, universal, single-payer health care financing system**, such as that embodied in the House bill, HR 676, with the following key components:
  - Coverage of all U.S. residents, including both documented and undocumented immigrants
  - No opt-out provision
  - Coverage of all medical services, mental health, dental and optical care, prescription medications, and such preventive services as screening tests, nutritional counseling, and case management.
  - Mandated bargaining with pharmaceutical companies to get the largest bulk discount rates
  - Identical rules and procedures for all states and cities, and a uniform set of administrative forms
  - Financing through income taxes and a tax on employers
  - The national system would replace private health insurance.

- In the absence of a single-payer system, incorporate expanded eligibility for Medicaid into any health care reform program.

- Expand access to public and private insurance programs so as to achieve universal coverage of women of childbearing age (15-44).

- Fully involve communities in decisions concerning the distribution of health resources and the formulation and execution of health promotion, education and care programs.

- Increase and ensure the active role of women in the formulation and execution of health promotion, education and care programs. They can participate in this process either as members of Community Advisory Boards or as Board members. In addition, the ongoing use of community-based participatory research can engage the community in the development and implementation of programs and services.
Bronx Health Link

Health Equity Report

Health Care Coverage: The Uninsured
Health Care Coverage: The Uninsured

**Equity Index**

*Measure: Percentage of adults under 65 who lack health insurance*

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**Issue:**

**Health Harms of Being Uninsured:**

Despite the wealth and economic stability of certain neighborhoods in New York, the Bronx exhibits particularly high levels of poverty, unemployment and underemployment. For residents facing any of these situations – or even working full-time but at a low-wage job – they are more likely to be uninsured or underinsured. This has a particular impact on maternal and infant health. Since it is difficult for poor women to qualify for Medicaid unless they are pregnant or have children, the program is out of reach for many childless, uninsured women, although they might be eligible for Family Health Plus with slightly higher incomes. As a result, women who lack or lose insurance often forgo necessary care. A 2007 poll found that 53% of New York State women who had interruptions in health insurance coverage reported skipping or postponing medical care or surgery, and 56% reported being unable to fill a prescription due to lack of money or insurance.

According to the Guttmacher Institute, 18% of women of childbearing age (15-44) in New York State are uninsured. In numerous studies, researchers have found that uninsured pregnant women are less likely to receive prenatal care than women who have private insurance. (For more detail, see also Prenatal Care section.) In addition, the absence of such coverage creates a significant barrier for women planning to have children to obtain any type of preconception care, which is increasingly being found to be important for achieving the healthiest birth outcome.

For the population in general as well, being uninsured is a threat to health. The uninsured often do not access medical care even for serious conditions, do not follow recommended treatment options because of the cost of prescription medicines, and cannot utilize preventive measures such as regularly scheduled routine medical care that may mean the difference between health and illness. According to a study in 2000 cited by the American College of Physicians, uninsured children, compared to the insured, are up to 40% less likely to receive medical attention for a serious injury. Uninsured Americans,
compared to the insured, are up to 3.2 times more likely to die in the hospital, and uninsured Americans, compared to the insured, are more likely to experience avoidable hospitalizations for diabetes.  

When faced with the burden of choosing between accessing medical care and the essential necessities of life such as rent, food, and clothing, many of the uninsured will forgo medical treatment and what may have been a minor problem will exacerbate and become a medical emergency resulting in lost wages, missed days of work, and a worsened health profile. Nearly a quarter of the uninsured reported changing their way of life significantly to pay medical bills.

**Who’s Covered By What (or Not):**

Being uninsured in America is a growing epidemic. In 2007, 45 million Americans, or 17% of the population under age 65, lived, worked, became ill and died without the benefit of health insurance. For children under 18, the numbers were 8.3 million and 7%. These numbers have grown during the current recession.

Medical insurance in the United States is provided in a number of ways. Individuals receive coverage through an employer; the elderly (over 65) and some disabled persons are covered by Medicare; Medicaid and State Children’s Health Insurance Program (SCHIP) cover non-elderly, low-income people, particularly children, regardless of immigration status. There is also a special NYS program called Family Health Plus which covers parents with children up to 150% of the federal poverty level (FPL), and single adults and childless couples at 100% of FPL. However, the undocumented, the working poor, and low-income Americans with family incomes below 200% of the poverty level (the last category of which constitute two thirds of NYC’s uninsured) are at risk of not having health insurance for long periods of time. Under NYS legislation enacted in October 2008, children up to age 19 in families with annual income up to $70,000 for a family of three or $84,000 for family of four are now eligible for free or low-cost/sliding-scale coverage under New York's Child Health Plus insurance program.

Currently, 61% of Americans under the age of 65 receive health insurance coverage through an employer. However, in recent years the number of individuals covered by an employer health plan has decreased. According to the Kaiser Commission on Medicaid and the Uninsured, “Uninsured workers are more likely to work in low-wage or blue collar jobs and to work for small firms or in service industries.” In New York City, according to 2005-2006 data compiled by the United Hospital Fund, 45% of the non-elderly population was covered by employer-sponsored insurance; 4% were covered by directly purchased health insurance; 33% were covered by public insurance and 18% were uninsured.

There are various public programs available for the uninsured – In addition to the public insurance programs, there are health care services available for free or on a sliding fee scale, including the Emergency Medical Treatment and Active Labor Act (EMTALA) in
emergency rooms, federally funded community health centers, public hospitals, and a new Patient Financial Assistance Law in all NYS hospitals. A 2007 survey found that more than 1 million (44%) of New York State’s uninsured residents - three-quarters of them adults - are eligible for Medicaid, Family Health Plus, or Child Health Plus.\textsuperscript{313}

But for a number of reasons (see Contributing Factors below), large numbers of the uninsured are not enrolled in these public programs. In some cases, those who do get enrolled find their coverage not renewed due to bureaucratic obstacles rather than their loss of eligibility. When cut off from insurance, the application process must be started anew, resulting in lost opportunities for care. Losing coverage results in a disinclination to apply for one of the programs and reliance on emergency room service as a source of health care.

**Facts:**

**Trends:** Nationally, employer-sponsored coverage declined 5.7\% between 2000 and 2007, resulting in a 2\% increase in the uninsured rate. In NYC during the same period, employer-sponsored coverage declined by 2.7\%. But due to expanded state eligibility rules, rates of public coverage more than compensated, increasing by 8.9\%, leading to a 6.6\% decline in the uninsured.\textsuperscript{314} The Kaiser Commission on Medicaid and the Uninsured has projected that as unemployment rises and former workers lose their employer-sponsored coverage, public insurance programs nationally will be unable to absorb the newly uninsured, and the rate of those who are uninsured will continue to rise.\textsuperscript{315}

**Inequities:** As with all aspects of health, people of color are worse off than white people in terms of lack of insurance coverage. According to Bronx Health REACH, “Black and Latino New Yorkers are more than twice as likely as whites to be uninsured, or to receive Medicaid or other public insurance. As a result, people of color face more barriers to accessing high-quality care, leading to disparities in health outcomes.”\textsuperscript{316} In 2006-7, a Census survey of NYC residents found that 13.4\% of whites under 65 were uninsured, compared with 19.8\% of Blacks and 21.2\% of Latinos. The same survey highlighted another inequity: Uninsurance rates were 13.7\% for those born U.S. citizens, 17.5\% for naturalized U.S. citizens, 31.5\% for noncitizens living here for under 5 years, and 35.9\% for noncitizens living here for 5 years or more.\textsuperscript{317}

**Contributing Factors:**

- **Lack of outreach/education programs about available public insurance benefits.** Many uninsured individuals who may be eligible for Medicaid or Family Health Plus (or whose children may qualify for Child Health Plus) are not aware of their eligibility. It is a daunting process for the uninsured to learn and understand what their legal rights are as patients, the various types of public coverage for which they may be eligible, the locations and the admission criteria of the various providers around the city who offer low-cost care. In some cases, this situation is made more difficult by the lack of available and reliable interpretation services or translated written information.
• **Barriers to enrollment or continued enrollment in public insurance programs.**
  The Bronx Working Group in Infant Morality reported: “A study sponsored by Children’s Defense Fund found that Medicaid, Child Health Plus, Family Health Plus and PCAP [Prenatal Care Assistance Program] have different eligibility levels, enrollment processes and reenrollment requirements, which make it hard for families to comply with the rules of these programs. Another study by the Commonwealth Fund found that…many eligible individuals inappropriately lost coverage from the State’s Medicaid, Family Health Plus or Child Health Plus programs because they failed to complete required documentation – not because changes in their economic or family circumstances made them ineligible for continued coverage.”318 Finally, surveys by the Commission on the Public Health System have found many procedural obstacles that prevent eligible people from enrolling and staying enrolled. Beyond these problems, many women – especially undocumented immigrants – encounter a range of obstacles when applying for Medicaid and PCAP: long waits; inadequate documentation; rude staff; lack of Spanish-speaking staff; and lack of air conditioned offices.319

• **“Charity Care” funds for hospitals not geared to actual numbers of uninsured patients served.** NYC hospitals receive hundreds of millions in state “Charity Care” funds for caring for the uninsured, most of whom are Black or Latino. According to a 2005 study by Bronx Health REACH, as many as 90 percent of patients at some hospitals are uninsured or publicly insured. But the study found that this funding is not tied to the actual number of patients treated and does not provide an adequate level of care: “Payments from the pools are calculated using a complex funding formula that does not adequately reflect the volume of charity care hospitals provide.”320 New York State has a Patient Financial Assistance Law (Manny’s Law) which requires that all hospitals have a Charity Care Policy that is made available to patients seeking care.

• **Community organizations’ lack of knowledge of free health care options.** A 2003 NYC study by the Commission on the Public’s Health System (CPHS) found a widespread lack of awareness by community-based organizations serving poor communities of the legal obligation of medical institutions to provide services to all community residents regardless of race, ethnicity, primary language, or ability to pay.321 (As a result of these findings, CPHS provided some training for CBOs and developed one-page fliers about how to help the uninsured.)

• **Discriminatory private insurance rates for women of childbearing age.** A 2008 survey of data from insurance brokers found a growing trend by insurance companies to charge young women higher rates than men of similar ages.
Recommendations for Action:

Community Recommendations

- **Designate and support an organization that can act as an information-source and advocate for the uninsured.** A specific NYC community-based organization should be charged with the responsibility of providing the uninsured with information, referral, and advocacy, and also serving as a source of information and education for community agencies that assist the uninsured. The designated agency should be given the institutional and financial support.

Health Care Service Recommendations

Improve access to health-care among the uninsured in the following ways:

- **Expand outreach to reach out and inform those eligible for public insurance benefits.**

- **Continue streamlining the application and documentation procedures** (beyond the simplifications recently implemented by New York State) so that eligible people do not slip between the cracks.

- **Raise eligibility levels, especially for people without dependents,** since public insurance programs currently reach only a fraction of those in need.

- **Allocate more funds to “safety-net” providers, both public and private.** At the same time, any hospitals and ambulatory care centers that receive extra money for serving the uninsured should be closely monitored to ensure that the funds are being used specifically for this purpose. Allocate more Indigent Care funds to ambulatory settings, so as to make certain that uninsured individuals have access to free or very low-cost primary and preventive care.

- **Expand funding of community health centers, particularly in underserved areas,** and hire the full range of health professionals (e.g., social workers, health educators, mental health counselors) to provide patients with a medical home and help with navigating the system.

Systems Recommendations

- **Provide consistent monitoring and enforcement of state, city and federal laws requiring hospitals to provide medical care to all, regardless of ability to pay, and to inform patients about their rights.** In particular, New York State must ensure enforcement of the Patient Financial Assistance Law (Manny’s Law), requiring all hospitals to make available charity care policies to their patients.

- **Fund the training and placement of patient navigators/ombudspeople in all major medical institutions,** including emergency rooms, who can provide coordination of care
and advocate for patients’ rights and the full attainment of the services to which they are entitled.

**Overarching Recommendations**

- **Adopt a national, universal, single-payer health care financing system**, such as that embodied in the House bill, HR 676, with the following key components:
  - Coverage of all U.S. residents, including both documented and undocumented immigrants
  - No opt-out provision
  - Coverage of all medical services, mental health, dental and optical care, prescription medications, and such preventive services as screening tests, nutritional counseling, and case management.
  - Mandated bargaining with pharmaceutical companies to get the largest bulk discount rates
  - Identical rules and procedures for all states and cities, and a uniform set of administrative forms
  - Financing through income taxes and a tax on employers
  - The national system would replace private health insurance.

- In the absence of a single-payer system, incorporate expanded eligibility for Medicaid into any health care reform program, and expand access to private coverage for the remaining uninsured population.

- Expand access to public and private insurance programs so as to achieve universal coverage of women of childbearing age (15-44)\(^35^2\).

- Fully involve communities in decisions concerning the distribution of health resources and the formulation and execution of health promotion, education and care programs.

- Increase and ensure the active role of women in the formulation and execution of health promotion, education and care programs. They can participate in this process either as members of Community Advisory Boards or as Board members. In addition, the ongoing use of community-based participatory research can engage the community in the development and implementation of programs and services.

- All research in disenfranchised communities should employ principles of community-based participatory research. All researchers should develop and implement studies that are culturally competent and sensitive. All research must involve the community as active participants, particularly in translating the findings and results of the inquiries into beneficial actions for the community.
Bronx Health Link

Health Equity Report

Charts and Graphs: Maternal and Infant Health in the Bronx
Technical Note:

The following are a series of charts and graphs prepared by the Bronx Health Link to supplement the 2009 Maternal Infant Health Equity Report. In creating the graphs and charts, we used data from the New York City Birth and Infant Mortality Trends, New York City Department of Health and Mental Hygiene, 2009.

The report presents trends in births and infant mortality in New York City over a ten period from 1998 – 2007. As noted in the preface to the report, birth trends are presented in a number of different ways relying on maternal characteristics and infant characteristics. In reviewing the data for this presentation, we did not use all of the included characteristics and only highlighted a few which include the following:

**Maternal Characteristics**
- Method of delivery
- Prenatal care
- Maternal age
- Nativity
- Medicaid coverage

**Infant Characteristics**
- Low birth weight
- Preterm birth

Infant Mortality is presented by demographic characteristics of the mother.

In preparing the graphs and charts herein, we considered a number of factors including:

- What representation of the data would articulate the best case for health equity
- What representation of the data would best highlight the severity of issues affecting maternal infant health in the Bronx
- What representation of the data would provide the reader with a clear view of the data and trends over a selected period of time, in many cases, a 5 year period from 2002-2007.

For further assistance or to discuss the contents of the graphs, please contact the Bronx Health Link by emailing lizette@bronxhealthlink.org.

Joann Casado, Executive Director
June 2009
Live births with LBW by Maternal Race/Ethnicity (2003-2007)

- Black women
- Latinas
- White
- Asian/PI

2007: 3609, 3250, 2701
2006: 3605, 3327, 2753
2005: 3766, 3146, 2697
2004: 3786, 3126, 2643
2003: 3571, 3078, 2562, 1311
In 2007, 6.5% of all births in New York city were to teens
The percentage of teen births was the highest in the Bronx (12% or 2601 live births)
In 2007, the Bronx had the highest IM rate at 6.2, followed by Brooklyn. At no point in the six years shown has the IM rate for Blacks approached the HP2010 goal.
## Bronx Infant Mortality Rate by Community District

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Bronx Health Link

Child Health Initiative
2008-2009

Asthma
Policy Development Document  
Child Health Clinic Initiative 2008 – 2009

**Issue Area:** Asthma  
**Facts in brief:**

1) The Bronx is an epicenter of asthma; the county has some of the highest rates of asthma in the United States.
2) Rates of death from asthma in the Bronx are about three times higher than the national average.
3) Hospitalization rates are about five times higher. In some neighborhoods in the Bronx it is estimated that 30% of the children have asthma.
4) Among borough children the hospitalization rates were 8.9 per 1000 compared to 5.4 per 1,000 citywide.
5) The Bronx is one of 10 counties in the state that exceed current federal air quality standards for fine particle pollution. The entire NYC metropolitan area is also out of compliance with ozone standards, both of which have been shown to trigger asthma.
6) The borough has high truck traffic, and also high asthma rates. Its asthma hospitalization rate for boys and girls under 14 is 8.9 per 1,000 children, higher than that of any other borough, according to state health data. At the Children’s Hospital at Montefiore Medical Center in the Bronx, 14 percent of the admissions in 2007 were asthma-related.
7) Poor children are disproportionately exposed to toxic matter and pound for pound children exhibit a higher biological vulnerability to the effects of exposure to these toxic materials.
8) Research studies have shown an effect on asthma at levels even below the “safe” standard of EPA fine-particle pollution levels.
9) Housing quality in many parts of the Bronx is poor, with infestations of vermin and mold, despite best efforts of families. Research studies have shown an interaction between exposure to diesel traffic-related pollution and an exaggerated allergenic response to mice proteins and other indoor allergens.

**Issues:**
**What are the problems**

1) Lack of access to quality care and a medical home leading to an overreliance on ER as a source of care for asthma.
2) High levels of hospitalizations due to asthma.
3) Unmanaged asthma due to a lack of education on asthma management techniques, triggers, peak flow meters, controller medications and other preventive measures.
4) A decaying, older housing stock often subject to inadequate code enforcement that results in the unchecked presence of known asthma triggers.
5) Children in the South Bronx are twice as likely to attend a school near a highway as were children in other parts of the city.
6) The public schools do not provide enough information and care to children about asthma prevention and care.
Not all local providers follow current medical guidance in the treatment and management of asthma, and many have been uninterested in educational opportunities available to them.

**Focus Group Comments**
“Asthma is like a family friend – everyone has it and when it comes, we go to the emergency room”
Youth participating in the two focus groups all included asthma as an issue affecting their health and the health of the community.

**Survey Responses on asthma**
42% of survey respondents cited asthma as one of the major health problems in the borough.

**Recommendations:**
What can be done to address the problem?

1) Increase level of education on asthma management techniques utilized by families and individuals to decrease or minimize the overreliance on ER as a source of care for asthma. Community-based, group health education based on the experience of the community and societal conditions offers an opportunity for patient asthma care empowerment and therefore we recommend these types of educational campaigns.

2) Increase number of children with access to a medical home where they can access quality comprehensive health care that is family-centered, culturally competent, available and continuous including in the evening and at night, and that promotes the prevention of disease. Physicians who continue to prescribe rescue medications only to moderate to severe asthmatics need to be alerted that their medical licenses may be jeopardized.

3) Advocate that Medicaid formalize the provision of asthma education and home remediation as a reimbursable expense.

4) To provide the community with skills-based asthma education programs that are linguistically and culturally appropriate aimed at improving the level of asthma prevention and maintenance ability of parents, caregivers and others. We suggest further review of existing asthma programs both in NYC like the HCZ Asthma Program, and others such as the Seattle COAT to provide models of care to improve the level of educational services and health promotion techniques available to the affected community.

5) Create and implement an educational campaign that addresses the value of a medical home.

6) Code enforcement of existing laws to ensure that the older Bronx housing stock is
free of known asthma triggers such as mold, roaches, etc., and that NYCHA as well as other landlords prioritize homes of asthmatics for maintenance and Integrated Pest Management.

7) Funding for and expansion of the Asthma Free Schools

**What do we have to do to address the issue on the community level?**

Conduct information campaigns on the issue of the importance of a medical home to ensure that children and youth with asthma access care, information and treatment on a continuous basis

Educate local elected officials about the asthma issue and the disproportionate effect that it is having on the children and youth of the Bronx.

Educate parents about asthma, pollution, healthy homes and diet

Strengthen existing laws and regulations related to clean air and asthma-safe housing

Participate in existing environmental justice campaigns in the borough

Collaborate with other environmental justice groups in the city

Advocate for compliance with the EPA standards and demand clean air in the South Bronx

**Who needs to be involved?**

Parents

Health care provider including hospitals, health centers, local providers

Schools

Day Care centers, family day care providers and others engaged in the care and supervision of infants, children and adolescents.

Local elected officials – Office of the Borough President, Planning Boards, City Council members

Faith-based organizations
Bronx Health Link

Child Health Initiative
2008-2009

Mental Health
**Issue Area: Mental Health**

**Facts:**

**Mental Health in New York State**

1) 1 in 10 children in New York State has a serious emotional disturbance.
2) More children suffer from psychiatric illness than from autism, leukemia, diabetes and AIDS combined.
3) 70,000 children are expelled from pre-school each year for behavioral reasons.
4) Of the 600,000 who use public mental health facilities in New York State, 10% are children.
5) There is a 2 to 4 month wait for intake appointments.

**Mental Health Issues in Bronx**

1) In 2007, 3420 children ages 18 and younger received mental health services per week in the Bronx.
2) In a survey conducted in 2003 of 21 Bronx-based mental health providers, 95% of the clinics identified day treatment as needed but unavailable.
3) In the same survey, 84% identified residential treatment as a necessary service but also unavailable.

**Issues:**

What are the problems:

1) Lack of culturally competent, linguistically appropriate mental health services for the community in the Bronx.
2) Lack of services specifically addressing the issues of young boys and male adolescents exposed to violence.
3) Lack of services for mother-baby dyad that promote attachment when the mother exhibits post-partum depression.
4) Funding for clinic-based mental health services.
5) Medical providers need training on how to identify and refer, when necessary, mental health issues to appropriate providers.
6) Many social workers, in underserved areas like the Bronx, are dealing with complex cases and the caseload that many of these professionals carry is beyond what is recommended to guarantee optimum care.
7) The prenatal period is an optimal time to address issues of depression, loneliness and the effects of parenthood yet it is a missed opportunity because of the pressures of providing care to patients that present with more obvious medical issues. Screening tools should be utilized at regular intervals of the prenatal period to ensure timely and effective referral to appropriate sources of care. Optimally, all patients should have a yearly assessment by a social worker.
8) Trauma and its attendant long lasting effects must be recognized and addressed by providers using a strength-based approach to care – the goal of mental health treatment.
and care is the eventual empowerment of the patient to address the presenting issues of violence, pain, isolation and other psychiatric issues.

**Recommendations:**

**What can be done to address the problem?**

What do we have to do to address the issue on the community level:

1) Conduct information campaigns promoting the importance of a medical home to ensure continuity of care to children and youth dealing with mental health issues. The campaign will emphasize the importance of quality, accessible care which includes education, behavioral skills development, and other mental health associated care for the child and family offered in a holistic, comprehensive way.

2) Train pediatricians, family physicians and other providers to identify and address mental health issues with clients to allow for appropriate and quality referrals to and engagement with mental health providers.

3) Recruit, train and hire social workers skilled in assessment and case management of clients with complex bio-psycho-social issues.

4) Mental health screenings should begin during prenatal care and should be offered at every appropriate opportunity during the pre and post natal period including the well child visit.

5) We recommend utilization of the adolescent health care model which provides comprehensive, confidential, and holistic services to young people. These services should be provided in a “one stop” environment, open hours that are convenient to youth with staff attuned and expert in engaging youth. We recommend that the Mt. Sinai Adolescent Center model be viewed as a best practice in the field of adolescent health care.

6) Lobby local elected officials to take action which will result in changes necessary to establish and fund programs to address mental health issues in the Bronx.

7) Educate parents about mental health issues.

8) Provide workshops for families on child development, early intervention programs and how to navigate the system including special education.

9) School- based mental health programs which will assist in identification of and treatment of issues.

10) Mother/baby in-patient program for mothers with severe post partum psychiatric problems.
11) Specific programs to target families and children traumatized by involvement in the child welfare system including foster care placement and post traumatic stress disorder stemming from exposure to violence and other traumas.

12) Providers must recognize and work utilizing a strengths-based approach to the treatment and care of mental health issues for the children and families of the Bronx.

**Who needs to be involved?**

Parents/caregivers

Health care providers including hospitals, health centers, local providers, and insurers

Schools, day Care centers, family day care providers and others engaged in the care and supervision of infants, children and adolescents.

Local elected officials – Office of the Borough President, Planning Boards, City Council members, and faith-based organizations

Mental health advocates
Bronx
Health Link

Child Health Initiative
2008-2009

Obesity
**Issue Area: Obesity**

Any child health agenda addressing obesity must also take on the levels of hunger, food insecurity and poverty with which this problem is inextricably tied. Poor children and their families face an increasingly hostile economic environment. Job losses, increasing food and housing costs and the diminution of existing safety net programs call for such a view. "Inconsistent access to nutritious food has been shown to be a main cause of the epidemic of overweight children among those living below the poverty level. Studies show that in response to inconsistent access to food, children tend to consume calorie-dense food when it is available, often leading to obesity." (Food Bank for NYC: Policy Report Series: *Child Hunger: The Unhealthy Return on Missed Investments*, 2008.) "Research shows that food-poor children are 90 percent more likely to have fair/poor health than excellent/good health. In New York City, more than one-half (53 percent) of elementary school children are overweight or obese."

**Facts:**

**Food insecurity, hunger and poverty in the Bronx**

1. In a recent survey of anti-hunger agencies, conducted by the NYC Coalition Against Hunger, among Bronx respondents, 88% reported feeding an increased number of people in the last 12 months.

2. According to the Census Bureau’s American Community Survey for 2007, 24% of families in the Bronx live in poverty and 38.1% of the children under 18 live in poverty.

3. The median family income in the Bronx is $37,977 or 55% of the Manhattan median family of $69,202

4. Twenty-four percent of borough residents receive food stamps.

5. Poverty increases the likelihood of children becoming overweight, as does being a member of a minority population.

6. Children are more vulnerable to obesity-related health problems because their bodies are growing and developing.

**Obesity in the Bronx**

1) Obesity is a major health problem in the country, the city and in the Bronx

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1 Sherry B, Mei Z, Scanlon KS et al. *Arch Pediat Adolesc Med.* 2004;158(12)1116-1118

2) According to the NYCDOHMH, nearly 1 in 3 children in Head Start in the South Bronx is obese; nearly 1 in 4 children in public elementary schools in the South Bronx is obese; nearly 4 in 10 are overweight or obese and about 1 in 6 high school students in the South Bronx is obese; and 1 in 3 are overweight or obese.

3) Poverty and lack of access to nutritious food has been shown to result in poor health among children as evidenced by high rates of nutrition-related diseases including diabetes and obesity.  

4) It is possible that, given the increasing prevalence of severe overweight, some children will live shorter and less healthy lives than their parents  

**Issues:**

**What are the problems:**

**Food Insecurity, hunger and poverty**

1) Current federal poverty measures, based on a model developed in the 1950’s, fail to account for realistic living costs such as rent, fuel, medical care and other living expenses.

2) Guidelines for eligibility for programs such as WIC, SNAP (Supplemental Nutrition Assistance Program - food stamps) and others are inconsistent and do not reflect the need for cost of food in the current market.

3) In 2007, according to the NYC Food Bank report: “Child Hunger: The Unhealthy Return on Missed Investment”, more than one out of five children in NYC received food in a soup kitchen or pantry, a 48% increase from 2006.

4) Despite the increase in the federal minimum wage, more than 69% of children living in poverty have at least one working parent.

5) According to FRAC's survey of families living below 185 percent of poverty -- the Community Childhood Hunger Identification Project (CCHIP) -- hungry children suffer from two to four times as many individual health problems, such as unwanted weight loss, fatigue, headaches, irritability, inability to concentrate and frequent colds, as compared to low-income children whose families do not experience food shortages. This relationship between hunger and health problems was unaffected by income. In other words, hunger had a strong effect on children's health no matter what the income level of their families.

6) The infant mortality rate is closely linked to inadequate quantity or quality in the diet of the infant's mother. In 2006, the infant mortality rate in the certain neighborhoods in

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3 Child Hunger: The Unhealthy Return on Missed Investments  
4 Olshansky S, Passaro DJ, Hershow RC, et al
the Bronx exceeded the national and city levels. The highest infant mortality rates are in Mott Haven (12.7), Williamsbridge (11.6) and Morrisania (9.6). Mirroring national trends, the infant mortality rate in New York City among African Americans continues to be double that of whites, with Puerto Ricans close behind.

**Lack of physical activity and school policy**

1) According to a May 5, 2008 article in the New York Sun, “Despite a legal mandate that gym classes be offered every school day, only 4% of New York City third-graders participate in daily physical education activities, a new report by the city's public advocate finds. The report, based on a survey of 100 randomly selected schools in the five boroughs, also concludes that only 12% of fourth-graders get the mandatory 120 minutes a week of physical education.”

2) Inadequate nutrition education in schools - Education on nutrition is offered in the school system, however, it is not systematic, culturally sensitive or consistently available at all grade levels.

**Focus Group Comments**

Youth participating in both focus groups all included exercise, eating well and not being overweight/obese as issues affecting their health and the health of the community

**Recommendations:**

**What can be done to address the problem**

**Government:**

1) Use of a universal school meal application and elimination of the means test application would address a barrier to enrollment and participation in the school meal program. It would reduce the burden of completing the forms and the stigma associated with receiving free school meals. It is estimated that many students in the New York City school system are eligible for the free school meal program but do not apply for fear of disclosing personal family information.

2) Continued and expanded funding of the Special Supplemental Nutrition Assistance Program for Women, Infants and Children.

3) In the Bronx, we currently have 19 WIC Centers and would recommend expansion to 26, one in each zip code.

4) Conduct an outreach campaign to increase the level of participation in the WIC program. According to the NYCDOHMH, an estimated 50% of residents who are eligible are not enrolled in the program.
5) Engage in an outreach campaign for the Supplemental Nutrition Assistance Program (food stamps) to increase the low level of enrollment in the program specifically among immigrants who currently have a low level of participation in the program.

6) Increase funding for Emergency Food programs in New York City.

7) Public parks – provide activities in parks that promote physical exercise for community residents. This must include measures that assure a safe environment in the parks.

**School-based:**

1) Ensure that the capital budget for the Department of Education includes new gym and recreation spaces.

2) Ensure compliance by New York City schools with the NYS mandated physical activity requirements for children (120 minutes per week).

3) The Department of education must open the school doors to allow community residents to use facilities.

4) Promote existing programs such as the Harlem Children’s Zone nutrition programs which emphasize healthy eating.

5) Oversight of school meal program.

**Food Justice:**

1) Increase the availability of fresh, affordable and nutritious food in low-income communities – expanding Green Markets, Community Gardens and Green Carts.

2) Increase funding for programs that educate the community about nutrition and fitness. Such programs must be in highly visible locations such as busy shopping districts, libraries, schools, and other community venues.

**What do we have to do to address the issue on the community level:**

1) Conduct information campaigns promoting the importance of a medical home to ensure continuity of care to children and youth dealing with the issues of overweight and obesity. The campaign will emphasize the importance of quality, accessible care which includes health education, behavioral skills development, and disease prevention for overweight and obese children and adolescents.
2) Train pediatricians, family physicians and obstetrician/gynecologists in successful methods to promote healthy lifestyles. This should begin during prenatal care and should be offered at very well child visit.

3) Lobby local elected officials to take action which will result in changes necessary to establish and fund programs to address food insecurity, hunger and obesity in the Bronx.

4) Educate parents about the health risks of obesity, and about the importance of healthy lifestyles. Offer methods which have been proven to promote behavior change.

5) Coordinate the efforts of the many food justice advocates and groups in the city to create a unified message and unified campaign.

**Who needs to be involved?**

Parents/caregivers

Health care providers including hospitals, health centers, local providers, and insurers

Schools

Day Care centers, family day care providers and others engaged in the care and supervision of infants, children and adolescents.

Local elected officials – Office of the Borough President, Planning Boards, City Council members

Faith-based organizations

Food justice advocates
ENDNOTES: FORWARD


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ENDNOTES: MATERNAL MOBIDITY AND MORTALITY


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FOOTNOTES: HEALTH CARE COVERAGE: MEDICAID


Ibid.


ENDNOTES: HEALTH CARE COVERAGE: THE UNINSURED


307 Ibid.
