CREATING A BETTER RESPONSE TO COMMUNITY NEEDS: REDUCING INFANT MORTALITY RATES OF AFRICAN AMERICANS IN THE CITY OF RACINE, WISCONSIN

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Approved by Tom Lo Guidice on August 1,2011

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Abstract

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Under the Supervision of Tom Lo Guidice, Ph.D.

The subject of this paper is a report on the comparison of infant mortality rates (IMR) globally, and the disparities in the rates that exist between African Americans and other races within the United States. The author examines the causes and leading risk factors that contribute to the deaths of African American babies to determine if those factors can be eliminated to reduce the rate of infant mortality in the city of Racine, Wisconsin's African American community.

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Chapter One: Introduction

Infant mortality rates (IMR) are commonly used as a tool of measurement, in determining the general health and well-being of a given population. Since the United States is the most industrialized and wealthiest country, one would assume or conclude that the U.S. would rank #1 for having the lowest rate; however, that conclusion is far from the truth. As a matter of fact, the U.S.' rate is actually worse than some third world countries, and in Southeastern Wisconsin, the rates are much higher than in other parts of the state, as well as rates in other states (Wisconsin Partnership Aims to Reduce Infant Mortality, 2009).

While there has been a decline of the IMR's amongst whites, the rate amongst African Americans has not, thus creating a considerable disparity. Rates amongst other minority groups are also higher than whites, but are still lower than that of African Americans. (Wisconsin Department of Health Services). DHS has also reported that the leading causes of African American IMR is attributed to preterm and low birthrates, Sudden Infant Death Syndrome (SIDS), and birth defects . There are some factors that contribute to or play a role in the high rates that exists, such as: access to health care, economics, education, nutrition, and stress (Eliminate Disparities in Infant Mortality). As an African American woman and a citizen of Racine, the high rate of Infant Mortality within my race and my community is both appalling and unacceptable. It represents a threat, as well as a decline in the African American population and to the entire health of the community.

Statement of the Problem

The problem to be addressed is, how can the factors that contribute to the high rate of infant mortality that exists in the city of Racine's African American community be addressed, in order to insure that African American women deliver healthy babies, and those babies live and grow up to be adults?

Definition of Terms

Infant: A child in the first period of life **(**Merriam-Webster, 2010).

Mortality: The number of deaths in a given time or place in proportion of deaths to population (Merriam-Webster).

Delimitations of Research

The references used for the review of literature were collected over a period of 40 days using the resources of the Karmann Library at the University of Wisconsin-Platteville. Several search engines provided by Ebscohost, Wilson, and Eric were used. The key search terms were "infant mortality," "African American," "Southeastern Wisconsin," and "Racine, Wisconsin." Additional government documents were located by the Reference Librarian, at the University of Wisconsin-Platteville.

Chapter Two: Review of Literature

Comparison of Infant Mortality Rates: The United States versus other countries

The United States may very well be considered one of the most wealthiest, if not the wealthiest nation globally; however, if one would measure wealth by the health of a given population, then the United States' wealthy status would very much be diminished. This decline is due to the number of infants that die before the age of one in the United States, on an annual basis. In 1960 the U.S. ranked 12th amongst other nations for the number of infant deaths, but by 1990 the number of infant deaths rose, putting the U.S. in 23rd place, right along the sides of Poland and Slovakia. In the five year period between 2000 – 2005, the number of infant deaths in the U.S. per 1000 live births was stagnated, only showing an improvement of .03 in 2005 from 2000. Within this time-frame "the level rate represents the first period of ongoing lack of decline in the U.S. infant mortality rate since the 1950's" (Krisberg, 2009). The Centers for Disease Control and Prevention's National Center for Health Statistics compiled statistical data and released a brief in 2008, indicating that in 2004, on a global scale, the U.S.'s ranking had risen even higher to 29 (Krisberg, 2009).

It is informative to examine infant mortality in other countries, other than the U.S. Like the U.S., as a well developed country, Canada is experiencing the same problem in its population. In 2006 infant mortality rates were calculated and compared with 17 other developed nations considered to be its peers, which includes Australia, Austria, Belgium, Denmark, Finland, France, Germany, Ireland, Italy, Japan, Netherlands, Norway, Sweden, Switzerland, United Kingdom, and the United States. All belong to the Organization for Economic Co-operation and Development. At that time Canada ranked 15th, reporting that five out of every 1000 live births resulted in death. The reporting of the before-mentioned data was released by the

Conference Board of Canada; however, K.S. Joseph, Professor at the University of British Columbia, and also an infant mortality rate expert, disagrees with this report. Joseph believes that not all countries are reporting infant death according to the same definition of when life and death occurs. Joseph points out that some countries do not consider or register babies when they are born, if it appears that they have a slim chance to live. Joseph does acknowledge that rates did increase in the 1990's when Canada experienced cuts to the federal budget. Since federal budget cuts usually has an effect on the disadvantaged population, one can assume that the budget cuts affected individuals financially and possibly their ability to afford healthcare, thus hindering prenatal care and delivery of a healthy baby (Barrera, 2009).

Many healthy babies are born in Singapore, as was evident in 2005, when Singapore boasted the lowest infant mortality rate in the world with 2.1 deaths for every 1000 live births, which was three times better than the United States rate at 6.9. This was disappointing news to the National Center for Health Statistics, who also reports that the United States infant mortality rate is worse than most European countries. Like Professor Joseph, the National Center for Health Statistics points out that because of the differences in reporting practices, these numbers may be misleading. It was also reported that there are a lot of preterm births that occur in the United States that result in death. Preterm babies are at risk because they are not fully developed which causes many complications for the chance of survival.

Comparison of African American Infant Mortality Rates to other races in the U.S.

When looking at the infant mortality rates within the United States, it is very apparent that there are great disparities between ethnic groups, especially when comparing whites to non-Hispanic African Americans. In some cases, there are also stark differences when comparing rates on a state by state basis. This is a trend that spans nationwide in all 50 states. According to

HealthDay Consumer News, 6.78 babies died before reaching their 1st birthday for every 1000 babies born in the United Sates, in 2004. African American infants contributed to this high rate dying at a rate of 13.60 for every 1000 born, making this the highest infant mortality rate of all ethnic groups. African American rates were also two times the rate of non-Hispanic whites with the rate of whites being 5.66 deaths for every 1000 babies born. Between the years of 2002 and 2004 infant mortality rates ranged from 4.2 in Vermont and 10.32 in Mississippi. In Wisconsin the rate for African Americans stood at an alarming 17.57, while Minnesota's rate was 8.75. "Other infant mortality rates broken down by race and origin included American Indian (8.45), Puerto Rican (7.82) Mexican (5.47), Asian/Pacific Islander (4.67) and Central/South American (4.65)" (staff, 2007). Findings in 2004 also revealed that 46 percent of African American babies that died after birth were born prematurely, and this percentage is higher than all causes for whites and other ethnic groups. Though no specific numbers were given by the House Energy and Commerce committee, during their congressional meeting on "Prematurity and Infant Mortality," held on May 12, 2010, they did report that in 2009 the death rate of African American babies In Hillsborough County (Tampa, Florida) was four times the number of whites (Mahan, 2010).

In Hamilton County, Ohio, a huge disparity also exists between the infant mortality rates for African Americans and Whites. The total infant mortality rate for the county in the years 2003-2007 was an average of 11, which was higher than the entire State of Ohio's rate of 7.8. The average for Whites living in the county was 7.0, but African American rates were almost three times as much at a dismal rate of 19.3. In Miami's Dade County Florida, the same trend persists with the African American infant mortality rates being twice the rate of Whites. The State of Georgia has a large population of African Americans, and is one of the 10 worst states

for the number of infant deaths. In 2004, the State of Wisconsin had the highest rate in the entire country with a rate of 19.2 infant deaths for every 1000 live births, compared to Whites with a rate of 4.5. The majority of the African American population in the State of Wisconsin (68%) resides in the city of Milwaukee. In the years 1979-1981, the State of Wisconsin had one of the best infant mortality rates in the United States. They ranked 3rd best, but as the years went on those rates increased dramatically, and in the years 1999-2001 they were considered to be the 3rd worst. (Byrd, Katcher, Peppard, Durkin & Remington, 2007)

Leading Contributing Factors of African American Infant Mortality

The phenomenon of high infant mortality rates for African Americans is one that needs to be examined to determine why the rate is so much higher than all other ethnic groups, especially when comparing African American infant mortality rates to those lower rates seen for Whites. One of the main culprits for the disparities that exist is the fact that many African American babies are born both prematurely, and at a very low birth weight. 12.4% of all births reported in 2004, in the United States, were babies that were born premature, with African American babies accounting for 46% of that total. The House Energy and Commerce Committee claim that when African American women are born prematurely it is very probable that they will give birth to premature babies and they refer to this as the "generational effect" (Mahan, 2010).

According to the Maternal Child Health Journal, a study was conducted in Wisconsin with the intent of providing an explanation of why such disparities in the infant mortality rate between African Americans and Whites exists. The article entitled "Infant Mortality: Explaining Black/White Disparities in Wisconsin" concludes that a short gestational period, or prematurity and babies born with a low birth rate, are the front runners for causes of death for African American babies. The third cause is sudden infant death syndrome, commonly known as SIDS.

The combination of these three causes of death for African American babies accounts for more than all other causes of deaths combined. The study also points out that the rate of homicides is not a significant cause affecting the mortality rate of African American babies, but African American babies are much more likely (6.2 times) to be victims of homicide, than White babies.

Babies born prematurely or born with a low birth weight, many times are delivered by mothers who may have physical and/or emotional health issues. Unhealthy mothers create medical complications for themselves and for their unborn child. Many African American women live in communities that are comprised of low income and impoverished individuals, who struggle financially just to meet their basic needs. Some needs such as purchasing nutritional foods (i.e. fruits, vegetables, etc.), preparing healthy meals, and health insurance, although they are very important, they are not met. The lack of these things creates potential health risks to African American women of child-bearing age. Though there are many contraceptives available on the market, most pregnancies, especially among teenagers, are unplanned. Unplanned parenthood presents the problem of lack of preconception care of the body to prepare for pregnancy. When a woman becomes pregnant, any health conditions known or unknown affects her unborn child. Without access to healthcare, many African American women do not receive the necessary prenatal care with the onset of pregnancy, and may not receive any care until after the first trimester of her pregnancy, therefore if there are any underlying health issues they may be undetected. As with a lack of nutrition and inadequate healthcare, other factors such as smoking during pregnancy and excessive stress experienced from external factors, affects a woman's unborn child. In addition to the lack of healthcare, the problem arises that when African American women do see a healthcare provider, they may not receive the same adequate health care received by White women by some health care providers.

Sudden infant death syndrome (SIDS) also plagues the African American community. The deaths of African American babies from sleep related causes is higher than all other ethnic groups, in fact, the probability of death occurring from SIDS is 12 times that of any other race. A study conducted in Cook County, Illinois, revealed that of all the African American babies that died, 20 percent of them died from causes related to unsafe sleep practices and sleeping in unsafe conditions. In 56.7 percent of those cases babies were not sleeping alone, but were sleeping with other individuals. Still another important fact is that another 30%, although sleeping alone as researchers suggest, were sleeping in improper locations. Those babies were said to be sleeping on couches and other places, other than in a crib or bassinet as recommended (Priedt, 2010).

Measures Taken by Other U. S. Cities to Address Infant Mortality

In attempts to address the issue of the high infant mortality rate that exists in African American communities, some cities have implemented intervention programs for at risk African American women and their babies. The Women, Infants, and Children program also known as WIC was developed in 1974, but began as a pilot program in 1972. The program focuses on the health and wellness of low income and disadvantaged women and children, providing services to assist women with improving their nutrition and the nutrition of their children. Since its inception in 1972, the program has evolved nationally and has expanded their services. Initially the program's main focus was on nutrition, supplying vouchers for baby formula, cereal, bread and other nutritional foods. They now provide many other services for women who qualify for their services, to include assistance with referrals for prenatal care. They also provide workshops on safe sleeping practices for infants and provide referrals for baby cribs. A study was conducted on the WIC program in Hamilton, Ohio, to determine if the WIC program had any effect on reducing the infant mortality rates for African Americans. Women enrolled in the program

received services that promoted their health to insure delivery of a healthy baby, and services continued after delivery to insure that mother and baby remained healthy. The program provided counseling and education on personal care and promoted the benefits of breast feeding. The results were quite promising. Those women who participated in the WIC program had a lower infant mortality rate than those that were not enrolled. Overall it was concluded that involvement with the WIC program reduces the infant mortality rates of African Americans and narrows the gap in the disparities that exist (Khanani, Elam, Hearn, Jones, & Maseru, 2010).

In Atlanta, Georgia, a program was developed to address preconception and interconception care, for African American women who were considered to be at risk for delivering a healthy baby. The program known as "The Grady Memorial Hospital Interpregnancy Care (IPC) Program, was implemented as a response to recommendations from Georgia's task force on reducing infant mortality and the racial disparities that exist.IPC provides integrated health care and case management services for 24 months. The nurse case manager help participants by discussing and developing a 24 month care plan, which addresses factors that may be linked to deliveries of infants with a very low birth weight. The Resource Mother is trained by the county's health department and acts as a liaison that coordinates services through community resources. Her objective is to provide support and services according to individual need, and includes enhancing life skills, preparing for parenthood and acquiring employment. The Resource Mother also conducts home visits when necessary. The program also provides a family physician, a nurse who is also trained as a midwife, and social workers. Preliminary results indicate that providing preconception care can be effective in identifying risk factors and implementing appropriate interventions (Biermann, J., Dunlop, A., Brady, C., & Brann, A., 2006).

Addressing infant mortality in the City of Racine

In 1998 the Maternal Child Health Bureau developed a community based systematic process, with the intended purpose of launching an investigation into the fetal and infant deaths that occur and the causes of those deaths. This process known as the Fetal and Infant Mortality Review (FIMR) is conducted when the death of a fetal or infant is reported. Community centered strategies are utilized by the FIMR as a tool in the evaluation of the existing public health components that are available for the care of women, children and families. The FIMR is comprised of individuals from community organizations, local health departments, staff from hospitals, and professionals in the health care industry, who fully participate in the review process. There are three steps involved in the FIMR process.

Collection of data and information is the first step of the FIMR process. This is conducted by individuals who are experts and are authorized to examine and review all information related to the case, to include both clinical and public health records. Experts contacted the mothers to request interviews in their homes and interviews were conducted for those women who consented to do so. The purpose for the interviews was to obtain information about both the man and woman's experience of losing a fetal or infant. Women were also asked about the services they received and services they may have wanted to receive. Information obtained from the interviews provided a better perception of the woman's experiences of the care she received, and the birth and death of her fetal or infant, from a cultural perspective. It also provided information about her relationships before, during, and after her pregnancy. Relationships included her relationship with the father, her support systems, and individuals who provided care. The interview also sought to determine if there were any stressors, whether they be physical or emotional, before the birth occurred and after her loss. As part of the FIMR process, referrals

were provided to those women who were determined to be in need of mental health and other community services.

The Case Review Team (CRT) is the second step of the FIMR process. The Case Review Team is comprised of individuals from the health and social services industry, as well as other individuals who are experts in the community. The purpose for the team is to examine each infant mortality case and identify and compare any similarities that may exist between the cases. In comparing the cases the team looks for "accessibility of service and performance of public health functions" (Johnson, 2008). If deficiencies in the healthcare system or in the community are detected that may have contributed to the death, the team will then make its' recommendations to address them.

The Community Action Team is the last step of the FIMR process. This team analyzes the Case Review Team's recommendations and establishes priorities. The team is responsible for developing and/or implementing programs, and making efforts to change existing practices and policies in the community, as necessary.

In the summer of 2006 a group of citizens in the city of Racine, came together to share their concerns about the high rate of infant deaths that had occurred in the city. Group members were from various health care settings searching for a systemic process that would provide insight into what factors may have contributed to the deaths of those infants. They adopted the FIMR process, which was the beginning of the Fetal and infant mortality review project of Racine. Developed in the spring of 2007, the project in collaboration with the UW-Milwaukee College of Nursing, Wheaton Franciscan Healthcare-All Saints, and the city of Racine's health department, received funding from the Center for Urban Population Health's (CUPH) Center Scientist Development Program. CUPH is also supported by the Wisconsin Partnership Fund for

a Healthy Future. In May of 2007 the collection of data began and the FIMR process would take place from January 2007, through December 2008. Funds appropriated for the first year were to develop the project's infrastructure; funds for the second year were appropriated to support the transfer of the project to the city's Health department. Initially it was agreed that the city's health department and the FIMR project would work together as a team. In addition, the Racine Infant Mortality Coalition would be the Community Action Team that would assume the responsibility of making efforts to promote the necessary changes to the community, with the purpose of improving the "outcomes for women, infants, and their families" (Johnson, 2008). The FIMR process was supposed to transfer to the city's Health department; however, internal issues at the health department prevented this transition.

The FIMR project of Racine began its investigation into finding common factors that would explain the high infant mortality rate of African Americans, first by providing a detailed description of the city of Racine. They examined its' location, economics, population/demographics, neighborhoods, architecture, entertainment, etc. At one time, Racine was known as a very successful manufacturing community; however, over the years the number of major manufacturers that were a part of the community has declined, resulting in a depressed labor market, and tough economic challenges for its' residents. According to the 2005-2007 US Census Bureau, the city of Racine's population consists of 56.6% Non-Hispanic Whites, 22.5% Non-Hispanic Black (African Americans), and 18.1% Hispanic (http//factfinder.census.gov). Although the percentages for high school graduates are higher for the state of Wisconsin, when making a comparison to the nation's, it is interesting to note that the city of Racine's graduation rate is below the nation's rate. Families living below the poverty level are also much higher than

the state's poverty level, even though the state of Wisconsin's poverty level is better than the nation's. The preceding illustrates the impact that poverty has on education.

After collecting data and information about the city, and the economical and educational status of its population, the project collected data on the infant mortality rates. Obtaining statistical data from the Wisconsin Dept. of Health Services, Division of Public health, for the years 2004 through 2007, it was noted that "in the city of Racine and Racine County, Non-Hispanic African American infants had 2 to 9.97 times higher risk of dying before their first birthday than non-Hispanic White infants, depending on the year the data was reported" (Johnson, 2008).

The Case Review Team utilized zip codes, to help determine the race and ethnicity of the mother and to determine what areas of the city were the deaths occurring the most. They thoroughly investigated each case that involved the death of a fetal or infant. Since there was no single entity to receive information surrounding the cause of death, various sources were utilized (i.e. death certificates from the city's health department, obituary notices in the newspaper, copies of death certificate in files with medical examiner's reports, etc.) Medical records for both mother and infant were reviewed with the intended purpose of finding common factors for the causes of death.

After thorough investigation, it was found that zip codes 53403 and 53404 had the largest number of fetal and infant deaths for African Americans, zip code 53403 the largest for Hispanics, and zip code 53402 for Whites. Overall, the largest number of fetal deaths occurred within the 53403 zip code, the second largest occurred in 53404, and the least number of deaths occurred in 53406. It was also noted that fetal and infant deaths during the years of 2007 and 2008, were due to prematurity and accounted for the highest percentage for causes of death, at a

rate of 37.8% (Johnson, 2008). Fetal deaths were considered to be 19-24 weeks. Causes for those deaths were found to be fatal birth defects, spontaneous preterm labor, and chorioamnionitis. Although there were many sleep related deaths during the years 2006 and 2007, those numbers improved in 2008. Improvement is accredited to the initiation of the Cribs for Kids program. Many of the families who suffered the loss of an infant were either receiving Medicaid or were eligible for the service.

The Case Review Team made the following recommendations:

1) Provide awareness and information about the Medicaid program to women that are eligible for Medicaid services and encourage them to enroll early.
2) Support and encourage women with chronic illnesses to get prenatal care when they become aware that they are pregnant.
3) Provide translators for those women who only speak Spanish.
4) Develop methods to provide informative messages throughout the community that focuses on promoting the health of women and babies.
5) Develop methods that will identify which women chose early enrollment for Medicaid and WIC services to determine if early enrollment had an impact on birth outcomes.
6) Develop methods to track those women known to have STDs, to assure that they are getting treatment.
7) Intra and preconception care: reducing risk by eliminating drug/alcohol usage; address chronic illness; stress reduction; preplanning for the next pregnancy; encourage those women who have experienced the loss of a fetal or infant to get interconception care; and encourage women to be a part of the decisions made for health care (Johnson, 2008) .

The Greater Racine Collaborative for Healthy Birth Outcomes/Racine Lifecourse Initiative for Health Families (GRC4HBO/RLIFH/"the Collaborative") began in 2010, and now serves as the Community Action Team responsible for planning, and making efforts to make changes to community resources, that have an impact on African American women, families and healthy birth outcomes. The Collaborative formed a partnership with The Johnson Foundation at Wingspread, with staff for the project being housed at the Racine Kenosha Community Action Agency (RKCAA). The Collaborative is a very diverse group, comprised of individuals from the

health profession, social and business sectors, and many other concerned citizens of the city of Racine, including The Racine Infant Mortality Coalition. Funded by the University of Wisconsin School of Medicine and Public Health through the Wisconsin Partnership Programs Life Course Initiative for Healthy Families, the Collaborative developed a strategic plan to reduce infant mortality in the city of Racine's African American population.

They analyzed the findings and recommendations from the FIMR project, as well as furthering investigation into the causes and factors contributing to fetal and infant deaths of African Americans. The areas of focus were census tracts 3, 4 and 5, where the highest concentration of African Americans resides. During their investigation they discovered that fetal and infant deaths were occurring just as much, if not more for educated African American women between the ages of 20 and 34, as opposed to those of teenage years. It was also noted that poverty and lack of access to health care did not appear to be an issue for most of the women in the 20-34 age group, but what appeared to be the main factor was external stressors. "Low birth weight, and preterm delivery in African Americans may result from group differences in exposure or susceptibility to prenatal stress, including stress related to racism and discrimination, as well as from differences in physiological responses to stress" (Giscombe, & Lobel, 2005).

Experiencing stress over a lifetime contributes to many chronic diseases such as, diabetes high blood pressure, and coronary heart disease. According to Dr. Michael Lu's research on disparities in infant mortality, entitled "Closing the Black-White gap in birth outcomes: A life-course approach," "Disparities in birth outcomes, are the consequences of both differential exposures during pregnancy and differential developmental trajectories across the life span" (Lu, Kotelchuck, Hogan, Jones, Wright & Hafon, 2010). The collaborative integrated Dr. Lu's life

course perspective and his recommendation which consists of a 12 point plan, as models to develop a plan for the city of Racine. In analyzing the plan the collaborative determined that there were three themes within the plan and formed three teams consistent with addressing the plan. Team #1 was assigned the first theme "improving health care services," team #2 assigned the second theme "strengthening families and communities," and team #3 assigned the third theme "social and economic inequities." Each team would prioritize and develop a strategic plan to complete their assignment, which included analyzing needs and resources available in the community to address those needs. In addition they conducted site visits to sites in other cities that were known to be successful with the possibility of using those sites as a model to implement evidence based programs in Racine. A few of the sites visited were, The Irvington Family Development Center, located in Essex County, NJ; WIC, located in Washington, DC; Northern Manhattan Perinatal Partnership, located in Harlem, NY; and Mary'sCenter-Carrera Adolescent Pregnancy Prevention Program, located in Chicago, IL.

CHAPTER III

Conclusions and Recommendations

On June 23, 2011, the Greater Racine Lifecourse of Healthy Families/Healthy Birth Outcomes held a meeting to present its Community Action Plan to the community, informing the community of its findings and plan to reduce fetal and infant death in the African American community in Racine. The meeting was held at their partner's location, The Johnson Foundation at Wingspread. They presented a detailed presentation of their research, collection of data and information, and the process used to obtain all information for the presentation. Many members from the community were present, including community leaders, health professionals and social service providers.

The Community Action Plan is divided into two parts. The first part lists six considerations that serve as a direction to determine what approaches to take, and the second part defines their approach to successfully meet the goals of those considerations. In addition, recommendations were made to implement five new programs, to address the building of relationships, reducing stress, and fatherhood. Most of the recommended programs are the results of the teams conducting site visits. The five recommended programs are, expanding the existing Nurturing Fathers program which is housed at Racine's YMCA, The Birthing Project U.S.A.: Barber Shop model, expanding the Foundations of Maternity program, The Birthing Project: Sister/Friends, and an expansion of The African American Women's health and Wellness program. The collaborative also recommends and is also advocating for the development of a neighborhood center that will house several programs to address family support, education and training, developing skills, pregnancy prevention for adolescents, etc. The city of Racine is looking at its' existing community centers and the programs that they already offer to the

community, possibly integrating programs that addresses the recommendations of the collaborative.

As previously stated, the leading causes of infant mortality in African American communities are preterm births/low birth weight, and sudden infant death syndrome. Though there are other factors that also contribute to this tragedy, it is imperative that focus be placed on the two most leading causes and prevention. It is imperative because they account for the majority of African American infant deaths.

The high rate of infant mortality for African Americans is nationwide and deserves much needed attention from the federal government. The federal government needs to provide more social justice to its citizens to assure that all basic needs are met, as with the need for adequate healthcare. Many preterm and low birth weight deaths can be prevented and/or reduced, if African American women of child bearing age had access to healthcare. This would enable them to seek out the necessary medical attention for both preconception and prenatal care. It would also detect any underlying medical conditions that exists, as well as can be addressed; therefore increasing the prospect of delivering a healthy baby. There is also a need to promote Planned Parenthood to eliminate unplanned and unwanted pregnancies, especially for young teenage girls who may not be physically or emotionally prepared for motherhood.

As in the state of Ohio, there are WIC programs available in the state of Wisconsin that provides services for low income women and children. In the city of Racine and Kenosha the WIC program is a part of the Racine/Kenosha Community Action Program (CAP), which provides some basic needs such as energy assistance and housing for low income individuals in the community. CAP has also received funding to specifically target reducing Racine's African American infant mortality rate. .

The WIC program in Racine does provide services from the onset of pregnancy until the child becomes the school age of 5 years old. They offer many of the same services that are provided by the WIC program in Ohio. African American women should be encouraged to enroll in the program, so that they can receive the necessary help and support needed to care for themselves and their babies.

The various social programs in Racine, along with the City of Racine health department should corroborate together to determine what programs can better serve the needs of African American women and their babies, to assure that African American babies have a chance to live. The programs should educate African American women about their health, and the role that stress can contribute to their physical and mental health, as well as the health of their unborn child. In addition, counseling services should be provided that will focus on stress reduction and developing appropriate skills and coping mechanisms to alleviate stress.

The high rate of infant mortality that exists in Racine's African American community can be reduced, if funding is provided to the Collaborative to achieve the goals set in the Community Action Plan, and with cooperation from the entire community of Racine.

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