Health Equity Column: From History to Action in Improving Maternal, Infant, and Neonatal Health Outcomes

Jenné Johns, MPH, Sheree H. Keitt, DrPH, MPH, CHES

This June, we celebrate, “June-teenth” a national holiday to commemorate the ending of slavery in the United States. As we acknowledge the ending of this traumatic lived experience for African American’s we, must also acknowledge the continued harm and injustice faced by African American’s who seek social and racial justice in healthcare.

The infant and maternal health crisis faced by Black women and babies forces us as a healthcare community to examine the root causes and deliver equity-oriented solutions to improve the birth outcomes for historically vulnerable yet deserving birthing populations. These equity-oriented solutions expand across the perinatal and neonatal spectrum, as these solutions will save deserving lives and reduce burdens placed on families, communities, and the healthcare system.

The National Healthy Start Association is a leading nonprofit organization focusing on saving our nation’s babies by delivering nationwide equity-oriented solutions. In this interview, I am honored to share highlights of my interview with a leading policy, advocacy, community engagement leader, and Premie Mom, Dr. Sheree Keitt. Through our interview, as you learn about the equity-focused maternal health initiatives led by Dr. Keitt and the national chapters of the National Healthy Start Association, I encourage you to leverage these resources within your respective institutions and to support the closing of racial and ethnic disparities in perinatal and neonatal health outcomes based on the non-hospital maternal safety bundles framework.

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What is your definition of health equity?

When I think about health equity, I use the definition provided by the American Public Health Association and World Health Organization, which states that equity is “when everyone has the opportunity to ‘attain their full health potential,’ and no one is ‘disadvantaged from achieving this potential because of their social position or other socially determined circumstance.” However, I

have learned that you cannot address health equity without first focusing on inequity at its core, which is deeply rooted in unjust practices based on race, social and economic status, demographics, and geographic status. All of which affect health, hence the social determinants of health.

What are your organizational priorities for addressing health and racial equity in neonatal care?

The National Healthy Start Association (NHSA) is the membership organization for federal Healthy Start programs. The federal Healthy Start initiative is the Health Resources and Services Administration Maternal and Child Health Bureau’s signature community-based and community-driven program focused on reducing infant mortality. Healthy Start was created as a demonstration project in 1991, primarily focused on improving pregnant women’s access to prenatal care, and has evolved to focus on improving women and men’s health starting preconception and infant health to early childhood. Healthy Start participants experience persistent health disparities, which stem from issues directly related to health equity and social justice. Healthy Start program sites are in communities where the infant mortality rate is at least 1.5 times that of the U.S. national average. In addition, the majority of communities are facing racial and ethnic disparities in birth and maternal health outcomes.

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As part of our mission, NHSA aims to be an effective advocate in policies and programs that improve the health status of women, men, and infants and strengthen the capacity of Healthy Start programs and community-based maternal and child organizations nationwide. Over the next three years, NHSA will expand its mission and strengthen our brand and commitment to members. Developing strategic partnerships, engaging consumers in programmatic activities, and successfully communicating the outcomes of

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Healthy Start projects are among the goals NHSA has put in place to become a more effective and vital organization.

Some of the work that we are doing at the association is below that directly addresses health and racial equity in neonatal care are below:

Alliance for Innovation on Maternal Health Community Care Initiative (AIM-CCI)

In 2019 HRSA awarded the NHSA a cooperative agreement for a five-year project to support the development and implementation of non-hospital maternal safety bundles within community-based organizations and outpatient clinical settings across the United States that serve communities experiencing high rates of maternal morbidity and mortality. NHSA is currently partnering with pilot sites comprised of community-based organizations to work together collaboratively through Local Maternal Safety Workgroups, implement safety bundles, and measure improvement with the goal of improving maternal health outcomes. The ultimate goal of AIM CCI is to establish a standard approach in all communities across the United States. In addition, the maternal safety bundles are framed around equity. Now you may ask if the focus is on maternal health, how does that address health and racial equity in neonatal care?

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Supporting Healthy Start Performance Project (SHSPP)

NHSA works in partnership with the National Institute for Child Health Quality on the SHSPP. The purpose of SHSPP is to promote consistency in service delivery across Healthy Start programs and support Healthy Start grant recipients in providing effective, evidence-based service delivery through training and technical assistance. SHSPP strengthens the implementation of Healthy Start activities by providing capacity-building assistance, including ongoing technical assistance training and education to HS grant recipients in the implementation of activities in accordance with the program's four approaches to reduce disparities in infant mortality and adverse perinatal outcomes. The four approaches are to 1) improve women's health, 2) improve family health and wellness, 3) promote systems change, and 4) assure impact and effectiveness through ongoing HS workforce development, data collection, quality improvement (QI), performance monitoring and program evaluation. NHSA is subcontracted through NICHQ to provide training and technical assistance in the area of Fatherhood, Community Action Networks, Maternal Morbidity Mortality, and Women's Health, and Equity, Implicit Bias and Racism and Disparities lead the Healthy Start Mentoring Program and support the development of publication and presentations and communications strategies to inform community stakeholders about their sustainability strategy

Where Dads Matter Initiative

Healthy Start projects have consistently expressed a need to make Healthy Start sites more father-inclusive by involving dads in program activities and in the lives of their children and the promotion of responsible fatherhood with or without marriage. During pregnancy, the absence of fathers during increases the risk of fetal and infant morbidities such as low birth weight, preterm birth, and small-for-gestational-age. Women whose partners are more involved in the pregnancy experience better birth outcomes. Moreover, infant death in the first 28 days of life is four times higher when a father is not involved. Based on the literature, father's presence significantly impacts infant birth outcomes and overall emotional and social well-being. Here at NHSA, we are taking a holistic approach by addressing the social determinants of health so that the total family can achieve health equity.

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What personal and professional experiences led you to focus on health equity in neonatal care?

I started my career working in health communications, serving as a trusted community voice to build a collaborative of organizations and community members to convene and develop strategies to address racial and ethnic disparities and inequities in maternal and infant health outcomes. At the time, I was not fully aware of the risk factors that can adversely affect the birth outcome of an infant. My background was in marketing and community engagement, so my role was not public health content-based but focused on coalition-building and partnerships efforts. Because of this work, I became passionate about reducing infant mortality and improving maternal health because I was unaware of the disparities and inequities that existed in my own zip code.

After working in maternal and child health for over ten years, while working on my dissertation, focused on preconception health and preterm birth, I became pregnant with Monoamniotic Monochorionic twins. I was told that my babies only had a 50% chance of surviving pregnancy, and if they made it to 32 weeks, they would be delivered via cesarean. I was also told to expect a lengthy NICU stay. My sons were born at 30 weeks and had a NICU stay of 30 days. Prior to my pregnancy, I focused most of my work on prevention; therefore, I was not fully educated about the NICU and parents' experiences. After experiencing the NICU, I became more interested in other parents' experiences, primarily those of color and low-income families. Because of my public health background, I was able to ask the right questions, understand

the medical terminology, and advocate for my children to have the best care. My NICU experience strengthened my capacity to provide training, technical assistance, and support to community-based organizations serving infants and their families. This experience also opened my eyes to the potential inequities, bias, and other unfair treatment that can occur when a parent does not fully understand things such as the medical rounds, the right to breastfeeding and obtain lactation support, or being engaged in decisions that they have a right to make.

What is your call to action for the industry as we seek to eliminate health and racial inequities in neonatal care?

I would like to see hospital systems collaborating with local health departments, community-based organizations, and community members to develop a framework to address health and racial equity. Many organizations are now taking an approach to review program policies and practices from an equity lens to address any unintended or intended consequences that are inequitable. A great way that hospitals can do this through their community health needs assessment (CHNA). Every three years, to maintain their tax-exempt status, nonprofit hospitals are required to conduct a CHNA. Within that CHNA, they must represent the broad interests of the community served by the hospital facility.

I have always valued and encourages community voice and participatory methods to engage community-level organizations and members in the decision-making process of programs and policies that affect their community. The involvement of community voices in CHNAs can create a dialogue about the root cause of equity. In addition, including community members provides an opportunity to voice their lived experiences and provide insight into issues in the community such as lack of resources, housing, or bias that certain groups may have experienced.

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Also, the involvement of community voice can provide support to a hospital in building their internal capacity related to understanding institutional and structural racism. For example, historical trauma can exist in communities suffering from post-traumatic stress passed down from previously experienced trauma from colonialism and federal policies resulting in cultural genocide, enslavement, and medical experimentation. Hospital staff should also be aware of theories such as weathering, which states that there are psychosocial factors in racial/ethnic minority groups living in the

U.S. that contribute to their health diminishing over time. To demonstrate, college-educated U.S.-born Black women have worse birth outcomes than white women who are high school dropouts. Furthermore, foreign-born Black women who give birth in the U.S. have similar birth outcomes to U.S.-born white women. This is directly related to the Immigrant Paradox. Individuals who migrate to the U.S. have superior health outcomes than U.S.-born individuals of the same racial and ethnic background. Overall, the assertion is that is foreign-born Black women have not experienced the racism that Black women have experienced across their life course. Having conversations and becoming educated about racism, equity, and disparities are necessary for hospitals to develop any type of framework that addresses health equity.

Overall, I believe the keyword to this question is “action.” The industry must make addressing eliminate health and racial inequities in neonatal care a priority. Also, the strategies should be realistic and actionable and focus on improving the health outcomes of infants AND about actions before birth that may mitigate a pre-term birth or undue stress of a birthing person.

Disclosure: *The authors have no disclosures.*

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Bio: Sheree H. Keitt, DrPH, MPH, CHES, has over 15 years of working in the nonprofit and public health sectors on the local, state, and national levels. Sheree is currently a Senior Program Manager at the National Healthy Start Association and an Adjunct Professor at Trinity Washington University. Sheree earned a Bachelor of Arts in advertising from Michigan State University, a graduate certificate in public health at the State University of New York, Albany, and both Master of Public Health in Community Health and Doctor of Public Health degrees from Walden University. Sheree is also a certified health education specialist.

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Jenné Johns, MPH is President of Once Upon A Premie, Founder of Once Upon A Premie Academy, mother of a micropreemie, author, speaker, advocate, and national senior health equity leader. Once Upon A Premie is a non-profit organization with a two-part mission: 1.) to donate Once Upon A Premie books to NICU families in under resourced communities, and 2.) lead virtual health and racial ethnic training programs and solutions to the neonatal and perinatal community through the Once Upon A Premie Academy. Jenné provides speaking, strategic planning and consultation services for fortune 500 companies focused on preemie parent needs from a cultural lens and reading as a tool for growth, development, and bonding. Jenné is also a national senior health equity thought leader and has led solutions-oriented health equity and quality improvement portfolios for the nations' largest health insurance and managed care companies.