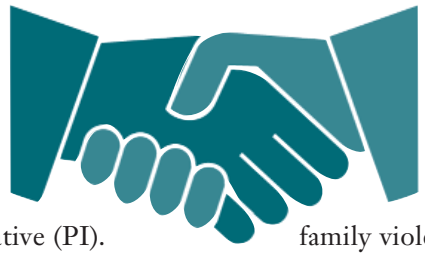
FIMR
Making Healthy Communities Happen
A PUBLICATION OF THE NATIONAL FETAL AND INFANT MORTALITY REVIEW PROGRAM
Spring 2004

Healthy Start and FIMR— A partnership that is making a difference

Local Healthy Start and FIMR partnerships improve a community's ability to reduce infant mortality and create effective services and resources for women, infants and families. The value of such partnerships with FIMR is documented by the Women's and Children's Health Policy Center at the Johns Hopkins University (JHU) FIMR national evaluation. JHU found that local health departments were two times more likely to report progress in meeting goals and objectives for pregnant women if they had either a FIMR or another perinatal initiative (PI). And, if both FIMR and a PI, such as Healthy Start, worked together, they were ***nine times*** more likely to report progress. This remarkable synergistic relationship can be a major benefit to Healthy Start communities.



Healthy Start began in 1991 as a Health Resources and Services Administration (HRSA) initiative in 15 urban and rural communities nationwide which were experiencing higher than national average infant mortality rates. Healthy Start promotes community-based maternal and child health programs, particularly those that focus on the reduction of infant mortality, low birthweight and racial disparities in perinatal outcomes. Today there are Healthy Start projects in 96 communities. These projects have five main focuses: disparities in perinatal health, border health, high-risk interconception care, perinatal depression and/or family violence. Healthy Start programs excel at community approaches such as outreach and home visiting programs.

FIMR is an action-oriented, community based continuous quality improvement process that complements Healthy Start efforts in addressing issues related to infant mortality, low birth weight and

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inside

NFIMR
NATIONAL FETAL INFANT MORTALITY REVIEW PROGRAM

VISIT THE NFIMR WEBPAGE http://www.acog.org/goto/nfimr

FIMR Faces Now in every issue!

Healthy Start/FIMR Faces

—Peter Schafer
Executive Director/
FIMR Team Member
Baltimore City Healthy Start, Inc.
Baltimore, MD

My experience serving on the Baltimore Perinatal Systems Review (PSR), as our FIMR is called, has provided me the opportunity to step back from the day-to-day responsibilities of directing the work of Baltimore City Healthy Start, to be able to view our mission of improving the health and well-being of some of Baltimore's most vulnerable residents from a uniquely illuminating perspective. It is especially rewarding to see a service component that benefits Healthy Start clients develop from the findings of case reviews.

For example, FIMR reviews found that many of the women interviewed by FIMR staff within 12 months of their most recent fetal or infant loss were again pregnant. Client data supported FIMR findings. Among Baltimore City Healthy Start clients, interpregnancy intervals of less than 12 months are common (35%), and less than 24 months even more so (55%). Yet, 82% report that they do not want to have more children.

Based largely on the FIMR findings, we were successful in securing funding to allow Healthy Start to hire a full-time Nurse Practitioner who now provides home-based postpartum clinical care, home-based family planning counseling and education.

For more information, contact Mr. Schafer at Baltimore City Healthy Start, Inc., 326 St. Paul Place, Suite 200, Baltimore, MD 21202.

FIMR Faces is a new editorial addition to *FIMR: Making Healthy Communities Happen*. To submit you articles on the challenges and joys of working with FIMR, please send your 500-word document to:

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NFIMR
Making Healthy Communities Happen

NFIMR is a collaborative effort between the American College of Obstetricians and Gynecologists (ACOG) and the federal Maternal and Child Health Bureau. Supported by Project #2U93MC00136-10 from the Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration, Department of Health and Human Services.

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Fifth National Fetal-Infant Mortality Review Conference

"Improving Communities Through Community Action"

August 12–August 14, 2004

Renaissance Hotel
Washington, DC

The registration fee is $335 and the hotel room rate is $139 single/double. The preliminary program will be availble soon.

The National Fetal and Infant Mortality Review Program is a partnership between ACOG and federal MCHB.

Healthy Start
Continued from page 1

health disparities. Three components of the FIMR process are especially valuable:

- Diverse coalition/community partnership building component of the process itself.
- Inclusion of the key informant/home interview with mothers who have lost their babies.
- Outcome interventions—based on the decisions of the whole community and the families who live there.

Today many Healthy Start programs are integrating their activities with FIMR. There are several ways that FIMR and Healthy Start are working together, including the following:

- FIMR findings may spur a community to apply for a Healthy Start grant;
- Healthy Start may fund FIMR in whole or part;
- FIMR may ask the Healthy Start Coalition to act as their FIMR community action team (CAT); and/or
- Healthy Start members may serve on the FIMR community action team.

FIMR Findings Contribute to Successful Healthy Start Applications

In some instances, it is the FIMR findings and recommendation for actions that spur communities to apply for and receive a federal Healthy Start program award. In Jacksonville, Florida, FIMR findings related to the need for improved pre-conceptional care led to a successful Healthy Start application to fund a Project Magnolia, a health care center for medically high-risk women of childbearing age.

Carol Brady, the Executive Director of the state's Northeast Florida Healthy Start Coalition said, "Our local FIMR findings drove the development of Project Magnolia. We developed specific interventions for the project based on risk factors identified through the FIMR process."

Healthy Start Funds FIMR In Whole or Part

The new Bootheel County Missouri Healthy Start program has received full funding to develop its FIMR program. Phyllis Rowe, FIMR coordinator said, "We wanted FIMR to be an integral part of our Healthy Start program because we know we need all the facts about fetal and infant mortality to be able to make a difference. FIMR is essential to paint the complete picture of gaps in community systems as well as gaps in family supports. FIMR will point out the best solutions to these problems."

In Tulsa, Oklahoma the FIMR coordinator at the Tulsa Health Department Megan Oehlke reported, "We share our findings with the Tulsa Healthy Start. This past year, the Healthy Start program has allocated a part-time staff person to FIMR for 8 hours a week. Her time was funded by both the Oklahoma State Department of Health and Healthy Start. This additional staff time has been incredibly helpful in our FIMR work!"

Healthy Start Acts as FIMR's Community Action Team

In New Haven, Connecticut, federal Healthy Start initially funded a FIMR physician consultant and data analyst. The FIMR CRT findings are reported to New Haven's Perinatal Partnership, a committee of the Healthy Start Program. Maria Damiani, director of Women's Health for the New Haven Health Department said, New Haven's FIMR and Healthy Start programs support and complement each other well. "We are pleased to be integrating our recommendations into Healthy Start. This collaborative effort assures that actions that emerge will be culturally competent, family friendly and specific to the needs of our city."

Healthy Start Members Serve on FIMR Community Action Teams

The FIMR Community Action Team can benefit from having Healthy Start representatives as members because they contribute to development of culturally appropriate interventions. From 1991 to the present, Saginaw, Michigan has had an active FIMR program with a dynamic 40-member community action team. In 1998, the Saginaw Healthy Start program was funded as a direct result of FIMR findings about gaps in prenatal care. Members of the Saginaw Healthy Start program and Healthy Start consumers now are an integral part of the FIMR community action team. Rosemary Fournier, Michigan State FIMR coordinator said, "FIMR programs have to be linked to the community. Having Saginaw Healthy Start consumers and staff participating in FIMR helped to develop an even-better understanding of culturally appropriate strategies to address local issues."

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Healthy Start Programs Also Utilize the National FIMR Resource Center

At the national level, the vast majority of Healthy Start programs (~89%) are currently subscribing to the NFIMR newsletter. As a NFIMR newsletter subscriber, Healthy Start projects also receive NFIMR Bulletins and other materials on a regular basis. Many also participate in the bi-weekly NFIMR listserv or log on to the NFIMR website. Healthy Start FIMR programs also take advantage of the technical assistance that NFIMR can offer. Kathleen Buckley, NFIMR director said, "In the past several months, we have provided in-depth information about FIMR start up to new Healthy Start FIMR projects in Arizona, Missouri and Louisiana. We also provide technical assistance to scores of ongoing Healthy Start FIMR programs, as well. It is gratifying to know that so many new and continuing federal Healthy Start projects are really committed to making FIMR an integral part of their efforts. FIMR and Healthy Start are ideal community partners."

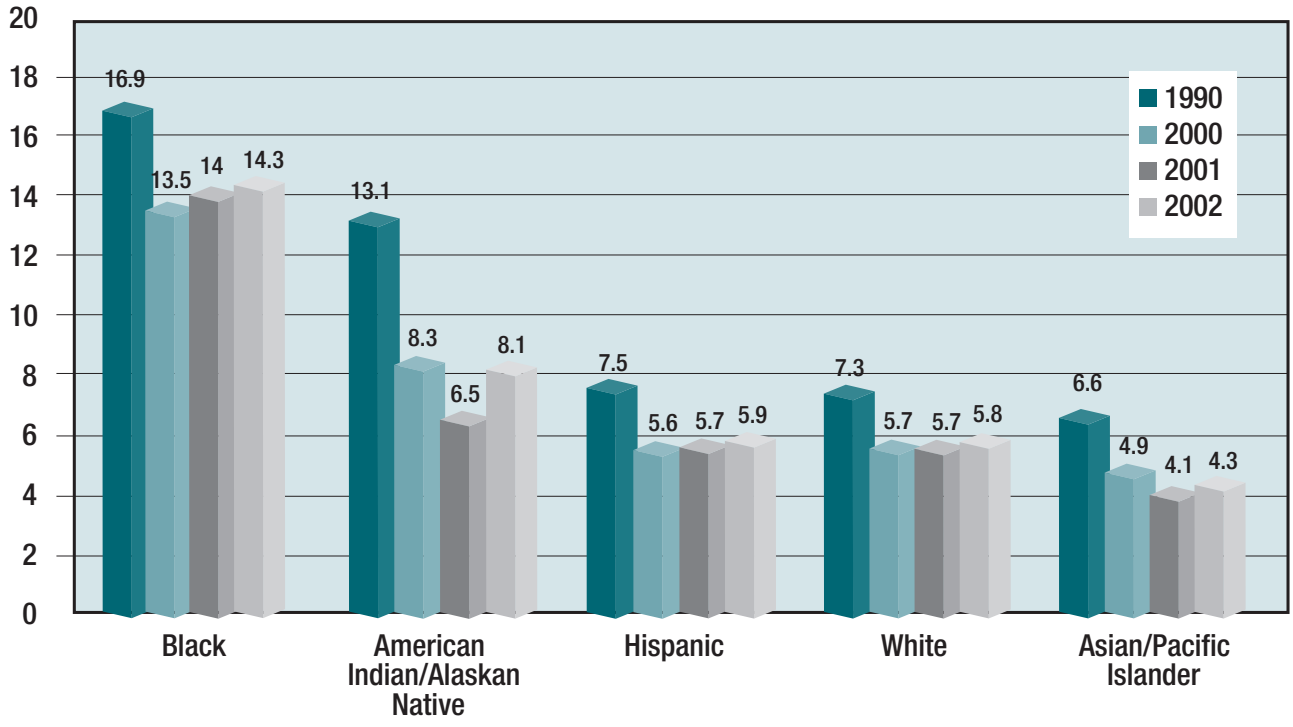
Healthy Start and FIMR succeed primarily because community partnerships are not incidental to their efforts to reduce infant mortality, low birth weight and health disparities. At the core of both programs is the mission to partner with diverse community stakeholders to address these issues. At the heart of both programs each believes that programs will never be able to bring about decreases in infant mortality without the upfront input and support of the community. Working together, FIMR and Healthy Start are significantly able to multiply their efforts to reduce infant mortality and health disparities, and improve the health and well being of women, infants and families.

References

The entire FIMR evaluation report can be viewed on the Johns Hopkins University website, www.med.jhu.edu/wchpc or call or write NFIMR for a copy. For more information about the Healthy Start Program, go to http://mchb.hrsa.gov/programs/default.htm. For the names and addresses of all of the Healthy Start programs, go to the National Healthy Start Association at http://www.healthystartassoc.org/.

US Infant Mortality Rates 1990, 2000-2002 Per 1,000 Live Births

Source: National Vital Statistics Report. National Center for Vital Statistics. Vol 52, No 13 Feb 11, 2003



FIMR PREMATURITY SUCCESS STORIES

Creating Community-Based Continuity of Care for Families Grieving an Infant Loss

In Tulsa, Oklahoma, FIMR is funded by the county health department. Healthy Start consumers and staff participate in the community action team. Tulsa County FIMR case review identified that most families were unaware of or unable to access appropriate medical, mental health and social support services after an infant death occurred.

Tulsa FIMR community action teams conducted the following series of related activities in order to address the lack of grief support services in the Tulsa County area. First, all area providers who offer services or come in contact with grieving families (both parents and siblings) were identified. FIMR staff then created a summary of current practices and a resource directory to aid referrals for follow up care.

The next step was to evaluate the institutional systems already in practice at key community providers. Members of the FIMR team identified current medically-based policies for caring for families at the time of death (and afterwards) were reviewed and compared with grief standards from non-medical settings and from other communities. After this review, the community action team issued a call-to-action for multiple service providers to convene to establish a minimum standard of care for grief support for families after infant death. First responders, social service agencies, medical and mental health providers, funeral directors and bereaved parents met on a monthly basis. They reviewed available information and constructed possible ways for meeting family support needs up to 16 months after the infant death event.

Recent changes in information-sharing liability (i.e. HIPAA regulations) were seen as a significant barrier to the implementation of any cross-agency standard of care. One big success to date has been the development of a cross-agency release of information (ROI) form.

The Tulsa community is now at the point of determining which proposed standards developed by the community action team should be incorporated as the minimum services any family should expect after death—regardless of individual circumstances.

Some of these options include:

- Mental health/family-support triage (outside the hospital setting) for parents and siblings within 24-48 hours after the death occurs;
- A core of trained, volunteer grief advocates to interface with affected families, one-on-one, up to 16 months after the death;
- Time-based informational mailings to families addressing issues from the acute grief period through resolution and acceptance of the loss; and
- 24/7 access to an internet-based community resource directory for bereaved families and those trying to assist them.

It is important to acknowledge community participants who committed staff and professional time. More than 30 agencies, including federal Healthy Start, came together to create the draft of a standard of grief support services for the Tulsa area. Tulsa FIMR team members feel that the broad-based support and early buy-in for creating the standards of care will continue to be critical as they move the next phase. As they move from preparation to implementation, FIMR has been able to incorporate training for community agency staff to increase their knowledge of the grieving process.

Tulsa's success story is still being written after three years of diligent effort. They expect this year will mark the beginning of important local institutional changes directed by a concerned community. By providing a structure for information and passion to come together, the FIMR process in Tulsa has allowed community members to make a difference in the lives of bereaved families.

For more information, please contact Pagette Hill or Megan Oehlke, TFIMR Program, Tulsa County Health Department, 5051 South 129th Avenue, Tulsa OK 74134.

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Reports from the Center for Budget and Policy Priorities

In December 2003, the Center for Budget and Policy Priorities released a report that documented that 34 states have made cuts over the past two years in public health insurance programs such as Medicaid and the State Children's Health Insurance Programs (SCHIP). The Center notes that some 1.2 million to 1.6 million low-income people—**including 490,000 to 650,000 children** and large numbers of parents, seniors, and people with disabilities—have lost publicly funded health coverage as a result.

A second Center report, also released in December 2003 examines one reason for the loss of coverage: some states have stopped enrolling eligible children in their SCHIP programs, denying coverage to tens of thousands of eligible low-income children. The new California governor has also just proposed freezing SCHIP enrollment, which would affect as many as 114,000 children.

"Cuts of this magnitude in health coverage for low-income families are unprecedented," stated Leighton Ku, a senior fellow at the Center. "The cuts also will mean fewer federal matching dollars going into the states," Ku added. A state loses up to $4 in federal matching funds for every dollar that it cuts state Medicaid funding and up to $7 in federal matching funds for every dollar it cuts state SCHIP expenditures.

States Cutting Enrollment in a Variety of Ways

Other states have cut enrollment by restricting Medicaid or SCHIP eligibility. For example, Missouri lowered the Medicaid eligibility limit for parents from 100 percent of the poverty line to 77 percent (from $15,260 for a family of three to $11,750). Other states have adopted policies that do not directly limit eligibility but result in lower enrollment by making it more difficult to enroll in the program or retain coverage. Texas has imposed an SCHIP asset test and added monthly premium, which is expected to reduce enrollment by one-third.

SCHIP Freezes Will Increase the Number of Uninsured Children

The decision by those states that freeze eligible children out of their SCHIP programs generally affect children in families with incomes between 100 percent and 200 percent of poverty. The Center notes that **a freeze generally applies to eligible newborns as well as other children.** This means newborn infants in low-income families may be denied coverage despite their vulnerability—and the critical importance of health care—in their first days and months of life. According to the Center report, one of these states, Florida, has frozen benefits and already has a waiting list contained more than 44,000 eligible children as of November 14. Colorado not only has stopped admitting eligible low-income children to SCHIP but also pregnant women, as well.

The Center's two reports—*Losing Out: States Are Cutting 1.2 to 1.6 Million Low-Income People from Medicaid, SCHIP and Other State Health Insurance Programs* and a summary version of *Out in the Cold: Enrollment Freezes in Six State Children's Health Insurance Programs Withhold Coverage from Eligible Children*—are available on the Center's website http://www.cbpp.org. The full version of the latter report has been published by the Kaiser Commission on Medicaid and the Uninsured and is available at http://www.kff.org.

Hunger and Homelessness Survey—The United States Conference of Mayors–Sodexho
A Status Report on Hunger and Homelessness in America's Cities
A 25-City Survey, December 2003

To assess the status of hunger and homelessness in America's cities during 2003, the U.S. Conference of Mayors surveyed 25 major cities whose mayors were members of its Task Force on Hunger and Homelessness. The survey (available at http://www.usmayors.org/USCM/home.asp) sought information and estimates from each city on 1) the demand for emergency food assistance and emergency shelter and the capacity of local agencies to meet that demand; 2) the causes of hunger and homelessness and the demographics of the populations experiencing these problems; 3) exemplary programs or efforts in the cities to respond to hunger and homelessness; 4) the availability of affordable housing for low income people; and 5) the outlook for the future and the impact of the economy on hunger and homelessness.

The findings of the 25-city survey, include but are not limited to the following:

Hunger

- Officials in the survey cities estimate that during the past year requests for emergency food assistance increased by an average of 17 percent, with 88 percent of the cities registering an increase. Requests for food assistance by families with children increased by an average of 18 percent.
- In 56 percent of the cities, emergency food assistance facilities may have to turn away people in need due to lack of resources.
- Fifty-nine percent of the people requesting emergency food assistance were members of families—children and their parents. Thirty-nine percent of the adults requesting food assistance were employed.

Homelessness

- Requests for shelter by homeless families alone increased by 15 percent, with 88 percent of the cities reporting an increase.
- In 84 percent of the cities, emergency shelters may have to turn away homeless families due to lack of resources.
- Officials estimate that, on average, single men comprise 41 percent of the homeless population, families with children 40 percent, single women 14 percent and unaccompanied youth five percent.
- In 60 percent of the cities, families may have to break up in order to be sheltered.

Housing

- Requests for assisted housing by low-income families and individuals increased in 83 percent of the cities during the last year.

The Outlook

- Ninety-one percent expect that requests for emergency food assistance by families with children will increase during 2004.
- Even with an improving economy, city officials believe that economic conditions will continue to have a negative impact on the problem of hunger and homelessness.

in the literature

Bhattacharya J, DeLeire T, Haider S and Currie S. Heat or Eat? Cold-Weather Shocks and Nutrition in Poor American Families. *American Journal of Public Health*. Vol 93, No. 7 pp 1149-1154

The authors sought to determine the effects of cold-weather periods on budgets and nutritional outcomes among poor American families. They used a Consumer Expenditure Survey to track expenditures on food and home fuels, and the Third National Health and Nutrition Examination Survey to track calorie consumption, dietary quality, vitamin deficiencies and anemia. The authors found that both poor and richer families increased fuel expenditures in response to unusually cold weather. Poor families reduced food expenditures by roughly the same amount as their increase in fuel expenditures, whereas richer families increased food expenditures. The authors conclude that poor parents and their children spend less on and eat less food during cold-weather budgetary shocks and that existing social programs fail to buffer against these shocks.

Wehler C et al. Risk and Protective Factors for Adult and Child Hunger Among Low-Income Housed and Homeless Female-Headed Families. *American Journal of Public Health*. Vol 94 No 1 pp 109-115

The authors sought to identify factors associated with adult or child hunger and to better understand why some poor families experience adult or child hunger and others do not. The authors interviewed low-income housed and homeless mothers who had at least one child living with them about socioeconomic, psychosocial, health and food sufficiency information. Multinomial logistic regression produced models predicting adult or child hunger. Predictors of adult hunger included mothers' childhood sexual molestation and current parenting difficulties or "hassles." Risk factors for child hunger included mothers' childhood sexual molestation, housing subsidies, brief local residence, having more or older children, and substandard housing. This study found that the odds of hunger, although affected by resource constraints in low-income female-headed families, were also worsened by mothers' poor physical and mental health. Eliminating hunger thus may require broader interventions than food programs.

Resources

The Zeta Phi Beta Sorority, Inc., is a nonprofit community-based organization. It is one of the largest Greek-lettered national sororities in the United States. Zeta Phi Beta Sorority was organized over 75 years ago and its members are primarily African American. The sorority has made contributions to more than 600 communities in the United States, West Africa, Germany and the Caribbean through volunteer work and outreach services. Since 1972, the March of Dimes, Zeta Phi Beta and cooperating community agencies have operated a program called Stork's Nest, which can be a wonderful partnership for local FIMR programs too! The Stork's Nest Program Objectives include:

- Providing incentives for expectant mothers to obtain early and regular prenatal care.
- Providing clothing and nursery items for pregnant women who use community health services.
- Providing educational opportunities for pregnant women to help them make informed choices and decisions relating to parenting, nutrition and health.
- Providing information and referral to community resources to enhance the physical and emotional well-being of mothers and their families.

Contact:

To find more about local Zeta Phi Beta Sorority, Inc. chapter or about the Stork's Nest, contact:

Stork's Nest National Coordinator
Evelyn Brown
evelyn756@aol.com
1349 Aniwaka Ave, SW, Atlanta, GA 30311
Tel: (404) 755-7170

The **Kaiser Family Foundation** released a report titled *Perspectives on the Epidemic: Women and Teenage Girls at Risk for HIV: Insights from Focus Groups*. This report summarizes findings from a series of focus groups with women and teenage girls at risk for HIV. Focus group participants discuss their views on a range of issues including prevention and testing, women's knowledge about HIV/AIDS and the effectiveness of public education messages. To read it, go to www.kff.org/hivaids/hiv3382report.cfm.

Healthy Mothers, Healthy Babies of Washington State has developed a set of multi-cultural prenatal and infant care books that are free to health care providers only in Washington State, but available to all.

The English, Spanish and Russian books feature:

- Nutrition and health information for pregnant women and their babies, including culturally specific sample menus.
- Information about pregnancy as well as questions to ask healthcare providers at prenatal appointments.
- Breastfeeding information and tips on caring for a new baby.
- Information on infant feeding, immunizations, oral health, growth milestones and well-child check-ups.
- Russian version includes side-by-side English/Russian translation.

The Chinese, Korean, Vietnamese and Somali baby books feature:

- Side-by-side English/other language translation.
- Culturally adapted information for a healthy pregnancy and birth practices in the United States.
- Cultural specific information on nutrition, including sample menus.

Contact Debbie Nakano to place an order at DebbieN@hmhbwa.org, (206) 830-5159 or 1-800-322-2588 (WA only).

For providers outside of Washington State, the cost is as follows:

1–24 $12.99 per book (includes shipping and handling)
25–49 $10.99, plus shipping and handling
50–99 $9.99, plus shipping and handling
100+ $8.99 plus shipping and handling

The **National Campaign to Prevent Teen Pregnancy** has released a new document titled *Parent Power: What Parents Need to Know and Do to Help Prevent Teen Pregnancy*. *Parent Power* offers good news for parents and those who work with, care for, and write about, young people. It compiles much of what is known about parental influences and offers parents practical things they can do to help their children delay sexual activity and avoid teen pregnancy. The simple and compelling message of *Parent Power* is that families matter. It is available in both English and Spanish. To view this document and other useful tips, go to www.teenpregnancy.org/resources/reading/tips/default.asp

National Practitioners Network for Fathers and Families (NPNFF) has developed a series of brochures designed to provide fathers with advice and tips on parent-

ing and nurturing their children. The brochure titles include: 1) Dads Count! How Fathers Can Support Healthy Development, 2) Baby You Can Depend on Me! Fifteen Ways to Support Your Child and 3) Tips for Being a Great Father. To order these brochures, call NPNFF at 800-346-7633 ext. 204 or email: info@npnff.org. The cost of each brochure for NPNFF members is $0.15 each or $12.00/100. The cost for each brochure for non-members is $0.20 each or $15.00/100.

Back to Sleep door hangers giving the SIDS Risk Reduction messages in English and Spanish are available free of charge by contacting Andrea Furia of the National Institute of Child Health Development at furiaa@mail.nih.gov. Include name, organization, phone number and quantity of door hangers.

NFIMR is highlighted in the new edition of the infant mortality knowledge path, which is produced by the **MCH Library**. This electronic resource guide points to a selection of current, high-quality resources that analyze data, describe public health campaigns and other prevention programs and report on research aimed at identifying causes and promising intervention strategies. The path is aimed at health professionals, policymakers, and researchers and is available at http://mchlibrary.info/KnowledgePaths/Web

NB: Thank you MCH Library!

Physicians for Human Rights has developed an annotated bibliography of key articles in the peer-reviewed literature on racial and ethnic disparities in medical care. These have been organized into 17 disease or clinical categories, including maternal and child health. Four additional sections present the related but non-categorical issues of Clinical Trials, Research Methods, Patient Trust and Cultural Competency. To view the website, go to www.phrusa.org/research/domestic/race/race_report/bibliography.html.

FIMR Success Stories
Continued from page 5

Jacksonville FIMR Collaborates with Project Moses

In Jacksonville, Florida, FIMR is funded by the Florida State Department of Health. Healthy Start consumers and staff participate in FIMR reviews. FIMR reviews found that Sudden Infant Death Syndrome (SIDS) sleeping positions and related conditions were the leading cause of infant mortality after the first month of life. African American babies accounted for nearly 50% of sleep-related deaths. Nearly 80% of these deaths occur to babies who were bed sharing or in an inappropriate bed.

The FIMR Community Action Team (CAT) did the initial assessment for developing Project Moses. Project Moses, an initiative of Hold-Out the Lifeline and the AME Ministerial Alliance, is a new prevention and awareness effort to reduce sleep-related infant deaths in the African American community. Project Moses includes efforts to provide bassinettes to all in need. Initially, CAT members conducted surveys of pregnant women to determine demand for bassinets. They also constructed a prototype based on a similar project in Fort Myers, Florida.

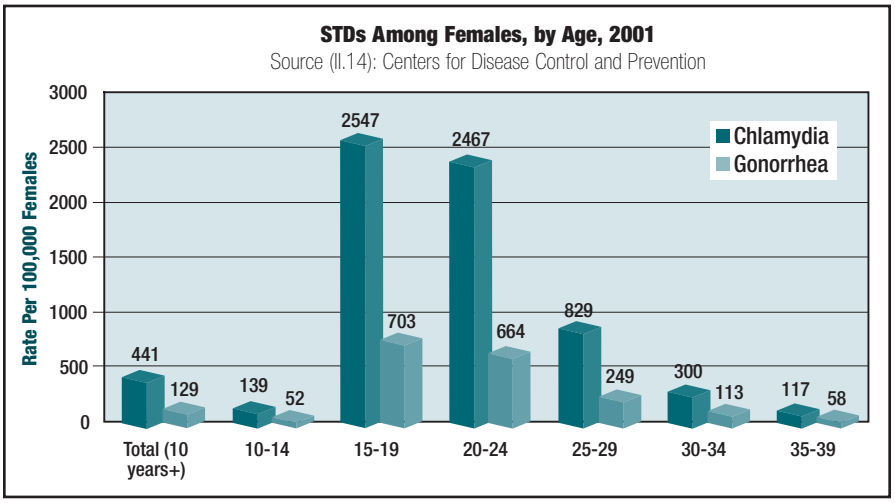
The goal of Hold-Out the Lifeline (HOTLL) is to distribute 500 bassinets over the next year. Initial funding for 250 bassinets has been provided by the Florida Department of Health through its "Closing the Gap" initiative. Additional funding is being sought to purchase supplies to build the rest of the bassinettes.

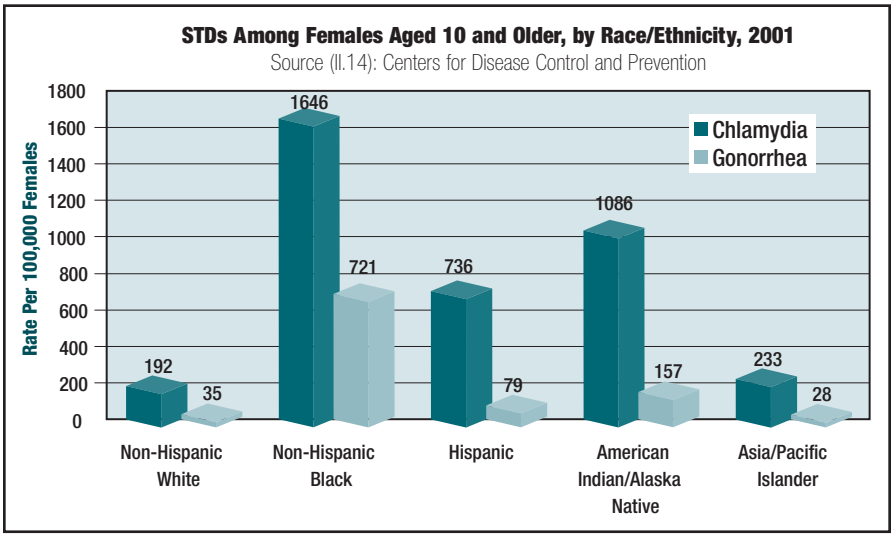
Senior church members, who also may be grandparents, will construct these bassinettes. Thus, building the bassinettes provides an additional benefit: opportunity for seniors to also learn about safe sleep. "Project Moses will work with member churches of the AME Ministerial Alliance to make and distribute special bassinets," said Karen Smithson, HOTLL coordinator. "These bassinets will be provided to new mothers through Shands Jacksonville Hospital, the GodParent Mentoring Program, and Healthy Start and Healthy Families programs serving the community."

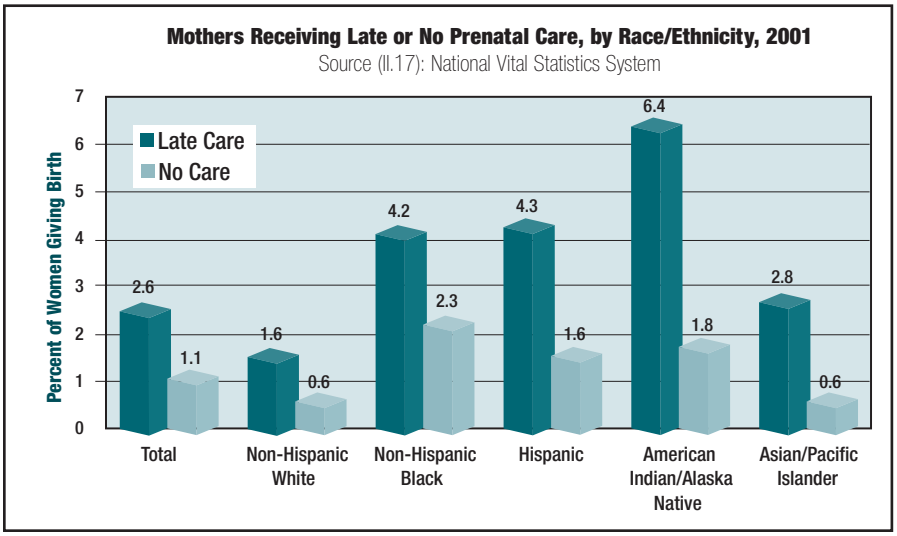
Project Moses will also provide education to the new families and the community about risk factors associated with SIDS and other sleep-related deaths. Each bassinet will include information about the importance of a safe sleeping environment, reducing the risk of SIDS and related material. Information on SIDS, risk factors, appropriate sleep position and sleep environment will also be distributed to church volunteers who will construct the bassinets.

For more information, contact Karen Smithson, Northeast Florida Healthy Start Coalition, 6850 Belford Oaks Place, Jacksonville Florida 32216.

Fast Stats About Women's Health







Sexually Transmitted Diseases (STDs)

Although these conditions are treatable with antibiotics, STDs can have serious health consequences and untreated STDs can lead to pelvic inflammatory disease, infertility and adverse outcomes of pregnancy.

- Rates of reportable sexually transmitted diseases are particularly high among adolescent females and young adult women.
- Rates of chlamydia and gonorrhea were much higher among non-Hispanic Black women than among women of other races and ethnicities.
- American Indian/Alaska Native women had the second highest rates of these diseases.

Prenatal Care

In 2001, there were 4,025,933 births in the United States. Of the women giving birth:

- 83.4 percent began prenatal care in the first trimester of pregnancy. This figure has risen 10 percent since 1989.
- Non-Hispanic Black, Hispanic and American Indian/Alaska Native women were 2.7 to 3.7 times more likely to begin care late or to receive no prenatal care than non-Hispanic White women in 2001.
- Almost 42,000 women received no prenatal care.

Immigrant Women

Immigrant populations, especially non-citizens, face challenges in accessing health care services, including language and cultural barriers.

With the year 2000:

- An estimated 12.8 million women aged 18 and older residing in the U.S. were born in other countries, 58% of these women were non-citizens.[1]

In the year 2001:

- Women who were non-citizens were more likely than naturalized citizens and U.S.-born women to lack a usual source of care.
- Non-citizens were more likely to report having no health insurance than U.S.-born citizens

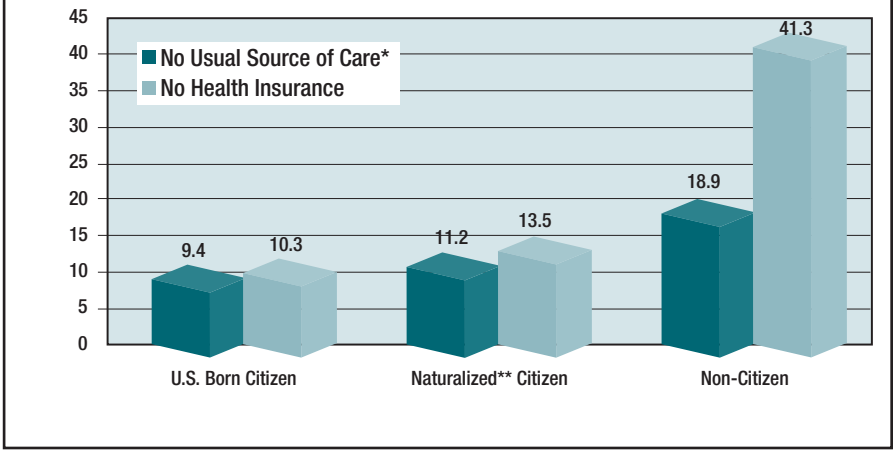
[1] *U.S. Census Bureau. Current Population Survey - March 2000 Detailed Tables (PPL-135) http://www.census.gov/population/www/socdemo/foreign/ p20-534.html*

These FAST STATS are adapted from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. *Women's Health USA 2003*. Rockville, Maryland: U.S. Department of Health and Human Services, 2003.

To see the full publication, go to HRSA's website at www.hrsa.gov/womenshealth/databook.htm

Women Lacking Usual Source of Care & Health Insurance, by Citizenship Status, 2001

Source (II.3): National Health Interview Survey



* *Defined as not having a place they usually go to when they are sick.*

** *Person not born in the U.S., but holds U.S. citizenship.*