

*The Interagency State
Council on Black and
Minority Health
2010 Annual Report*



Indiana State Department of Health
Office of Minority Health
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Since 1992, the leadership of Indiana started on an important journey by the creation of the Interagency State Council on Black and Minority Health (IAC).

Since then, many activities which have engaged literally hundreds of Hoosier leaders from the State Legislature, community organizations, churches and health fields have investigated the social/economical and medical elements unique to both the Black and Minority populations.

In 2010, the challenges and opportunities in improving the peri mortality and morbidity of Black and Minority infants were targeted for investigation. Indiana, not unlike most of the states in the union, has a much higher rate of adverse outcomes within the African-American infant population when compared to either Caucasian or Hispanic newborns.

What has been learned is that there is no one simple answer to questions raised about this disparity. Instead, there are a host of various “best outcome” influencers that seem to be consistently less adopted or available by segments of the Minority maternal population.

This report demonstrates an aggressive state-wide effort to solicit and recruit input and experiences from many different areas of expertise and representative populations.

This journey to improve the health of Hoosier infants and specifically those with seemingly greater challenges will be a long one, but the first steps are defining problems within credible and reliable processes. Second, raise to a critical level, the awareness of important peri natal and post natal maternal choices, supportive services and cultural variations that support both the mother and infant at the most fragile moments of early life.

I hope you find the 2010 report both informative and more importantly, a directional beacon of the need for continual commitment toward reducing the comparative disparity of healthy infant outcomes among our Indiana populations.

Sincerely,

GREGORY N. LARKIN, MD
STATE HEALTH COMMISSIONER

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Executive Summary

In 1992, legislation was passed to adopt the first five-year Strategic Plan for Indiana on Minority Health, as well as the appropriation of a budget to carry out programming. The Indiana General Assembly also ratified legislation creating the Interagency State Council on Black and Minority Health (IAC). *Indiana Code 16-46-6* directed the Indiana State Department of Health (ISDH) to establish the IAC with representation from the Indiana House of Representatives, Indiana Senate, and Governor's Office, as well as various other agencies and organizations.¹

Each year, the IAC addresses one or more of the duties outlined in *Indiana Code 16-46-6*. <http://www.ai.org/legislative/ic/code/title16/ar46/ch6.html>. During 2010, IAC examined the impact of infant mortality and prenatal initiatives, including but not limited to, HIV perinatal prevention.

Infant mortality is a major indicator of the health of a nation. Over the past five years, the U.S. infant mortality rate has remained constant. However, there have been large disparities among racial and ethnic groups. Blacks had infant mortality rates twice that of whites and Hispanics.² Similar to national trends, Indiana infant mortality rates did not decline significantly from 2003 to 2007. Blacks in Indiana had the highest rates of infant mortality.³

Key Findings:

- Indiana ranked 35th in the nation for overall infant mortality in 2007.²
- In 2007, the infant mortality rate among blacks was 15.7 per 1,000 births, more than twice the rates of whites (6.5 per 1,000 live births) and Hispanics (6.8 per 1,000 live births).³
- Black mothers had the highest percentage of premature births followed by whites and Hispanics during 2007.⁴
- From 2003 to 2006, Hispanic and black pregnant women were less likely than whites to receive prenatal care in the first trimester of their pregnancies.⁴
- According to the Indiana Family & Social Services Administration (FSSA), more than half of all births in Indiana are funded by Medicaid.⁵
- Pregnant women on Medicaid smoked at a rate of 30% compared to 17.9% in pregnant women not on Medicaid in Indiana.⁶
- In 63 of Indiana's 92 counties (68 percent), the smoking rate ranged from 30 percent to 48 percent among the pregnant Medicaid population.⁶

- The infant mortality rate for unmarried non-Hispanic black mothers was nearly twice that of unmarried non-Hispanic white mothers and more than twice the rate for Hispanic unmarried mothers.⁷

The Healthy People (HP) 2010 objective and Indiana's objective related to infant mortality is to reduce the overall infant mortality rate to 4.5/1,000 by 2010.⁸ In 2007, Indiana's infant mortality rate for the total population was over one and a half times that of the HP 2010 objective, and the black infant mortality rate was over three times the HP 2010 rate.³ It does not appear the mortality rates of Indiana's populations, particularly its minority populations, are improving. The complicated interrelationships between genetics, socioeconomic status, race, and ethnicity result in health disparities. It is difficult to tease out the individual contributions the above mentioned variables play in obscuring the racial and ethnic disparities related to infant mortality. This problem is compounded by a lack of reliable data. Many health care organizations routinely collect data, but there is neither uniformity nor standardized practices for data collecting, coding, and reporting, particularly race and ethnicity data. Valid and reliable data are just as important prerequisites to eliminating health disparities as having access to quality healthcare.

In order to ensure the survival and optimal health of all Indiana residents, racial and ethnic minority families need to be adequately prepared for pregnancy. The IAC recommended statewide sustained initiatives in the following areas:

- Improve minority health research, data collection, and reporting methods
- Increase coalition and capacity building
- Increase capacity (including development and implementation of recruitment and retention strategies)
- Increase cultural competency
- Reduce barriers limiting access to care

The IAC supports programs, policies, and legislation involving prenatal health and infant mortality, including mandatory HIV screening. Interventions that prevent infant mortality will change the course of lives of women and children in Indiana, and consequently, lead to better health for all Indiana residents.

Background

The ISDH Office of Minority Health (OMH) works closely with the Indiana Minority Health Coalition and its local coalitions, as well as the IAC and other institutions and organizations within minority communities to address health disparities as outlined in IC 16-46-1 (Table 1).¹

Table 1. IAC Members – 2009-2011

Statutory appointees:	
Two (2) members of the House of Representatives from different political parties appointed by the Speaker of the House of Representatives.	Rep. Jim Buck Rep. Charlie Brown
Two (2) members of the Senate from different political parties appointed by the President pro tempore of the Senate.	Senator Tom Wyss Senator Jean Breaux
The Governor or the governor's designee.	Jamal Smith
The State Health Commissioner or the commissioner's designee	Dr. Gregory N. Larkin Antoniette Holt (Proxy)
The director of the Division of Family and Children or the director's designee	James Garrett
The director of the Office of Medicaid Policy and Planning or the director's designee	Jackie Cissell
The director of the Division of Mental Health and Addiction or the director's designee	Lynn Smith
The commissioner of the Department of Corrections or the commissioner's designee	Edwin G. Buss Tim J. Brown & Rose Vaisvilas (Proxy)
One (1) representative of a local health department	Vacant
Governor's appointments:	
One (1) representative of a public health care facility appointed by the governor	Jose M. Pérez (Marion)
One (1) psychologist appointed by the governor who: (A) is licensed to practice psychology in Indiana; and (B) has knowledge and experience in the special health needs of minorities.	Vacant
One (1) member appointed by the governor based on the recommendation of the Indiana State Medical Association	Dr. Meredith Cousin
One (1) member appointed by the governor based on the recommendation of the American Medical Association	Lili A. Leavell-Hayes, M.D. (Indpls.)
One (1) member appointed by the governor based on the recommendation of the Indiana Hospital and Health Association	Dr. Edward Williams
One (1) member appointed by the governor based on the recommendation of the American Cancer Society	Vacant
One (1) member appointed by the governor based on the recommendation of the American Heart Association	Lynne Griffin
One (1) member appointed by the governor based on the recommendation of the American Diabetes Association	Vacant
One (1) member appointed by the governor based on the recommendation of the Black Nurses Association	Maple Murrell
One (1) member appointed by the governor based on the recommendation of the Indiana Minority Health Coalition	Teri Cardwell

Invited advisors: Nancy Jewell, Indiana Minority Health Coalition; Edwin C. Marshall, O.D., Indiana University School of Medicine; Margie Fort, National Kidney Foundation

Year-end Review

In 2010, IAC examined and recommended preventive measures concerning infant mortality and prenatal initiatives, including but not limited to, perinatal HIV prevention among minorities. The following are some of the many infant mortality and perinatal initiatives connected to last year's recommendations, which IAC and member agencies sponsored and/or supported during 2010.

Recommendation 1: Improve minority health research, data collection, and reporting methods

The Indiana Minority Health Coalition (IMHC) has been facilitating the State Master Research Planning Committee. This group was established to provide the ISDH and the Indiana FSSA a forum for examining what key stakeholders view as research priorities in minority health while also leveraging the expertise of key stakeholders for developing strategies to address the priorities identified. IMHC envisions that the committee would transition to become a Research Consortium that provides a forum for the following to take place:

- Identify data gaps and research needs
- Recommend community perspective on what the state can do to fill data gaps and research needs
- Foster joint research initiatives among consortium members
- Share promising and best practice research efforts
- Increase the level of federal funds received by Indiana through joint proposal submissions

As a result of many discussions during State Master Research Planning Committee meetings, a Race Ethnicity Work Group was formed. The purpose of the group is to explore the current methods of race ethnicity data collection and make recommendations to state and local agencies about standardizing the collection and reporting of race ethnicity data throughout the state. The work group has taken the following steps to reach the above mentioned goal:

- Discuss current state and federal data collection
- Identify rationale for standardization of race ethnicity data
- Determine race ethnicity data elements required
- Review what other states have done
- Review the literature for views of race ethnicity data collection
- Explore existing race ethnicity toolkits
- Select race ethnicity and language questions

- Plan focus groups to obtain feedback from the community

In May 2010, the U.S. Department Health and Human Services, the State Offices of Minority Health (SOMH) in Region V (Illinois, Indiana, Ohio, Michigan, Minnesota, and Wisconsin) held a conference on data which was hosted by Indiana. A common complaint among the SOMHs in Region V was the lack of state and local level data available for designing programs to eliminate health disparities. In addition, there are no consistent collecting and reporting practices of racial and ethnic health data among various state agencies. The overarching goal of the conference was to bring together regional expertise in data and research to address data-related issues. As a result of the information gathered during the conference, Region V will develop a pilot project to capture data on populations that are seen as insignificant in data collection and address issues that affect these different populations. This will be achieved by:

- Sharing information about current data practices and barriers that exist within each state
- Recruiting local and state partners to develop a regional strategy for more consistent data collection of racial and ethnic data in Region V
- Providing training to community leaders on data collecting and reporting

Recommendation 2: Increase coalition and capacity building

The IMHC invited local coalition affiliates to host town hall meetings in their communities to raise awareness and encourage conversation about infant mortality. WellPoint, Inc. provided funding for the town hall events. Local coalition affiliates arranged for subject matter experts to present or participate in a panel discussion to inform the audience on the issues of infant mortality and actions that can help to reduce / prevent infant mortality, particularly among our most vulnerable populations. During March and April, more than 200 individuals participated in eleven local events held in the following counties: Allen, Delaware, Elkhart, Grant, Lake, La Porte, Madison, Marion, St. Joseph, and Vanderburgh.

- The Delaware County town hall meeting covered a variety of issues related to infant mortality such as limited access to health care, poverty, mother's health status before and during pregnancy, substance abuse, and poor nutrition. Strategies to reduce infant mortality included access to prenatal care, breastfeeding, educational programs with emphasis on health promotion, nutrition, pregnancy, and safe sleeping practices.
- The town hall meeting held in Elkhart County included a discussion of HIV/AIDS testing during pregnancy, lack of awareness of reproductive health issues, pregnancy prevention, little or no prenatal care, and poor nutrition and other issues that affect women and children before, during and after pregnancy. In addition, participants discussed other health issues that affect infant mortality such as domestic violence, poverty, undiagnosed/untreated gestational diabetes, and poor health status before pregnancy. Attendees expressed concern about the

- The town hall meeting held in Grant County included a presentation on the high rates of infant mortality particularly among African Americans/Blacks. The speaker underscored factors that contribute to infant mortality, such as smoking, limited breastfeeding, lack of prenatal care, and safe sleep practices. Barriers to breastfeeding consist of lack of awareness, culture, and easy access to baby formula. Participants offered the following suggestions to increase breastfeeding: involvement of educators, families, and providers to encourage, instruct, and support breastfeeding practices in settings such as churches, communities, health care settings, home, and social clubs.
- The Lake County town hall meeting opened with a presentation on the recent increases in infant mortality and factors that contribute to infant mortality. Specific topics discussed included poor prenatal care, lack of outreach/education targeting pregnant women, breastfeeding education, lack of insurance, low birth weight babies, and growing infant mortality rates. Participants recommended improved communication, education, and support for pregnant women and mothers in the community and at home, as solutions to reduce infant mortality.
- The town hall meeting held in La Porte County revealed a variety of issues contributing to infant mortality, including the lack of prenatal care, poor nutrition, HIV infection, substance abuse, and unsafe sleeping practices. The discussion emphasized the following recommendations for preventing infant mortality: early and continuous prenatal care, placing infants on their backs to sleep in a crib rather than in a bed with adults, and practicing safe sex.
- The Madison County town hall meeting included a round table discussion of the issues contributing to infant mortality, which included lack of breastfeeding, cultural and language barriers, and smoking among pregnant women. The discussion also touched on local programs to increase prenatal care and underreporting of infant deaths, particularly those babies transported to specialty hospitals for care.
- Two town hall meetings were conducted in Marion County. The first meeting was conducted in Spanish. The presentation included information about safe sleeping practices, proper nutrition and folic acid, the importance of mental health support, and infant care. The meeting highlighted programs that specifically targeted the Hispanic/Latino population.
- The second town hall meeting held in Marion County included a panel discussion of infant mortality issues such as the high number of infant deaths among minorities, risk factors, unplanned pregnancies, poor nutrition, and poor living conditions. Participants made the following recommendations for reducing infant mortality: encourage women to take care of their bodies before, during, and after

pregnancy, improve prenatal care, increase breastfeeding, increase education (including fathers), increase cultural competency, and improve housing.

- The town hall meeting held in St. Joseph County included a discussion of the high infant mortality rates in the county, particularly among minorities. Attendees discussed issues related to infant mortality such as lack of (insurance) coverage, lack of access to prenatal care, lack of presumptive eligibility, poverty, lack of awareness and competing priorities of young mothers. Participants made the following recommendations to address infant mortality: improved healthcare access and coverage and increase awareness of existing programs.
- The Vanderburgh County town hall meeting consisted of a discussion on the high infant mortality rates in the county, particularly among minorities. Participants discussed the following strategies for reducing infant mortality: enhance the care a woman gives her body before, during and after pregnancy, prenatal care, safe sleeping practices, breastfeeding, consumer and provider education, and access to care.

The IMHC sponsored the 2010 Minority Health Initiative Annual Luncheon - *Healthy Babies, A Healthy Future: Preventing Infant Mortality*. The April 2010 event featured Tonya Lewis-Lee (wife of filmmaker Spike Lee). Mrs. Lewis-Lee is the national spokesperson for the *A Healthy Baby Begins with You* campaign through the U. S. Department of Health and Human Services Office of Minority Health (U.S. Dept. of H.H.S., OMH). Tonya Lewis-Lee used her celebrity to bring awareness and educate those in minority communities about infant mortality. The U.S. Dept. of H.H.S., OMH started the *A Healthy Baby Begins with You* campaign in May 2007. This is a national campaign to raise awareness about infant mortality and eliminate health disparities among minorities, particularly in African Americans.⁹

A Healthy Baby Begins with You campaign has the following goals:

1. Extend and continue broad infant mortality awareness campaign; add preconception and inter-conception health messages.
2. Develop activities targeted to the 18+ population.
 - Reach the college-age (black) population with targeted health messages emphasizing preconception health and health care.
 - Train minority college students—blacks in particular—as health ambassadors.
 - Increase OMH involvement with colleges and universities, in particular minority-serving institutions such as Historically Black Colleges and Universities.
3. Strengthen OMH leadership at the local level through the establishment of working partnerships with Healthy Start Programs, State/City Health Departments, State OMHs and Community-Based Organizations (CBO).⁹

IMHC's *Have a Healthy Baby* program is a health education program which focuses on the reduction of infant mortality, especially black infant mortality. The program is

designed to familiarize pregnant women or those women who are planning to become pregnant, as well as interested family members/significant others on pregnancy, nutrition, risk reduction, prenatal care, infant feeding and the impact of mother's behavior on her health and her baby. The training program consists of five lessons on prenatal care presented by facilitators in a community-based setting. The sessions are gender and culturally relevant, and include lectures, instructional materials, group discussion, videos, and educational handouts.

The IAC and the IMHC conducted infant mortality roundtable discussions hosted by Indiana State Senator Jean Breaux (D). The purpose of these meetings was to bring together doctors, nurses, social workers and other individuals who are engaged in the process of filling out the birth certificate/live birth worksheets and address the optional and mandatory reporting on birth certificates. Three regional roundtable meetings were held in Indianapolis, Columbus, and Evansville. The following sections include summary information from those meetings:

- The Indianapolis meeting consisted of an overview of current methodology used to collect birth certificate data, including who collects the data. The group discussed information missing from the worksheet and why the form is not being completed in its entirety. Participants offered the following solutions: a standardized data collection process, prioritizing prenatal and patient care, and adequate allocation of money, people, and jobs for accurate completion of the birth certificate worksheet.
- The Columbus roundtable discussion included dialogue about infant mortality risk factors, methodology used for collecting birth certificate data, and who collects the data. Participants suggested improving the data collection process by having a point and click versus data entry reporting system. In addition, participants suggested examining the current methodology used for collecting data, determining what data is needed, and doing a cost analysis.
- At the Evansville roundtable meeting, participants indicated that the current birth certificate worksheet is fragmented and it needs to be redesigned. Attendees suggested that the form include sections on prenatal care, patient labor/delivery, post partum, and nursery/NICU, as well as rephrasing how questions are asked. Participants recommended looking at how other states collect birth certificate data, reviewing the NIH PRAMS study, and determine what we really need. It was pointed out that Indiana missed a possible grant opportunity from the March of Dimes (prematurity) due to the lack of data.

The ISDH Office of Public Affairs, Maternal and Child Health program, and Office of Minority Health collaborated to develop a statewide message on infant mortality. This message emphasizes the following points:

- Plan Ahead
 - Plan Your Family

- See Your Doctor Early
 - Get Information
- Make Yourself A Priority
 - Remain Stress Free
 - Eat Healthy
 - No Smoking or Alcohol

One Test Two Lives - Prevent HIV Indiana Campaign is a collaborative effort of multiple agencies. The campaign partners include the ISDH; Indiana University School of Medicine; Indiana Perinatal Network; Midwest AIDS Training + Education Center (MATEC); Ryan White Center for Pediatric Infectious Disease; and the Indiana University National Center of Excellence in Women's Health. This statewide campaign aims to improve clinical practices that prevent perinatal HIV transmission by emphasizing opt-out (in writing) prenatal testing of pregnant women in accordance with Indiana law. The *One Test Two Lives* - Prevent HIV Indiana Campaign partners sent toolkits to healthcare providers with a cover letter encouraging them to routinely educate and screen pregnant women and their newborns for HIV. If HIV screening is refused at early prenatal visits, providers are asked to address the issue throughout the pregnancy.¹¹

The IAC supports *One Test Two Lives* - Prevent HIV Indiana Campaign as well the following recommendations:

- Simplify the consent process.
- Change verbiage in legislature to note that all pregnant mothers should be tested for HIV.
- Mandate that all physicians must make sure that all of the information on the birth certificate/data forms on newborns are filled out.
- Redesign the birth certificate form.

Recommendation 3: Increase capacity (including development and implementation of recruitment and retention strategies)

The Partners Recruiting Opportunity for Minority Student Education (PROMiSE) program was a partnership between the ISDH-OMH, IMHC and the Indiana Area Health Education Centers (AHECs). The goal of the PROMiSE program was to eliminate health disparities in the health care professions by collaborating with state and community organizations to remove barriers that prevent minority students from being successful health care professionals. The program, which primarily targeted ninth-grade minority students, sought to recruit and retain minority students in healthcare professions. PROMiSE was funded through 2010 via a five-year State Partnership grant from the U.S. Dept. of H.H.S., OMH.

Recently, the ISDH-OMH was awarded a three-year State Partnership grant from the U.S. Dept. H.H.S., OMH with funding from 09/01/2010 through 09/31/2013.

The ISDH-OMH developed the Enhancing Minority Partnership Opportunities; Working to Eliminate Racial and Ethnic Disparities (EMPOWERED) project. This program will focus on the following aspects of access to health care:

- Access to a diverse workforce reflective of the communities that suffer health disparities
 - The ISDH-OMH and its partners will utilize lessons learned from PROMiSE to introduce health careers to students and offer mentoring and enrichment activities for those interested in pursuing a career in health. By starting activities in middle school rather than high school, students will learn of health care career opportunities earlier, influencing the future health care workforce of Indiana.
- Access to quality care
 - The ISDH-OMH will implement the Culturally and Linguistically Appropriate Services (CLAS) in Health Care Standards of functioning effectively in the context of cultural differences.⁹ Cultural competency training will be offered to employees of the ISDH, partnering educational institutions, and collaborative partners.
- Access to data and research focused on eliminating health disparities
 - The ISDH-OMH will utilize existing and new partnerships to enhance infrastructure to improve the capacity for improving racial/ethnic data collection at the state, county, and local levels.

Recommendation 4: Increase cultural competency

Throughout 2010, the IMHC offered regional cultural competency trainings across the state. The purpose of these trainings was to:

- increase awareness of the need and importance of cultural competency in the workplace,
- introduce basic cultural competency principles and practices,
- enhance skills development in employing cultural competency in the agency, and
- learn about specific population segments and some associated cultural beliefs and practices that could affect interaction, diagnosis, treatment and retention.

The IMHC, with support from the ISDH – OMH, continues to provide cultural competency training workshops throughout the state. In April 2010, the IMHC, in partnership with the Indiana FSSA, Division of Mental Health and Addictions (DMHA) and Indiana University School of Medicine (IUSOM) hosted the 9th Annual Indiana Cultural Competency Conference for Behavioral Healthcare. The 16th Surgeon General of the United States, David Satcher, M.D., was the keynote speaker. This conference targeted a vast array of healthcare professionals, including mental health providers, substance abuse providers, nurses, social workers, physicians, health care administrators, public health officials, and students, etc. The conference objectives were to:

- Improve the quality of service and health outcomes

- Identify challenges in implementing strategies toward cultural competency
- Create awareness of benefits that accrue from being culturally competent
- Enhance leadership involvement in cultural competence through leadership commitment

Recommendation 5: Reduce barriers limiting access to care

The ISDH Prenatal Care / Prenatal Care Coordination Services Program, through funding from Title V Maternal and Child Health (MCH) Block Grant, addresses infant mortality and low birth weight infants by providing holistic health care to low income pregnant women in community settings. While the services are intended for all pregnant women and their families, the target populations are those individuals with low incomes and those individuals who are high-risk because they reside in medically underserved areas. The program is a collaborative effort with Medicaid and three managed care organizations. Since 1990, Medicaid reimbursed at a small rate. Medicaid recently increased its support. Services include physical exams, nutrition, social services, education, interventions, dental and health screenings, counseling and referral services. There are Care Coordinators throughout the state that assists pregnant women and their families with navigating the system. Care Coordinators are registered nurses, social workers, and registered dietitians. There are also Community Care Coordinators (paraprofessionals) who work within communities throughout Indiana.¹²

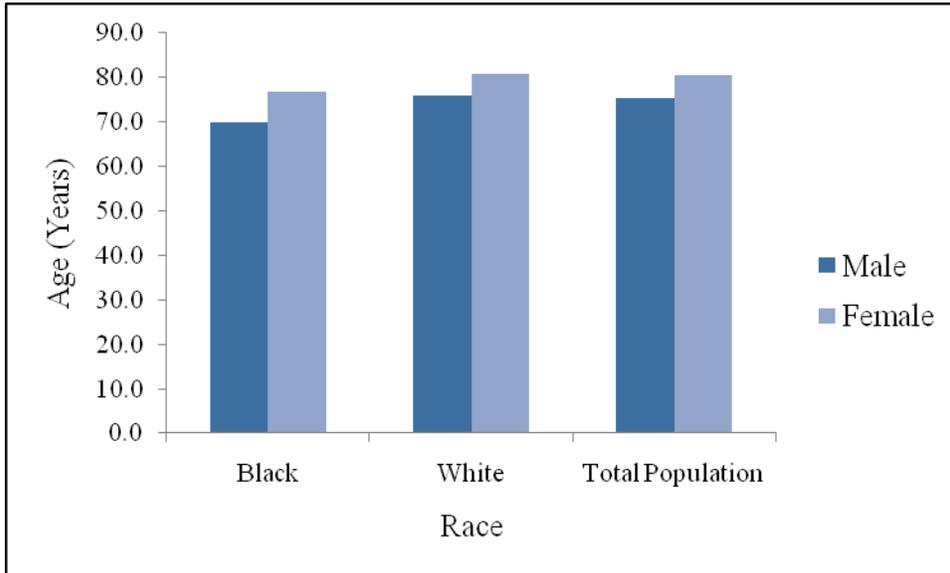
Overview

Healthy People 2010 is a comprehensive health promotion and disease prevention agenda established by the U.S. Department of Health and Human Services. It is built on the 1979 Surgeon General's Report, *Healthy People*, and *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*. These objectives are the result of a collaborative effort among the U.S. Department of Health and Human Services, federal agencies, and other experts. For more than 20 years, these objectives have served as the basis for State and local plans to improve health. *Healthy People 2010* has two overarching goals: (1) to increase life expectancy and improve quality of life and (2) to eliminate health disparities among population subgroups based on characteristics such as race and ethnicity, gender, and income.⁸

Life expectancy in the United States has dramatically increased since 1900. At the beginning of the twentieth century, many Americans did not live past 65 years of age. Infectious diseases often ended many lives. Today the primary causes of death in the U.S. are chronic diseases. The overall health and longevity of Americans has improved, due to advances in health care and medical technology.²

The U.S. life expectancy at birth continues to increase. In 2007, life expectancy at birth for the total U.S. population was 77.9 years (Figure 1).² Despite these trends in increased life expectancy at birth, blacks had a shorter life expectancy at birth than whites and the total population. At 70.0 years, black males had the shortest life at birth expectancy followed by white males (75.9 years). White (80.8 years) and black (76.8 years) women had the highest life expectancies at birth during 2007 (Figure 1).²

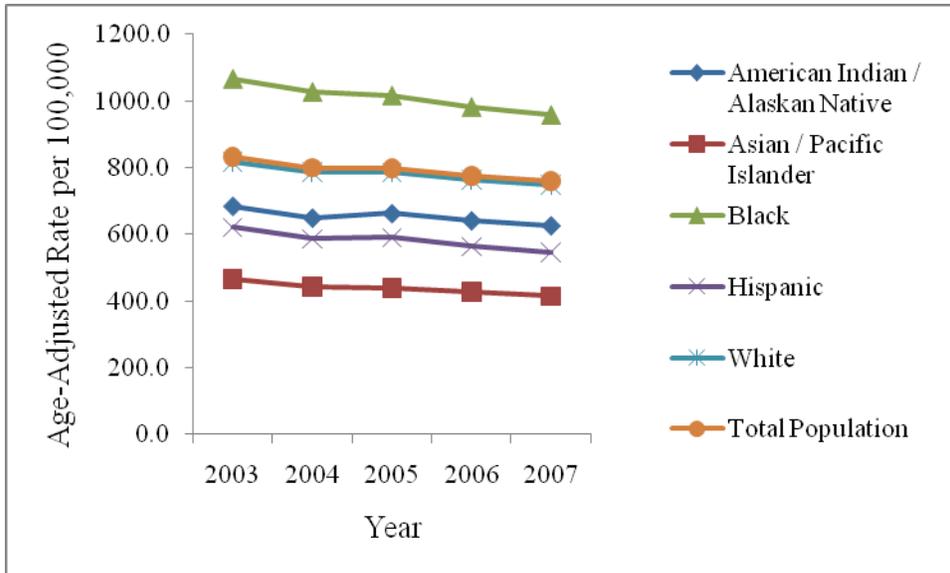
Figure 1. Life Expectancy at Birth by Race and Gender – U.S. – 2007



Source: Indiana State Department of Health, Office of Minority Health, September 2010. Original data obtained from the National Center of Health Statistics, Vital Statistics Reports, Volume 58, Number 19.

According to the National Center for Health Statistics, death rates for the three leading causes, heart disease, cancer, and stroke, continued to decrease. In 2007, the U.S. age-adjusted death rate for all populations, due to all causes was a record low of 760.3 deaths per 100,000.² Despite decreases in mortality rates, there was a long-term trend in differences in mortality between the black and white populations (Figure 2).²

Figure 2. Age-Adjusted Death Rates Due to All Causes by Race and Ethnicity – U.S. – 2003 – 2007

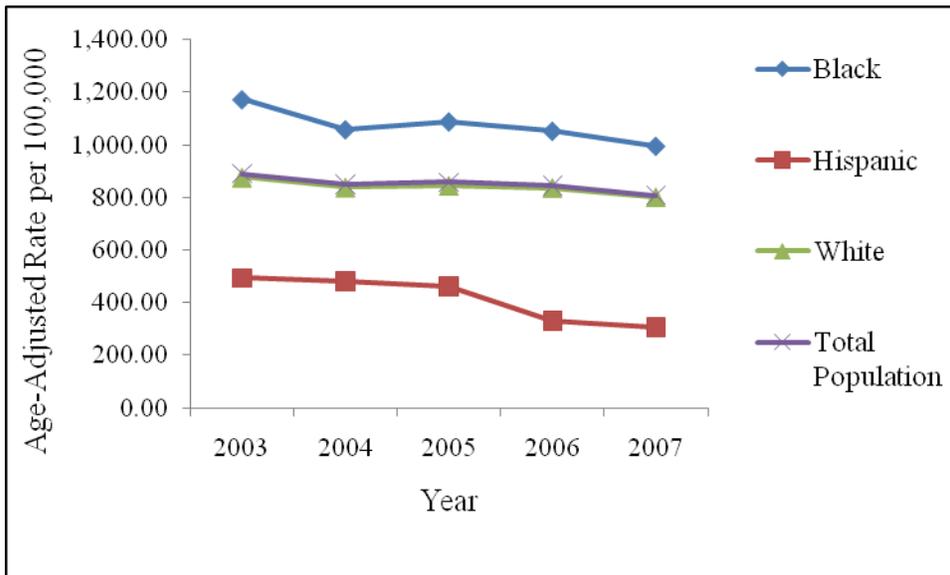


*Hispanic can be of any race

Source: Indiana State Department of Health, Office of Minority Health, September 2010. Original data obtained from the National Center of Health Statistics, Vital Statistics Reports, Volume 58, Number 19.

Similar to the U.S., the leading causes of death in Indiana from 2003 to 2007 were heart disease, cancer, and stroke. During the same period, the age-adjusted death rates also decreased in Indiana. Despite the decreasing trend, blacks had the highest age-adjusted death rates due to all causes than any other racial or ethnicity group in Indiana (Figure 3).³

Figure 3. Age-Adjusted Death Rates Due to All Causes by Race and Ethnicity – Indiana – 2003 - 2007



*Hispanic can be of any race

Age-adjusted rates are calculated using the 2000 standard million population, U.S. Bureau of Census.

Source: Indiana State Department of Health, Office of Minority Health, September 2010. Original data obtained from National Vital Statistics Reports and Indiana State Department of Health, Public Health Preparedness Commission, Epidemiology Resource Center, Data Analysis Team.

During 2010, the IAC focused its efforts on infant mortality and prenatal initiatives, including but not limited to HIV perinatal prevention.

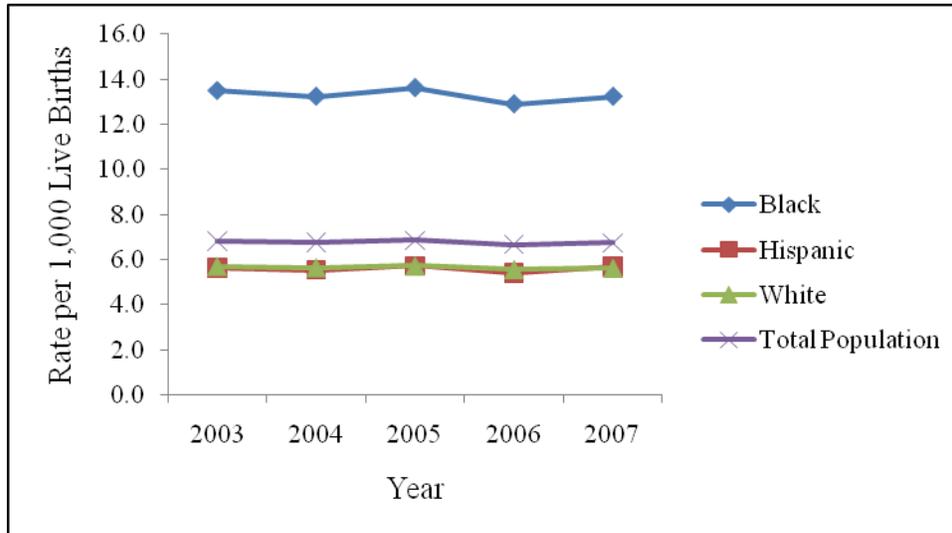
Infant Mortality

In 2005, “the United States ranked 30th in the world in infant mortality, behind most European countries, Canada, Australia, New Zealand, Hong Kong, Singapore, Japan, and Israel. There are some differences among countries in the reporting of very small infants who may die soon after birth. However, it appears unlikely that differences in reporting are the primary explanation for the United States’ relatively low international ranking.”¹³

Over the past five years, the infant mortality rate for the total U.S. population has remained constant (Figure 4). In 2007, the infant mortality rate for the total population

was 6.8 per 1,000 live births.² There were large disparities among racial and ethnic groups. Blacks (13.2 per 1,000 live births) had an infant mortality more than twice that of whites (5.6 per 1,000 live births) and Hispanics (5.7 per 1,000 live births).²

Figure 4. Infant Mortality Rate by Race and Ethnicity – U.S. - 2003 – 2007

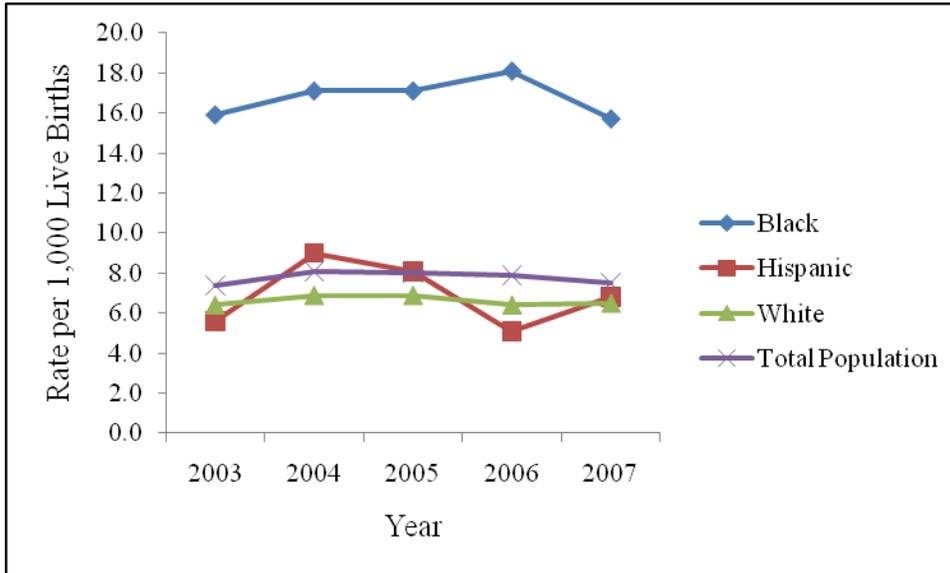


*Hispanic can be of any race.

Source: Indiana State Department of Health, Office of Minority Health, September 2010. Original data obtained from the National Center of Health Statistics, Vital Statistics Reports, Volume 58, Number 19.

Similar to national trends, Indiana infant mortality rates did not decline significantly from 2003 to 2007 (Figure 5). The infant mortality rates for blacks were persistently higher than the rates for whites and Hispanics. In 2007, the infant mortality rate in Indiana was 7.5 per 1,000 live births. The infant mortality rate among blacks was 15.7 per 1,000 live births, more than twice the rates of whites (6.5 per 1,000 live births) and Hispanics (6.8 per 1,000 live births).³ Indiana's infant mortality rate ranked 35th in the nation during 2007.²

Figure 5. Infant Mortality Rate by Race and Ethnicity – Indiana – 2003 – 2007



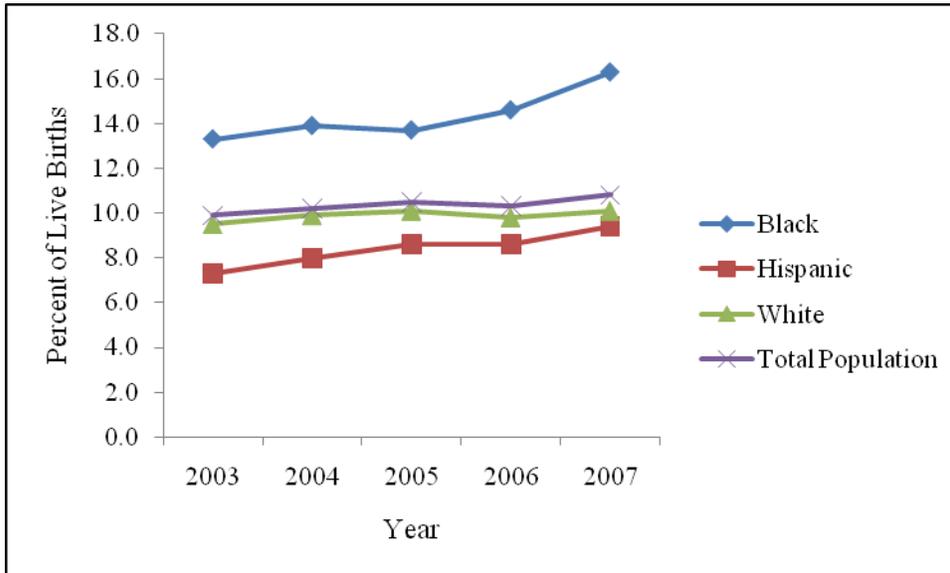
*Hispanic can be of any race.

Source: Indiana State Department of Health, Office of Minority Health, September 2010.
 Indiana State Department of Health, HHOSC, Maternal & Child Health, Children's Special Health Care Services. Indiana State Department of Health, Public Health Preparedness Commission, Epidemiology Resource Center, Data Analysis Team.

Infant Mortality

Infant mortality can be attributed to numerous factors. The gestational age of an infant is one of the most important predictors of survival and subsequent health. Premature infants have a greater risk of death and disability.¹⁴ The percentage of preterm (less than 37 weeks gestation) babies born in Indiana rose from 9.9 percent of live births in 2003 to 10.8 percent live births in 2007 (difference is statistically significant). During this period, the percentage of premature births increased among all races (Figure 6). Black mothers had higher percentages of premature births than white and Hispanic mothers (difference is statistically significant).⁴

Figure 6. Percent of Premature Live Births by Race and Ethnicity of Mothers – Indiana – 2003 – 2007



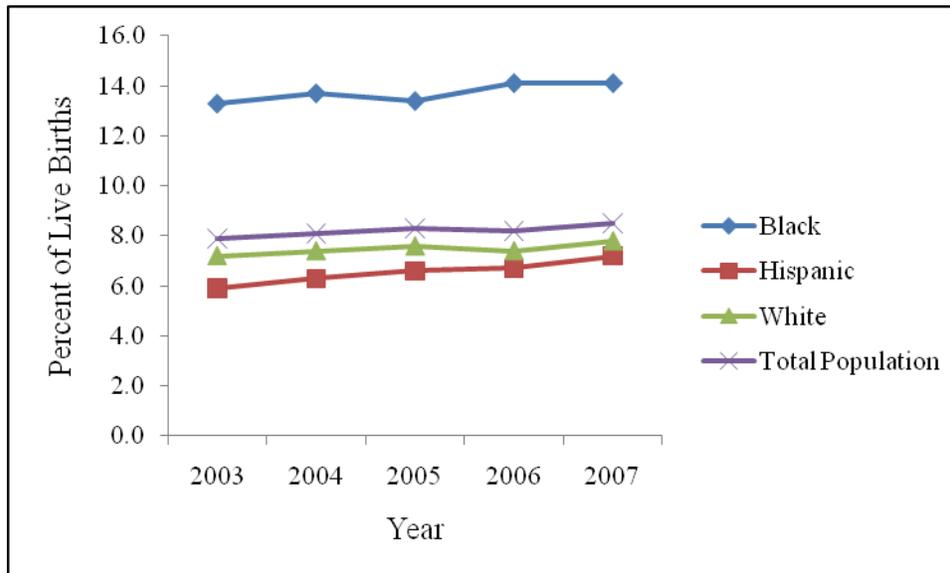
*Hispanic can be of any race.

Source: Indiana State Department of Health, Office of Minority Health, September 2010. Indiana State Department of Health, Public Health System Development and Data Commission, Data Analysis Team.

Birth weight is also a major predictor of infant health. According to the National Center for Health Statistics, birth weight is “closely associated but does not exactly correspond with the period of gestation.” Infant mortality is highest for the smallest of babies and it decreases as birth weight increases.¹⁴

Low birth weight is defined as a baby weighing less than 2,500 grams (5 pounds, 8 ounces) at birth.⁴ In Indiana, the percentage of infants born at low birth weight increased from 7.9 percent to 8.5 percent (statistically significant) of live births from 2003 to 2007.⁴ Consistent with infant mortality and premature live births, blacks had the highest percentages of low birth weight infants (Figure 7).

Figure 7. Percent of Low Birth Weight Infants by Race and Ethnicity of Mother – Indiana – 2003 – 2007



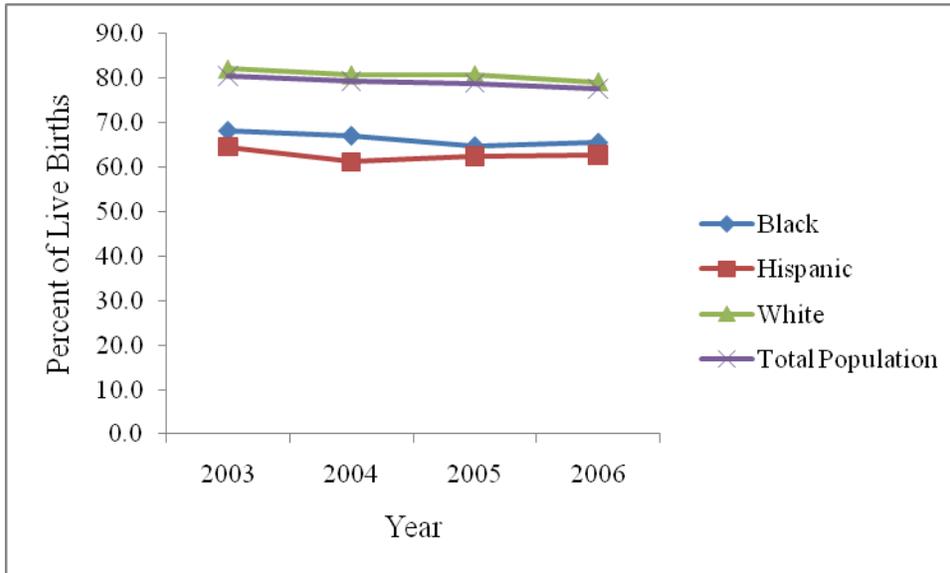
*Hispanic can be of any race.

Source: Indiana State Department of Health, Office of Minority Health, September 2010. Original data obtained from Indiana State Department of Health, Public Health System Development and Data Commission, Data Analysis Team.

Early and continuous prenatal care helps identify conditions and behaviors such as smoking that can result in low birth weight infants. Mothers who receive no prenatal care are three times more likely to give birth to low birth weight infants and five times more likely to die than mothers who receive prenatal care.¹⁵

From 2003 to 2006, the percent of pregnant women in Indiana who received prenatal care in the first trimester decreased from 80.6 percent to 77.6 percent (statistically significant). During this period, Hispanic and black pregnant women were less likely than white pregnant women to receive prenatal care in the first trimester of their pregnancies (Figure 8).⁴

Figure 8. Percent of Mothers Who Received Prenatal Care in the First Trimester – Indiana – 2003 - 2006



*Hispanic can be of any race.

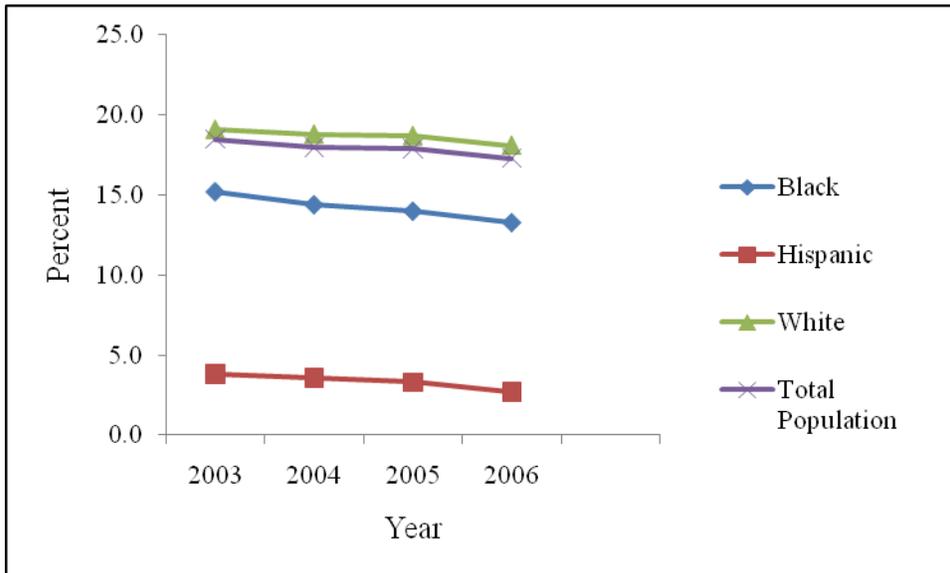
Source: Indiana State Department of Health, Office of Minority Health, September 2010. Original data obtained from Indiana State Department of Health, Public Health System Development and Data Commission, Data Analysis Team.

In 2007, Indiana started using the revised birth certificate (2003 version), which had different questions about prenatal care in the first trimester. The data from 2007 cannot be compared with previous data on prenatal care in the first trimester. Indiana was notified by the Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS) that the state would see decreases in the percent of mothers receiving prenatal care in the first trimester and these changes had been observed in every state using the revised birth certificate. Therefore, 2007 data will be the new baseline percentage.⁶ The 2007 data showed that 67.5 percent of Indiana mothers received prenatal care in the first trimester. Hispanic mothers (49.5 percent) and black mothers (53.4 percent) were less likely than white mothers (69.4 percent) to have received prenatal care in the first trimester.⁴

Smoking during pregnancy has been associated with poor birth outcomes. “Tobacco use during pregnancy causes the passage of substances such as nicotine, hydrogen cyanide, and carbon monoxide from the placenta into the fetal blood supply. These substances restrict the growing infant’s access to oxygen and can lead to adverse pregnancy and birth outcomes such as low birth weight, preterm delivery, intrauterine growth retardation, and infant mortality.”¹⁴

The percent of women who smoked during pregnancy remained consistent from 2003 to 2006. White women had the highest rate of smoking (statistically significant) during pregnancy followed by black and Hispanic pregnant women (Figure 9).⁴

Figure 9. Percent of Women Who Smoked During Pregnancy – Indiana – 2003 – 2007



*Hispanic can be of any race.

Source: Indiana State Department of Health, Office of Minority Health, September 2010. Original data obtained from Indiana State Department of Health, Public Health System Development and Data Commission, Data Analysis Team.

As previously noted, Indiana started using the revised birth certificate (2003 version) in 2007. The tobacco question on the new birth certificate also changed. Therefore, the 2007 data are not comparable with data from 2003 through 2006. The 2007 data for women who smoked during pregnancy will be the new baseline. The data showed that 18.5 percent of pregnant women in Indiana smoked during pregnancy. Hispanic women (4.1 percent) and black women (13.3 percent) were less likely than white women (19.6 percent) to smoke during pregnancy.⁴

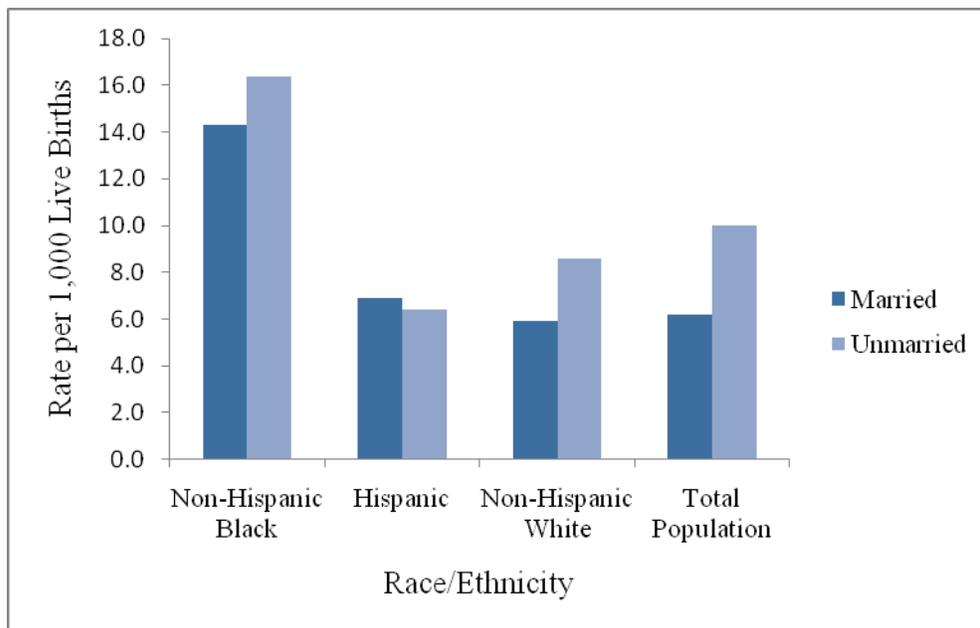
In 2007, the Indiana FSSA Office of Medicaid Policy and Planning claim data and birth certificate information identified a relationship between smoking and the Medicaid population. Pregnant women on Medicaid smoked at a rate of 30 percent. In contrast, pregnant women not on Medicaid in Indiana smoked at a rate of 17.9 percent. In 63 of Indiana's 92 counties (68 percent), the smoking rate ranged from 30 percent to 48 percent among the pregnant Medicaid population.⁶

Babies born to unmarried mothers are more likely to be the result of unplanned pregnancies. Women who have unplanned pregnancies are up to 2.5 times more likely to

begin prenatal care after their first trimester of pregnancy, compared to women who planned their pregnancies. Infants born to unmarried mothers are at higher risk of infant mortality.¹⁵

From 2004 to 2006, the infant mortality rate among unmarried mothers was 10.0 per 1,000 live births in Indiana. In comparison, the infant mortality rate among married mothers was 6.2 per live births. The infant mortality rate for unmarried non-Hispanic black mothers was 16.4 per 1,000 live births and 14.3 per 1,000 live births for married non-Hispanic black mothers. The infant mortality rate for unmarried non-Hispanic white mothers was 8.6 per 1,000 live births and 5.9 per 1,000 live births for married non-Hispanic white mothers. Unmarried Hispanic and married Hispanic mothers had the lowest infant mortality rates at 6.4 and 6.9 per 1,000, respectively. Unmarried non-Hispanic black mothers had an infant mortality rate nearly twice that of unmarried non-Hispanic white mothers and more than twice that of unmarried Hispanic mothers. Infant mortality rates were consistently higher for non-Hispanic black mothers compared to white mothers, regardless of marital status. (Figure 10).⁷

Figure 10. Infant Mortality Rates by Marital Status, Race and Ethnicity, 3-Year Average – Indiana – 2004 - 2006



*Hispanic can be of any race.

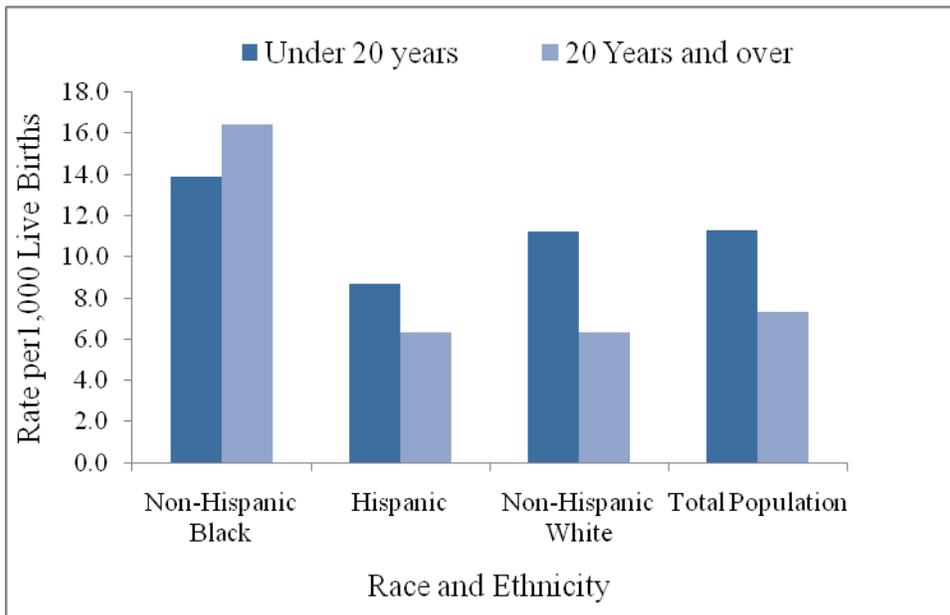
Source: Indiana State Department of Health, Office of Minority Health, September 2010. Original data obtained from Indiana State Department of Health, HHOSC, Maternal & Child Health, Children's Special Health Care Services.

It is estimated that half of all pregnancies in the U.S. are unplanned or unintended.¹⁶ Unplanned or unintended pregnancies are most often associated with teenagers. According to the National Campaign to Prevent Teen and Unplanned Pregnancy, more than half (55 percent) of all unplanned pregnancies occur to women in their twenties.

In comparison, 21 percent occur to teen girls (age 19 years and younger).¹⁶

From 2004 to 2006, Indiana's infant mortality rates varied with maternal age. Infant mortality rates were highest among teenagers or mothers less than 20 years of age. While non-Hispanic black mothers, regardless of their age, had the highest infant mortality rates, it was higher among non-Hispanic black mothers 20 years of age and over (16.4 per 1,000 live births) followed by non-Hispanic black mothers less than 20 years of age (13.9 per 1,000 live births). The infant mortality rate among Hispanic mothers less than 20 years of age was 8.7 per 1,000 live births and 6.3 per 1,000 live births among Hispanic mothers over 20 years of age. The infant mortality rate for non-Hispanic white mothers less than 20 years of age (11.2 per 1,000 live births) was nearly twice that of non-Hispanic white mothers 20 years of age and older (6.3 per 1,000 live births) (Figure 11).⁷ Babies born to teens are at higher risk of being low birth weight. Teen mothers are less likely to receive prenatal care in the first trimester of their pregnancy.

Figure 11. Infant Mortality Rates by Age (females less than 20 years of age and females equal to or greater than 20 years of age), Race, and Ethnicity, 3-Year Average – Indiana – 2004 - 2006



*Hispanic can be of any race.

Source: Indiana State Department of Health, Office of Minority Health, September 2010. Original data obtained from Indiana State Department of Health, HHOSC, Maternal & Child Health, Children's Special Health Care Services.

In addition to factors like maternal marital status and age, many social determinants of health such as employment, income, and insurance influence health care outcomes and health disparities. According to the Indiana FSSA, more than half of all births in Indiana

are funded by Medicaid with up to 25 percent having complications which vary with age and race.⁵

Perinatal HIV Prevention

According to the Centers for Disease Control and Prevention (CDC), “individuals who are infected with STDs are at least two to five times more likely than uninfected individuals to acquire HIV infection if they are exposed to the virus through sexual contact. In addition, if an HIV-infected individual is also infected with another STD, that person is more likely to transmit HIV through sexual contact than other HIV-infected persons.”¹⁷

Sexually transmitted diseases are risk factors for poor birth outcomes such as miscarriage, preterm delivery, and stillbirth.¹⁷ Gonorrhea, chlamydia, and HIV can be passed from a mother to her unborn baby before, during, or after the baby’s birth. HIV can cross the placenta during pregnancy; infect the baby during the birth process, and unlike most other STDs, infect the baby through breastfeeding.¹⁸

More than 95 percent of HIV/AIDS cases in children under 13 years of age occurred as a result of mother to baby transmission. In many cases, these women did not know that they were infected with HIV until their baby or child was diagnosed.^{11, 19} During the last two and a half years, eight babies have been infected with HIV in Indiana.¹⁰ From 1982 through June 30, 2010, there have been 151 children born to HIV positive mothers who have been tested and confirmed as HIV positive in Indiana (Table 2).²⁰

Table 2. Children Born to HIV Infected Mothers by Race and Ethnicity – Indiana Residents - Cumulative 1982 through June 30, 2010

Race	Total Exposures	Child Exposures Now with HIV Disease
Black	391	62
Hispanic	71	8
White	240	68
Non-Hispanic Multiracial	67	12
Other	<5	<5
Total	773	151

*Hispanic can be of any race

Exposed = Children born to HIV+ women. Laboratory testing has not yet determined their HIV status.
HIV Disease = Children born to HIV+ women. Laboratory testing has confirmed that the child is HIV+.

Source: Indiana State Department of Health, Office of Minority Health, July 2010.
Original data obtained from Indiana State Department of Health, HIV /STD Division Semi-Annual Report - June 2010, Perinatal HIV Transmission
Retrieved on Sept 27, 2010 from [http://www.in.gov/isdh/files/Perinatal_HIV_Transmission-June\(1\).pdf](http://www.in.gov/isdh/files/Perinatal_HIV_Transmission-June(1).pdf)

In 2006, the CDC revised its recommendations for HIV testing of pregnant women in health care settings to include the following guidelines:

- HIV screening should be included in the routine panel of prenatal screening tests for all pregnant women.
- HIV screening is recommended after the patient is notified that testing will be performed unless the patient declines (opt-out screening).
- Separate written consent for HIV testing should not be required; general consent for medical care should be considered sufficient to encompass consent for HIV testing.
- Repeat screening in the third trimester is recommended in certain jurisdictions with elevated rates of HIV infection among pregnant women.¹⁸

Currently, Indiana law requires all health care providers to offer all pregnant women HIV testing along with their other prenatal tests. Pregnant women can choose to refuse HIV screening, in writing, or “opt-out” throughout the course of their prenatal care. Indiana law (IC 16-41-2-1) requires the reporting of each HIV case and each AIDS case. Although a newborn’s HIV status may not be known until later, all babies born to an HIV positive mother should be reported.^{11,20}

Studies have shown that pregnant women who are HIV positive can reduce the risk of passing the virus on their unborn child by two-thirds with the appropriate prenatal care and anti-viral treatment during pregnancy, labor, delivery, and after birth.¹¹

The IAC will continue to address infant mortality and prenatal initiatives, including HIV perinatal prevention during 2011. Therefore, the following recommended initiatives developed in 2009 will not change.

Recommendations

The IAC recognizes that in order to eliminate health disparities in Indiana, particularly those related to infant mortality and prenatal initiatives, the following efforts have to be initiated and sustained throughout the state:

- Improve minority health research, data collection, and reporting methods
- Increase coalition and capacity building
- Increase capacity (including development and implementation of recruitment and retention strategies)
- Increase cultural competency
- Reduce barriers limiting access to care

Data collection and research recommendation:

- Support the missions and goals of the IMHC Racial and Ethnic Minority Epidemiology (REME) Center and State Master Research Planning Committee.

Rationale:

In order to develop effective data-driven programs and policies, complete, reliable, and valid minority health data, as well as standardized reporting of race and ethnicity, are needed.

Coalition and capacity building recommendation:

- Establish new and maintain collaboration with institutions and community-based organizations that develop and implement programs which increase accessibility to health care, medical preventive services and health education, especially those related to infant mortality and unplanned pregnancy.

Rationale:

Establishing partnerships with new organizations and maintaining existing ones will help increase awareness of community issues and enhance support for programs and policies associated with health disparities.

Capacity recommendations:

- Support efforts to recruit and retain minority students, especially those from underserved areas, low-income and minority populations, at all levels into health care professions, including obstetrics, pediatrics, and family practice.
- Promote efforts that require Indiana institutions of higher learning to create strategic plans that include specific goals, policies, and accountability mechanisms that ensure minority students are represented in all academic programs, including health programs.

Rationale: A focused approach of recruiting and retaining minority students can help diversify Indiana's health care workforce.

Cultural competency recommendations:

- Continue to support current cultural competency trainings with health care professionals, including those that provide family planning services, and support efforts to initiate new trainings throughout the state.
- Support efforts to create new language translation services and expand existing services to health professionals and patients.

Rationale: Indiana's health care workforce should be culturally competent and reflect the state's racial and ethnic composition.

Reduce barriers limiting access to care recommendations:

- Support the expansion of existing health coverage programs, including those that provide family planning services, to expand services to low-income and minority populations.
- Endorse policies which strengthen incentives for providing primary care in underserved areas, especially for low-income, minority, and immigrant populations.

Rationale:

Improve the health care of Indiana's low-income, minority, and immigrant populations.

Conclusion

Indiana's infant mortality rate has been constant over the last several years. The *Healthy People 2010* objective and Indiana's objective related to infant mortality was to reduce the infant mortality rate to 4.5/1,000 by 2010.⁸ In 2007, Indiana's infant mortality rate for the total population was over one and a half times that of the HP 2010 objective, and the black infant mortality rate was over three times the HP 2010 rate.³ Infant mortality is a major indicator of the health of a population. It does not appear the mortality rates of Indiana's populations, particularly its minority populations, are improving. The complicated interrelationships between genetics, socioeconomic status, race, and ethnicity result in health disparities. It is difficult to tease out the individual contributions the above mentioned variables play in obscuring the racial and ethnic disparities related to infant mortality. This problem is compounded by a lack of reliable data. Many health care organizations routinely collect data, but there is neither uniformity nor standardized practices for data collecting, coding, and reporting, especially race and ethnicity data. Valid and reliable data are just as important to eliminating health disparities as having access to quality healthcare.

The IAC supports programs, policies, and legislation involving prenatal health and infant mortality, including as mandatory HIV screening. Interventions that prevent infant mortality will change the course of lives of women and children in Indiana, and consequently, lead to better health for all Indiana residents.

Technical Notes

Age-Adjusted Rate – When comparing rates over time or across different populations, crude rates (the number of deaths per 100,000 persons) can be misleading, because differences in the age distribution of the various populations are not considered. Since death is age-dependent, the comparison of crude rates of death can be especially deceptive.

Age adjustment, using the direct method, is the application of age-specific rates in a population of interest to a standardized age distribution in order to eliminate differences in observed rates that result from age differences in population composition. According to the National Center for Health Statistics (NCHS), age adjustment is usually done when comparing two or more populations at one point in time or one population at two or more points in time.

The direct method of adjustment was used to produce the age-adjusted rates for this report. In this method, the population is first divided into reasonably homogenous age ranges, and the age-specific rate is calculated for each age range. Then, each age-specific rate is weighted by multiplying it by the proportion of the standard population in the respective age group. The age-adjusted rate is the sum of the weighted age-specific rates. Further information regarding the calculation of age-adjusted rates can be found in *The Methods and Materials of Demography*, by Henry S. Shryock, Jacob S. Siegel and Associates, U.S. Department of Commerce. Age adjustment by the direct method requires use of a standard age distribution. The 2000 population replaces the 1940 U.S. population for age adjusting mortality statistics. The 2000 standard population also replaces the 1970 civilian non-institutionalized population and 1980 U.S. resident population, which previously had been used as standard age distributions for age adjusting estimates from NCHS surveys. The 2000 standard has implications for race and ethnic differentials in mortality.

Source: National Vital Statistics Report, Volume 47, Number 3

Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr47/nvs47_03pdf

“Rates for the American Indian/Alaska Native (AIAN) and Asian/Pacific Islander populations should be interpreted with caution because of reporting problems with respect to correct identification of race on the death certificate and in the population censuses and surveys.” [NVSS}

Infant Mortality is the number of deaths in children under the age of 1 year.

Life Expectancy at birth represents the average number of years that a group of infants would live if the infants were to experience throughout life the age-specific death rates present in the year of birth.

Low Birth Weight describes an infant weighing less than 2,500 grams (5 pounds, 8 ounces) at birth.

Reliability of Rates refers to some of the rates shown in this report, which are based on small populations, a small number of deaths, or both. The rates based on small numbers

may be unstable due to random chance factors and should be used with caution. Rates for counties with small populations also may vary considerably from year to year. In addition, allowances must be made for differences in age distributions, etc., when rates are not age-adjusted.

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Appendix A

In 1988, the Interagency Council on Black and Minority Health was created to:

- (1) Identify and study the special health care needs and health problems of minorities.
- (2) Examine the factors and conditions affecting the health of minorities.
- (3) Examine the health care services available to minorities in the public and private sector and determine the extent to which these services meet the needs of minorities.
- (4) Study the state and federal laws concerning the health needs of minorities.
- (5) Examine the coordination of services to minorities and recommend improvements in the delivery of services.
- (6) Examine funding sources for minority health care.
- (7) Examine and recommend preventive measures concerning the leading causes of death or injury among minorities, including the following:
 - (A) Heart disease
 - (B) Stroke
 - (C) Cancer
 - (D) Intentional injuries
 - (E) Accidental death and injury
 - (F) Cirrhosis
 - (G) Diabetes
 - (H) Infant mortality
 - (I) HIV and acquired immune deficiency syndrome
 - (J) Mental health
 - (K) Substance abuse
- (8) Examine the impact of the following on minorities:
 - (A) Adolescent pregnancy
 - (B) Sexually transmitted and other communicable diseases
 - (C) Lead poisoning
 - (D) Long term disability and aging
 - (E) Sickle cell anemia
- (9) Monitor the Indiana minority health initiative and other public policies that affect the health status of minorities.
- (10) Develop and implement a comprehensive plan and time line to address health disparities and health issues of minority populations in Indiana.

Appendix B (Tables)

Table 1. IAC Members – 2009-2011

Table 2. Children Born to HIV Infected Mothers by Race and Ethnicity – Indiana Residents - Cumulative 1982 through June 30, 2010

Appendix C (Figures)

Figure 1. Life Expectancy at Birth by Race and Gender – U.S. – 2007

Figure 2. Age-Adjusted Death Rates Due to All Causes by Race and Ethnicity – U.S. – 2003 – 2007

Figure 3. Age-Adjusted Death Rates Due to All Causes by Race and Ethnicity – Indiana – 2003 – 2007

Figure 4. Infant Mortality Rate by Race and Ethnicity – U.S. - 2003 – 2007

Figure 5. Infant Mortality Rate by Race and Ethnicity – Indiana – 2003 – 2007

Figure 6. Percent of Premature Live Births by Race and Ethnicity – Indiana – 2003 – 2007

Figure 7. Percent of Low Birth Weight Infants by Race and Ethnicity – Indiana – 2003 – 2007

Figure 8. Percent of Mothers Who Received Prenatal Care in the First Trimester – Indiana – 2003 - 2006

Figure 9. Percent of Women Who Smoked During Pregnancy – Indiana – 2003 – 2007

Figure 10. Infant Mortality Rates by Marital Status, Race and Ethnicity, 3-Year Moving Averages – Indiana – 2004 – 2006

Figure 11. Infant Mortality Rates by Age (females less than 20 years of age and females equal to or greater than 20 years of age), Race, and Ethnicity, 3-Year Moving Averages – Indiana – 2004 - 2006