Equity and Preterm Birth: A Context for Action

October 3, 2017
3 PM – 5 PM EST
This *Continuing Professional Education Program* is generously supported by the March of Dimes in partnership with Johnson & Johnson
Paul Jarris, MD, MBA (Moderator)
Chief Medical Officer, Sr. Vice President Mission Impact, March of Dimes Foundation
Today’s Speakers

Paula Braveman, MD, MPH
Professor of Family and Community Medicine and Director of the Center on Social Disparities in Health, University of California San Francisco, School of Medicine

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Interim Executive Director, Kirwan Institute for the Study of Race and Ethnicity, Associate Clinical Professor, Dept OB/GYN, Wexner Medical Center The Ohio State University

Donald K. Warne, MD, MPH
Chair of the Department of Public Health, North Dakota State University, Department of Public Health

Paul Jarris, MD, MBA (Moderator)
Chief Medical Officer, Sr. Vice President Mission Impact, March of Dimes Foundation
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Professor of Family and Community Medicine and Director of the Center on Social Disparities in Health, University of California San Francisco, School of Medicine
Black-White disparities in preterm birth: Do we know enough to act?

October 3, 2017
March of Dimes Webinar on PTB and Health Equity

Paula Braveman, MD, MPH
Professor of Family & Community Medicine
Director, Center on Social Disparities in Health
University of California, San Francisco
www.ucsf.edu/csdh
Persistent racial disparities in PTB: a key health equity issue

- Infant deaths
- Starting life unequal
  - Disability-- physical, mental, emotional
  - Adult heart disease, diabetes
- Burden on families
- Economic costs
  - Medical care
  - Special education
  - Social services
  - Productivity lost

(NY Times 2/27/07. With permission Photo: Dilip Vishwanat. Article: Nicholas Bakalar)
Causes unknown

Not explained by:
- Standard prenatal care
- Tobacco, alcohol, drugs
- Current income or education

Some researchers suspect:
- Infections
- Elective C-sections
- Environmental toxins
- Neighborhood/work conditions
- Genes or gene-environment interactions
- Stress, social support
- Lifelong experiences, especially in childhood
Evidence suggests social causes are important in the Black-White disparity in PTB

- Black immigrants from Africa/Caribbean have birthweight outcomes similar to Whites’
  - But their daughters’ outcomes are worse
- No/little PTB disparity among poor women
- Neighborhood effects observed often (physical & social environments associated with SES and racial inequity)
- Often (but not 100%) linked with stress
- Lower PTB rates among Black women in RCT of Centering Pregnancy
Plausible explanations: Unmeasured factors

- Structural racism tracks Black women into lower SES, e.g. via segregation
- SES = education, occupation, income, wealth = Resources and opportunities to be healthy
  - Polluted neighborhoods
  - Substandard housing (lead, mold, mites, roaches)
  - Inferior schools
  - Poor access to jobs and services
Unmeasured factors, continued

- **Structural racism, continued**
  - Health-promoting vs -damaging exposures
  - Produces chronic stress associated with constantly facing challenges with inadequate resources

- **Added stress, regardless of SES**
  - Intended or unintended, overtly or subtly discriminatory incidents, re self or loved ones
  - Anxiety/vigilance could be stressful and, if persistent, harm health.
Neighborhood options vary by race & SES. How could a neighborhood affect health?

- Pollution, toxins, crime
- Safe places to exercise
- Access to healthy food
- Ads for harmful substances
- Social networks & support
- Norms, role models, peers
- Despair
- Access to (good) jobs
- Quality of schools

Neighborhood options vary by race & SES. How could a neighborhood affect health?

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- Access to healthy food
- Ads for harmful substances
- Social networks & support
- Norms, role models, peers
- Despair
- Access to (good) jobs
- Quality of schools
- **Racial segregation tracks Blacks into poorer neighborhoods than Whites of similar income**

Stress is a biologically plausible cause

- Neuro-endocrine processes → immune/inflammatory mechanisms which could trigger labor
  - HPA axis, CRH
  - Autonomic Nervous System
  - Telomere shortening
  - Epigenetic effects of stressful experiences

The stress → PTB link: Biologically plausible?

Hypothalamus

Pituitary Gland

Adrenal Glands

Center on Social Disparities in Health, University of CA, San Francisco
The stress → PTB link: Biologically plausible?

STRESSOR

Hypothalamus

Pituitary Gland

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Center on Social Disparities in Health, University of CA, San Francisco
The stress → PTB link: Biologically plausible?

Center on Social Disparities in Health, University of CA, San Francisco
The stress $\rightarrow$ PTB link: Biologically plausible?

STRESSOR

Hypothalamus

CRH

Pituitary Gland

ACTH

Adrenal Glands

Center on Social Disparities in Health, University of CA, San Francisco
The stress → PTB link: Biologically plausible?

- STRESSOR
- Hypothalamus
  - CRH
  - Pituitary Gland
    - ACTH
    - Adrenal Glands
      - CORTISOL

Affects multiple organs & systems, including immune system

Center on Social Disparities in Health, University of CA, San Francisco
Does chronic worry about racism contribute to the racial disparity in PTB?

- 37% of Black women reported that they “very or somewhat often” worried they “might be treated or viewed unfairly because of their race…”
- Black women who chronically worried had twice the rate of PTB as those who did not
  - Before and after adjustment for many social, demographic, behavioral, & medical factors
- No racial disparity in PTB after adjusting for chronic worry & social/demographic factors
More questions than answers

- But stress is a plausible contributor
- Many studies conclude a racial difference is due to underlying biological differences because it persists after “controlling for SES” without considering unmeasured experiences/exposures across the life course
  - Impossible to control fully for SES
- Unmeasured racism-related disadvantages could be key—including severe poverty, lack of wealth, & range of experiences of bias, from childhood on
What produces health disparities across the life course and across generations?

Adapted from Diderichsen, U. Copenhagen
What to do, in the face of uncertainty?

• Paralysis?
• Await definitive research? (decades/generations?)
• Be guided by the best available information.
  • Target plausible causes
  • Use approaches likely to have favorable effects on other important factors whose health effects are more established, e.g., poverty, empowerment (self-efficacy/self-esteem), health-related behaviors, healthier environments
Arthur R. James, MD, FACOG
Interim Executive Director, Kirwan Institute for the Study of Race and Ethnicity, Associate Clinical Professor, Dept OB/GYN, Wexner Medical Center
The Ohio State University
“EQUITY”...

a dream deferred

“Vicissitudes” Artist, Jason DeCaires Taylor
Birth Outcomes and Health Equity: Creating the Healthiest Nation with Healthy Pregnancies

Arthur R. James MD, FACOG
Associate Professor
The Ohio State University Wexner Medical Center
Department of Ob/Gyn and Nationwide Children’s Hospital

Interim Executive Director
The Kirwan Institute for the Study of Race and Ethnicity

October 03, 2017
Disclosures:

I am a member of the:
• March of Dimes/Centers of Disease Control’s Health Equity Work Group
• Centering HealthCare Institute, Inc. Board of Directors
• GABE Advisory Board
• Center for Excellence, University of Illinois @ Chicago, School of Public Health

Conflict of Interest:

• I have no conflicts of interest
Objectives:

By the end of this lecture I hope attendees will...

1. Understand the significance of America’s Black:White racial legacy regarding the attainment of infant mortality goals.
2. Appreciate how history and past discriminatory practices have contributed to racial disparities.
3. Appreciate that the racial disparity in infant mortality is ‘not natural”, but man-made.
4. Appreciate the importance of taking a Social Determinants of Health approach to “undo” this disparity.
Infant Mortality

Definition: The death of any live born baby prior to his/her first birthday.

“The most sensitive index we possess of social welfare . . .”
Julia Lathrop, Children’s Bureau, 1913
Infant mortality is a community mirror, reflecting our collective capacity to promote and protect the health and well-being of our very youngest and most vulnerable.” (from City Lights, 9:2, p1)
Infant mortality is an internationally recognized measure of a society’s ability to provide food, housing, income, education, employment and health care to its citizens.
Infant Mortality is...

Multi-factorial. Rates reflect a society’s *commitment* to the provision of:

1. High quality health care
2. Adequate food and good nutrition
3. Safe and stable housing
4. A healthy psychological and physical environment
5. Sufficient income to prevent impoverishment

“As such, our ability to prevent infant deaths and to address long-standing disparities in infant mortality rates between population groups is a *barometer* of our society’s *commitment* to the health and well-being of all women, children and families.”
Overall U.S. Infant Mortality Rate (IMR) has improved

United States Infant Mortality Rate: 1980-2013

By 2013, IMR reached 5.96

52% decline

2014 IMR = 5.82

TABLE 20
Black:White IMR Disparity Gap:

Infant Mortality Rate by Race, U.S., 1980-2013

Note: Data are presented here by race only; data on Hispanic origin of mothers were not routinely collected until 1989
Survival Interval/Gap:
**Black:White IMR Disparity Gap:**

Infant Mortality Rate by Race, U.S., 1980-2013

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*In 2014, BIMR = 11.05

*US Historical Best
Black IMR = 11.2
Black:White IMR Disparity Gap:

Infant Mortality Rate by Race, U.S., 1980-2013

This difference in comparable rates represents a 33-year “Survival Gap”, meaning that unless we change this pattern, black babies will have to wait until the year 2046 to have the same opportunity of surviving the first year of life as white babies did in 2013. Unfair, unjust. We can do better.

Note: Data are presented here by race only; data on Hispanic origin of mothers were not routinely collected until 1989
“Healthy People” History regarding IMR:

- 1990-Healthy People
- 2000-Healthy People
- 2010-Healthy People
- 2020-Healthy People
Healthy People IMR Goals:

Infant Mortality Rate by Race, U.S., 1980-2013

HP 1990:

- a: HP 1990 Overall IMR Goal of 9
- b: HP 1990 Black IMR Goal of 12

*: Achieved Overall IMR goal for whites in 1986 with wimr of 8.8, well in advance of the Overall goal date.

Note: Data are presented here by race only; data on Hispanic origin of mothers were not routinely collected until 1989
Healthy People IMR Goals:

- **c**: HP 2000 Overall IMR Goal of 7
- **d**: HP 2000 Black IMR Goal of 11
- ^: Achieved Overall IMR goal for whites in 1992 with wimr of 6.9, well in advance of the Overall goal date.


Note: Data are presented here by race only; data on Hispanic origin of mothers were not routinely collected until 1989.
Healthy People IMR Goals:

Infant Mortality Rate by Race, U.S., 1980-2013

- HP 2010 IMR Goal of 4.5

Data from: http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_02.pdf. Deaths: Final Data for 2013. TABLE 20

Note: Data are presented here by race only; data on Hispanic origin of mothers were not routinely collected until 1989.
Healthy People IMR Goals:

Infant Mortality Rate by Race, U.S., 1980-2013

- IMR per 1,000 live births
- Black
- White

- HP 2010 IMR Goal of 4.5
- Achieved HP-1990 goal for black imr, 20 years after the goal date

Note: Data are presented here by race only; data on Hispanic origin of mothers were not routinely collected until 1989
Healthy People 2020
A society in which all people live long, healthy lives

Overarching Goals:

- Attain high quality, longer lives free of preventable disease, disability, injury, and premature death.
- Achieve health equity, eliminate disparities, and improve the health of all groups.
- Create social and physical environments that promote good health for all.
- Promote quality of life, healthy development and healthy behaviors across all life stages.
Healthy People IMR Goals:

Infant Mortality Rate by Race, U.S., 1980-2013

- **Black**
- **White**

**HP 2020**

- IMR Goal of 6

- **X**: achieved HP 2020 goal for white IMR in 1998 (22 years in advance of the goal date)


Note: Data are presented here by race only; data on Hispanic origin of mothers were not routinely collected until 1989
Patterns/Trends:

As a nation, we have established a pattern of...

• Achieving White IMR Goals well in advance of the goal dates...
• Simultaneously, achieving Black IMR Goals long after the goal dates
Do Black babies matter?

Do they matter as much as White babies?
Everyone says “yes”....

But, our action doesn’t support this response?
Despite the data, there are many who still believe that the Black IMR cannot improve...that the Black IMR is as high/bad as it is because of group level flaws amongst those of us who are Black.

Black people don’t love their babies as much

Dead-beat dads

Teen-aged pregnancies

Drug addicts

School drop outs

Genetics

Welfare Queens
But...there is no science to support that “group level flaws” amongst Black people are responsible for the disparity.
2011-2013 USA Infant Mortality Rates, by State and by Race, from Worse to Best:

<table>
<thead>
<tr>
<th>State</th>
<th>Overall</th>
<th>White</th>
<th>Black</th>
<th>Hispanic</th>
</tr>
</thead>
<tbody>
<tr>
<td>USA</td>
<td>6.01</td>
<td>5.06</td>
<td>11.25</td>
<td>5.09</td>
</tr>
<tr>
<td>MS</td>
<td>9.25</td>
<td>6.99</td>
<td>14.18</td>
<td>7.22</td>
</tr>
<tr>
<td>AL</td>
<td>8.57</td>
<td>6.92</td>
<td>14</td>
<td>6.99</td>
</tr>
<tr>
<td>LA</td>
<td>8.35</td>
<td>6.77</td>
<td>13.57</td>
<td>6.92</td>
</tr>
<tr>
<td>DE</td>
<td>7.64</td>
<td>6.76</td>
<td>13.13</td>
<td>6.84</td>
</tr>
<tr>
<td>OH</td>
<td>7.6</td>
<td>6.7</td>
<td>12.93</td>
<td>6.75</td>
</tr>
<tr>
<td>AR</td>
<td>7.41</td>
<td>6.51</td>
<td>12.9</td>
<td>6.68</td>
</tr>
<tr>
<td>SC</td>
<td>7.23</td>
<td>6.46</td>
<td>12.89</td>
<td>6.54</td>
</tr>
<tr>
<td>NC</td>
<td>7.2</td>
<td>6.4</td>
<td>12.87</td>
<td>6.35</td>
</tr>
<tr>
<td>IN</td>
<td>7.19</td>
<td>6.31</td>
<td>12.82</td>
<td>6.15</td>
</tr>
<tr>
<td>OK</td>
<td>7.17</td>
<td>6.15</td>
<td>12.66</td>
<td>6.09</td>
</tr>
<tr>
<td>TN</td>
<td>7.16</td>
<td>6.09</td>
<td>12.57</td>
<td>6.08</td>
</tr>
<tr>
<td>*MA</td>
<td>4.21</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*NJ</td>
<td>3.20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*MA</td>
<td>6.90</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*IA</td>
<td>2.65</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Best Rates in Green

NCHS: 8/6/2015
For the past 26 years...

- In different neighborhoods
  - To be a HS site IMRs at least 1.5x the national average

- Different demographics

- Different Races: Ghettoes/Inner City, Barrios, Indian Reservations

- Despite inadequate funding

- No matter how high risk the population

- No matter how under-resourced the community

HS has REPEATEDLY produced IMRs better than the national average...
Why the disparity?
Infant Mortality:

- Premature Births
- Congenital Anomalies
- SUID
- Maternal pregnancy Complications
- Placental or cord anomalies

Arthur R. James
Infant Mortality:

- Premature Births
- Congenital Anomalies
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Disparities

Social Determinants of Health/Lifecourse

Arthur R. James
Disparities in Birth Outcomes:

Social Determinants of Health:

Racism
Fatherless households
Poverty
Limited Access to Care
Under-Education
Lower graduation rates

Housing
Incarceration rates
Unemployment
Hopelessness

No Insurance
Neighborhoods
“Medical baggage”

Weathering

Smoking

Policies

Unemployment

Hopelessness

Stress

Language

Substance Use

Poor Working Conditions

Nutrition

Family Support

Teen Births

Nutrition

Weathering
Most HS sites reside in historically REDLINED (or otherwise marginalized) communities...

where “conditions” have been created that have had deleterious “consequences” on our health
Disparities are Natural
Racial Disparities: we made it this way?

We often perceive racial health disparities as consequences of “nature”. As such, we convince ourselves that these differences are “fixed” or “hardwired”; a part of what is different about us as people and therefore cannot be changed.

Similarly, we also often see America as it is instead of an America as it should be…and we accept the difference between the two as “normal”.

However, these disparities are differences that we created, differences that occur as a consequence of systems that we put into place. Therefore, we know they can be changed and would suggest that their persistence is in part because of our unwillingness to “undo” what we have done.
The Real Narrative About What Creates Health Inequities

• Disparities are not just because of lack of access to health care or to poor individual choices.

• Disparities are mostly the result of policy decisions that systematically disadvantage some populations over others.
  • Especially, populations of color and low income
  • Structural Racism
What does history tell us about how our cities took shape?

STRUCTURAL Determinants (policies/systems/"isms")

CONDITIONS (Social Determinants)

CONSEQUENCES ("marginalization", increased risk for infant mortality)
CAUSES

CONDITIONS

CONSEQUENCES
The persistence of this “gap” says something about us!

"...our ability to prevent infant deaths and to address long-standing disparities in infant mortality rates between population groups is a barometer of our society’s commitment to the health and well-being of all women, children and families.”...SACIM

Note: Data are presented here by race only; data on Hispanic origin of mothers were not routinely collected until 1989
### African American Citizenship Status: 1619-2017

<table>
<thead>
<tr>
<th>Time Span:</th>
<th>Status:</th>
<th>Years:</th>
<th>% U.S. Experience:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1619-1865</td>
<td>Slaves:</td>
<td>246</td>
<td>62%</td>
</tr>
<tr>
<td></td>
<td>“Chattel”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1865-1964</td>
<td>Jim Crow:</td>
<td>99</td>
<td>25.0%</td>
</tr>
<tr>
<td></td>
<td>virtually no</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Citizenship rights</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1964-2017*</td>
<td>“Equal”</td>
<td>52</td>
<td>13%</td>
</tr>
<tr>
<td>1619-2017</td>
<td>“Struggle”</td>
<td>398</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>“Unfairness”</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* USA struggles to transition from segregation & discrimination to integration of AA’s
Time-line of African American Experience:

- **Slavery:** 246 yrs. (62% of time)
- **Jim Crow:** 99 yrs. (25% of time)
- **Since CRA:** 52 yrs. (13% of time)

**87% of the AA experience either as Slaves or under Jim Crow**

*CRA: Civil Rights Act*
Strive for EQUITY...
According to many researchers, the situation to the right is our current reality and helps to understand why this work is so difficult. Nevertheless, we have to persevere...because **Black Babies Should Matter too**.
Erasing the Gap(s):
Advocacy can be challenging because some of us work for organizations that prohibit advocacy or the organization might insist that you can only say what they approve of...even if it is not in the best interest of improving infant mortality or improving the racial disparity in birth outcomes. You have to follow your own personal “moral compass.”

By themselves are not good enough... we must advocate AND mobilize to save our babies.
...because 400 years is enough!
It always seems impossible until it's done.

--Nelson Mandela
1918-2013
Thank you
Contact Information:

arthur.james2@osumc.edu
614.293.4929
Donald K. Warne, MD, MPH
Chair of the Department of Public Health, North Dakota State University, Department of Public Health
Impact of Unresolved Trauma on American Indian Health Equity and Preterm Birth

March of Dimes Webcast
October 3, 2017

Donald Warne, MD, MPH
Oglala Lakota
Professor and Chair, Department of Public Health
North Dakota State University
### Overview

#### Learning Objectives:

1. Describe American Indian Health Disparities in Historical Context

2. Explain the role of epigenetics in unresolved trauma

3. Assess potential solutions to preterm birth disparities in tribal communities
Traditional View of Public Health
AI Health Disparities

Average age at death in ND (2010 – 2014):

77.4 Years in the White Population

56.6 Years in the AI Population

AI/AN Health Disparities

Average age at death in SD: 81 v 54
AI/AN Health Disparities

Life expectancy at birth, males, 2012
Historical Context
Historical Context
Historical Context
Historical Context
AI/AN Population by County

Alone or in Combination

Source: U.S. Census Bureau, 2010 Census Redistricting Data (Public Law 94-171) Summary File, Table P1.
AI/AN Population Decline and Recovery, 1492 – 2010
Inter-Generational Basis for Chronic Disease Disparities Among American Indians and Alaska Natives

Historical Trauma

Genocide

Chronic Disease Disparities

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Epigenetics

- **Epigenetics** refers to the study of changes in the regulation of gene activity and expression that are not dependent on DNA sequence.
Inter-Generational Basis for Chronic Disease Disparities Among American Indians and Alaska Natives

Historical Trauma

- Genocide

Gestational Stressors

Birth

Chronic Disease Disparities

Boarding School Experiences

- Abuse (physical, sexual)
- Neglect
- Abandonment
- Forced Removal
- Loss of culture & language
- Forced Christianity
- Lost traditional parenting & family structure

© Warne & Lajimodiere 2012
Historical trauma is the collective emotional wounding across generations that results from massive cataclysmic events – Historically Traumatic Events (HTE)*

- The trauma is held personally and transmitted over generations. Thus, even family members who have not directly experienced the trauma can feel the effects of the event generations later
Inter-Generational Basis for Chronic Disease Disparities Among American Indians and Alaska Natives

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Gestational Stressors

Birth

WIC

Childhood Stressors

FDPIR

Chronic Disease Disparities

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Gestational Stressors

Birth

Childhood Stressors

WIC

FDPIR

Adverse Childhood Experiences
- Abuse (physical, sexual)
- Neglect
- Substance Abuse in home
- Mental Health Dx in home
- Witnessing violence
- Divorce
- Food insecurity
- Family member in prison

Chronic Disease Disparities

© Warne & Lajimodiere 2012
Long Term Health Effects of ACEs

- 103% more likely to smoke.
- 43% more likely to become suicidal
- 103% more likely to become addicted to alcohol
- 192% more likely to develop a drug addiction
- Increased risk for diabetes, heart disease, cancer
- Strong correlation to poverty and risk factors for preterm birth
Inter-Generational Basis for Chronic Disease Disparities Among American Indians and Alaska Natives

Historical Trauma

Gestational Stressors
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Adulthood Stressors
- Adverse Adulthood Experiences
  - Alcoholism & SA
  - Suicide rates / death rates
  - Poverty / Poor nutrition
  - Racism / Toxic Stress
  - Role models
    - Few positive
    - Many negative
    - Parenting

Chronic Disease Disparities

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Inter-Generational Basis for Chronic Disease Disparities Among American Indians and Alaska Natives

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Chronic Disease Disparities

Genocide

© Warne & Lajimodiere 2012

Next generation
# Significant Challenges

## Social Determinants
- Poverty
- Trauma
- Politics
- Inattention/Neglect
- Racism
- Inequity

## Outcomes
- Health Disparities
- Education Inequality
- Generational Poverty
- Ongoing Racism
- Worsening Inequity
- Suffering and Death

---

Need to address issues in a comprehensive manner—medical, behavioral, public health…
Promising Practices

• ACE Prevention
  – Home Visiting Program (also decreases IMR)
  – Parenting Skills Programs
  – Culturally Relevance

• ACE Mitigation
  – SMART Protocol and related programming
  – Engage traditional healers
Building a movement
Invitation to participate in Prematurity Campaign Collaborative

Purpose: To engage a wide array of organizations, drawing on their collective expertise to identify issues and new ideas, as well as opportunities for outreach, alignment, and implementation.

You are invited to do the following as a Collaborative participant:

- Join quarterly virtual meetings of full Collaborative
- Suggest ideas or topics for consideration by the Steering Committees or workgroups
- Sign up for a workgroup and participate in their virtual meetings – each workgroup meets once every two months.

Use one of two ways to sign up for a workgroup:
1. Complete the sign-up form on marchofdimes.org/collaborative
2. Email collaborative@marchofdimes.org

Website: marchofdimes.org/collaborative
Full Collaborative Participants

Steering Committee

Clinical and Public Health Practice Workgroup
Research Workgroup
Health Equity Workgroup
Policy Workgroup Communications Workgroup
Funding & Resources Workgroup

March of Dimes Staff Support
Questions?