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Infant Mortality

Public Health Brief

Shelby Graves, Health Policy Analyst

Infant Mortality [1]

The health and well-being of mothers and their infants is a strong predictor of the health of future generations. Favorable birth outcomes, early detection of health conditions, and strong support for maternal and child health (MCH) make children and their families more likely to thrive throughout the lifespan. Infant mortality is the death of an infant before their first birthday. Infant mortality remains a high concern throughout the United States, despite modern advancements in medicine and technology.

Infant mortality rate: the number of infant deaths per 1,000 live births.

Leading causes include:

- Birth Defects
- Preterm Birth
- Low Birth Weight
- Sudden Infant Death Syndrome
- Pregnancy Complications
- Injuries

Safe Sleep [2]

A safe sleep environment reduces risk for sleep-related infant mortality. To create a safe sleep environment for infants:

- **Back to sleep.** Babies who sleep on their backs are much less likely to die of SIDS than babies who sleep on their sides or stomachs.
- **Remove soft bedding.** Keep soft bedding such as blankets, pillows, bumper pads, and soft toys away from your baby's sleep area.
- **Firm & flat surfaces.** Use a firm, flat sleep surface, such as a mattress in a safety-approved crib, covered only by a fitted sheet.

MCH OVERVIEW & SERVICES*

# Live births, 2018	2,634
# Children under 5	14,064
# New insurance applications	1,997
# Healthy Families home visits completed	588
# MEGAN's Place care coordination encounters	750

*Harford County Health Department. Family Health Data, FY 2020.

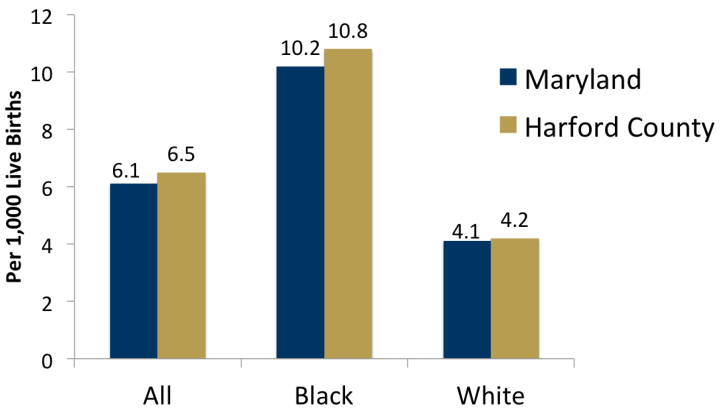
Health Disparities [3]

A health disparity is a difference in health outcomes and their causes among groups of people. The United States holds the highest rates of infant mortality among comparable developed countries. It also has the starkest disparities in infant mortality between racial groups. The infant mortality rate for Black infants is twice that of non-Hispanic white infants throughout the United States. This disparity persists even when accounting for maternal income and education.

Potential solutions include:

- **Address institutionalized racism.** Research has linked racism and discrimination to disparities in infant mortality.
- **Expand maternal and child support services.** Access to comprehensive wraparound services improve maternal and child health outcomes.

Racial Disparities in Infant Mortality
Harford County, Maryland 2017 [4]



Harford County's overall infant mortality rate is 6.5 deaths per 1,000 live births. This is higher than Maryland's rate (6.1). Significant racial disparities persist between Black and white infants. In 2018, the rate of infant mortality was significantly higher for Black infants (10.8) as compared to white non-Hispanic infants (4.2).

Sources:
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NACCHO Exchange

Volume 18, Issue 1
Communications

Promoting Effective Local Public Health Practice

Public Health Communications: Responsive, Adaptable, and Ready to Lead

By Andrea Grenadier, Communications Specialist, and Kim Rodgers, MA, Communications Manager, NACCHO

There are as many ways to effectively manage public health communications as there are communicators in public health. Sharing information effectively to improve the quality of life for individuals, communities, and populations is an immense task, both rewarding and vital, and can often serve as a critical link between crisis and safety in both day-to-day and risk communications. The current state of the field is one that is always moving, advancing, testing, analyzing, and refining what works. Adding to that, public health communicators are also thinking about their brand, how to cut through the noise of too many competing messages, the value they bring to peoples' lives, how to reach more people, and the best way to do that.

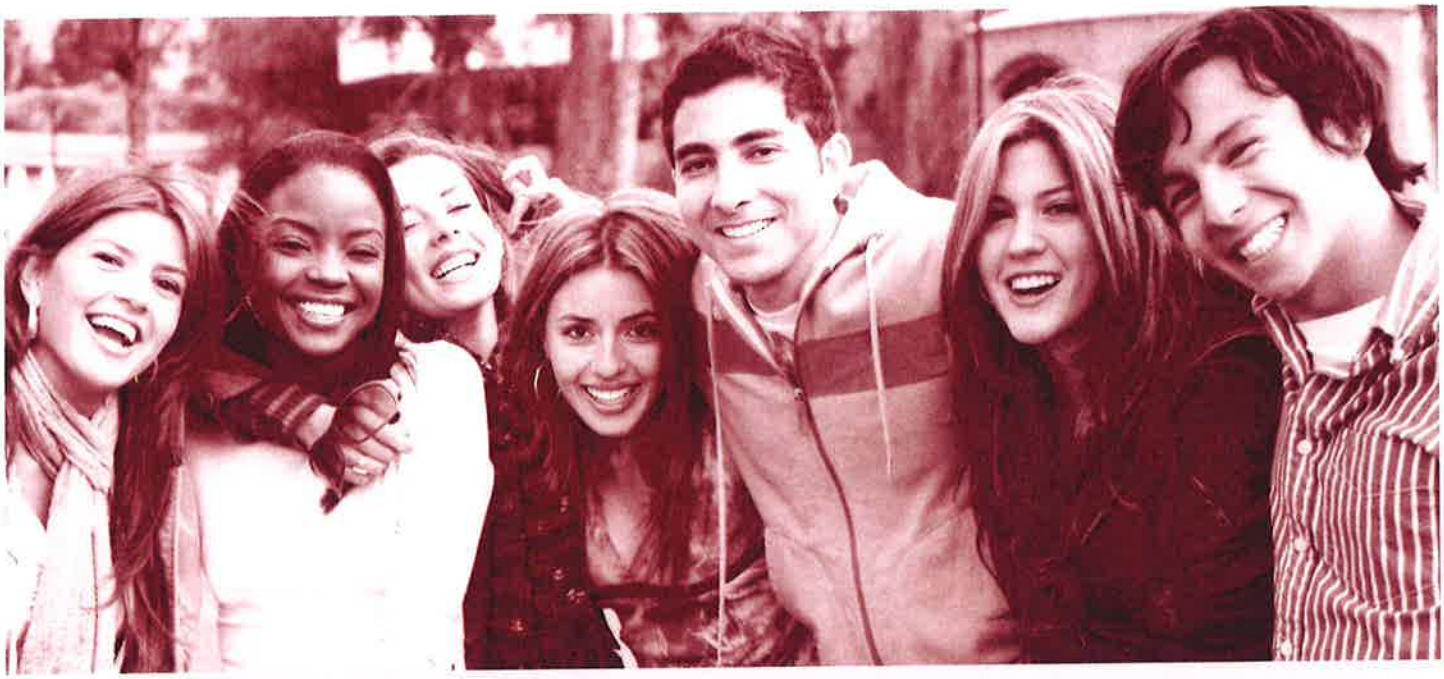
In the spirit of continuous improvement, NACCHO has undertaken efforts to better understand local health departments' communications capacity, capabilities, and preferences. Through this work—notably for the 2017 Centers for Disease Control and Prevention (CDC)-funded program *Strengthening the Health Communication Capacity of U.S. Local Public Health Officials*—we found that, at most local health departments, communications activities are sometimes managed by staff whose primary duties are not communications-focused. As a result, the people communicating often do not have enough bandwidth, training, or capacity for evaluation.

What's Inside...

NACCHO

Prioritizing Health Literacy and Cultural Competency as Key Components of Health Equity

By Molly Mraz, Communications Director, Harford County Health Department; and Shelby L. Graves, MPH, CHES, Health Policy Analyst, for the Harford County Health Department, Bel Air, MD



Achieving the vision of the Harford County Health Department means making Harford County the healthiest community in Maryland. The following article explores how this relatively small health department has prioritized health literacy and cultural competency to turn its organizational vision into a reality.

Understanding Health Literacy and Cultural Competency: An Overview

Health literacy is defined as the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.[1] In the United States, just 12% of the population has proficient health literacy skills, while more than one-third (35%) of adults—77 million people—have basic or below-basic health literacy skills.[2] People with low health literacy are at increased risk for poor health status and poor health outcomes.

Health literacy depends on a variety of factors. For that reason, low health literacy can and does affect people across demographic groups (e.g., race/ethnicity, socioeconomic status, education). In the same way that a person who is illiterate would face challenges in processing and understanding health information—whether it be the instructions on a prescription bottle or a take-home pamphlet on sexual health—so could a college-educated individual who speaks English as a second language. Still, the impacts of low health literacy disproportionately affect individuals who have lower socioeconomic status or belong to minority groups.[3]

While health literacy focuses on the consumer's understanding of health information, cultural competency involves an understanding of culture and is defined as the ability of providers and organizations to effectively deliver healthcare services that meet the social, cultural, and linguistic needs of patients.[4] The level of cultural competency that providers and organizations possess directly affects their ability to

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Prioritizing Health Literacy and Cultural Competency as Key Components of Health Equity

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develop health information materials and communications that meet the health literacy needs of the people they serve.

Increasing equity in health outcomes requires that public health messaging and health communication engage everyone. Health literacy and cultural competency are key components to this engagement, but understanding these concepts can be complicated. What makes sense to one individual or organization may not make sense to another. So how can a local health department overcome this challenge? In Harford County, the health department started with a Community Health Needs Assessment (CHNA).

Assessing Demographics and the Landscape of Health in Harford County

Located in the northeast region of Maryland, Harford County is a mix of rural and suburban development outside of Baltimore. Home to approximately 252,160 residents, Harford is the sixth largest county in the state and the population only continues to grow each year. Its geographic location and abundant economic opportunities allow many people to thrive in the area. According to the 2017 Census, only 7.2% of Harford County residents live in poverty. Though Harford County is one of Maryland's wealthiest in terms of income, the income is not equally distributed among jurisdictions. In fact, a closer examination of each zip code within the county reveals significant disparities in health, access, and opportunity.

Understanding the diverse demographics of Harford County is essential to developing a clear understanding of the health of the community. Demographics, such as race/ethnicity, level of educational attainment, and income, have a profound impact on one's health; therefore, health messaging must consider each of these factors in order to provide clear and equitable health communication to every member of the community. To better understand how to improve health messaging, the health department first needed a snapshot of the landscape of health. As such, Harford County Health Department, in partnership with the local hospital system, prepared the Harford County CHNA[5] to understand how to better serve the community.

The 2018 CHNA revealed that wealth distribution is significantly unequal in the county and that the areas with the highest poverty rates had notable increases in risky health behaviors and adverse health outcomes. In response to these findings, the health department developed a new strategic plan that reflects a commitment to improving health equity in the community and incorporating this concept into daily work. The 2019–2024 Harford County Health Department Strategic Plan creates greater awareness about the importance of health equity in the community and aims to increase the understanding of these issues among employees. As part of this plan, the health department prioritizes a range of objectives, such as standardizing public health messaging through community outreach workers and increasing cultural competency of staff. These objectives will be completed by working on a unified health promotion, education, and communications strategy and identifying effective cultural competency trainings to offer to all health department staff members.

Additionally, the health department will look to the Public Health Accreditation Board (PHAB) standards for guidance. The PHAB standards are consistent with the 10 Essential Public Health Services and directly align with the Harford County Strategic Plan and the Community Health Improvement Plan (CHIP). Harford County Health Department authors the CHIP and leads the Harford County Local Health Improvement Coalition (LHIC), which executes the CHIP within the community. Three CHIP priorities, which align with the LHIC workgroups, include Behavioral Health, Family Health and Resilience, and Chronic Disease Prevention & Wellness. The health department has prioritized health literacy and cultural competency within this improvement plan and the LHIC work plans.

"Recognizing that low health literacy and low cultural competency is prevalent in Harford County, the health department is now striving to promote public health and prevention in the community while helping to minimize barriers to receiving care."

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Prioritizing Health Literacy and Cultural Competency as Key Components of Health Equity

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Advancing Health Literacy and Cultural Competence as Components of Health Equity

Recognizing that low health literacy and low cultural competency is prevalent in Harford County, the health department is now striving to promote public health and prevention in the community while helping to minimize barriers to receiving care. By failing to promote messaging that can be understood across the health literacy spectrum, public health and healthcare institutions exacerbate barriers to health services and favorable health outcomes. Using evidence-based programs, the health department is working on a new, direct approach to health communications.

Institutionally, and with the aim of improving health literacy throughout the county, the department created a new communication plan that includes standards for the creation of culturally competent health communication materials that are accurate and easy to understand. Through the efforts of the Harford County LHIC's Chronic Disease Prevention and Wellness Workgroup, the department is creating health communication materials that focus primarily on health literacy. The goal of the Chronic Disease Prevention and Wellness Workgroup is to prevent chronic disease and promote healthy living among residents in Harford County, with a special emphasis on addressing prevention through accessible health communication methods. The messaging that the workgroup develops must meet the Harford County Health Department guidelines for creating culturally competent and clear health messaging, and the group currently references the CDC's clear communication index for additional guidance. The workgroup is currently in its infancy, but has selected three areas of focus based on the findings of the CHNA: tobacco, cancer, and healthy eating/active living.

Implementation of the new standards of communication has just begun, but Harford County Health Department is already making changes to its website to ensure the health communication messaging is culturally competent and aids in improving health literacy for readers. Since health literacy is not just about the message itself—it also relates to formatting and dissemination—the health department addressed the imperative need for a more user-friendly website. This was done through a series of updates that involved ensuring the ability to translate the website into different languages, extensively editing program descriptions to meet plain language recommendations, adding phone numbers and locations at the top of each page, and integrating a new section for users to comment or post a complaint, which receives approximately 20 inquiries per month.

Lessons Learned

Prior to the establishment of Harford County Health Department's new communication standards, the communications team was already familiar with how challenging it could be to keep up with its diverse audiences in an evolving digital age. But the team knew it had to start somewhere.

In 2012, the health department began making small improvements to its website. Over a period of three years, Harford County Health Department's website experienced a dramatic uptick in users with per-month visits increasing from several hundred to several thousand. The significant increase in users demonstrated to the health department that the changes were effective, and website updates and usability should remain a priority. Around the time those website changes were made, the health department also joined the social media world. As engagement slowly increased on the department's social media platforms, new platforms targeting new demographics began to emerge. It did not take long to realize that in today's digital age, public health communicators must continuously learn where their audience lives online and how to communicate with them. Ensuring that staff are culturally competent and that health department communications can be understood across literacy levels is all a part of that continuous growth.

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Prioritizing Health Literacy and Cultural Competency as Key Components of Health Equity

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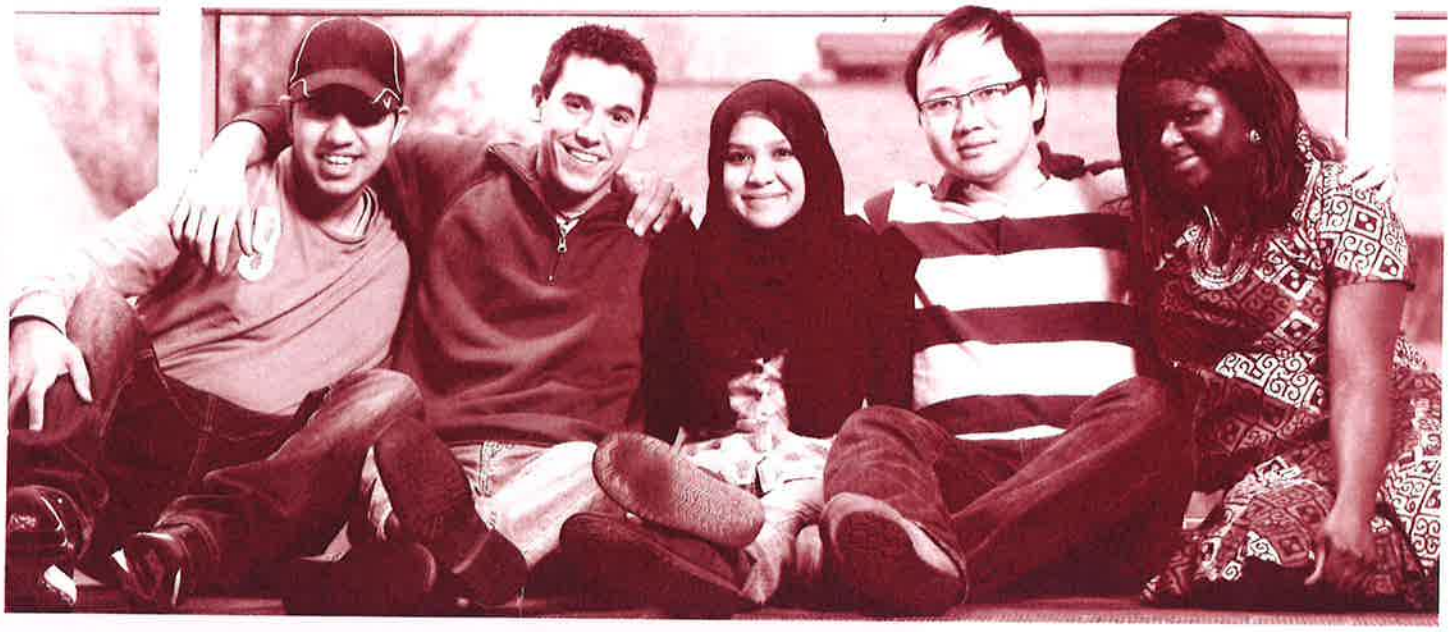

Despite finding some success in growing social media engagement and website communication over the past few years, challenges remain. Following a department-wide assessment of cultural competency, the health department found that many staff members lacked an effective understanding of the concept. An essential part of engaging everyone from the community is having a consistent, shared understanding of health literacy and cultural competency within the organization and among community partners. As such, Harford County Health Department is working across all its programs to ensure that staff members are trained and educated on the importance of both. Key activities include providing training, addressing uncertainties about the definitions of and distinctions between health literacy and cultural competency, and advocating for a mutual understanding of these principles among community partners.

An additional challenge the health department faces is reaching populations that are vulnerable and underserved throughout the county. Certain zip codes in Harford County require a different level of care and additional resources, so the health department is striving to direct more effort to the residents in those at-risk areas.

Lastly, the ubiquitous challenge of funding, which affects all local health departments and the field of public health in general, remains. Until there are more funds available to support efforts to improve public health communication—and, more specifically, address health literacy and cultural competency—health departments will struggle to develop and implement robust communications initiatives that could improve community and population health.

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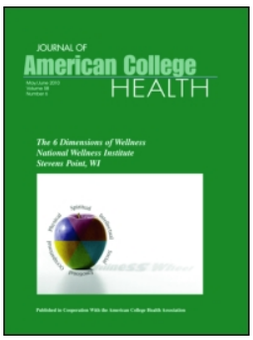

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Employing the right annual data collection efforts to combat IPV on college campuses

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VIEWPOINT

Employing the right annual data collection efforts to combat IPV on college campuses

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ABSTRACT

Present data collection efforts to identify and address intimate partner violence on college campuses and universities are flawed. Traditional methods utilized to report on intimate partner violence on campus, including Campus Climate Surveys and Clery Act reporting guidelines, are insufficient in that they do not capture the full scope of intimate partner violence. Inconsistent operationalization of intimate partner violence affects prevalence rates, generalizations across entities, and subsequent programing efforts. This viewpoint is a call for universities to standardize data collection efforts that accurately capture the wide range of actions and perpetrations that constitute intimate partner violence so as to prevent the further loss of student lives on campus.

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College health; gender-based violence; intimate partner violence

Intimate partner violence (IPV) on college campuses

Prevalence and national priority

Intimate partner violence (IPV) encompasses sexual violence, stalking, physical violence, and psychological aggression experienced at the hands of an intimate partner, described as "a romantic or sexual partner and includes spouses, boyfriends, girlfriends, people with whom they dated, were seeing, or "hooked up".[1] Victimization estimates put the national prevalence of IPV at roughly 1 in 3 women and 1 in 10 male.[1] Of those victimized, 75% of women and 56% of male experienced IPV for the first time before age 25, an age at which many young adults in the United States are attending institutions of higher education.[1] The incidence of IPV victimization in this young population justifies the incorporation of IPV prevention and intervention efforts on college campuses. Sexual violence programing has spread across campuses since the publishing of the Dear Colleague Letter in 2011, and more recently, the formation of the White Hours Task Force to Protect Students from Sexual Assault in 2017.[2] However, other forms of IPV, including physical violence, psychological aggression, and stalking, have largely been neglected in prevention and intervention efforts at institutions of higher education.

In the last year alone, two campus community members at a large University in a Western U.S. state, one student-athlete and one medical resident, were murdered in intimate partner violence-related homicides. In an investigation into one college senior's homicide, several breakdowns in communication between various campus organizations and the senior were noted in an independent investigation, which yielded 30 recommendations for administrators to undertake to reduce the likelihood of this event repeating in the future.[3] Three months later, a University Family Medicine resident was murdered at her apartment by her longtime domestic partner.[4] Each of these tragedies highlighted areas of improvement for the University to address, though they are undoubtedly not the only North American University needing more effective responses to on-campus IPV. However, there is a dearth of data available about IPV at institutions of higher education, making responding to it all the more difficult.

The college context: Risk factors for and occurrence of victimization

The college environment provides opportunities for the occurrence of IPV, with the normalization of individual risk factors for domestic violence, including engaging in risky sexual behaviors and substance use.[5] Other factors that create discord in relationships that can lead to violence include low income, stress, and unemployment.[6] Among more than 95,000 college students, 34% report their current financial situation is always stressful (13.2%) or often stressful (20.8%). From 2009 to 2015, college students' utilization of counseling services increased 30–40%, with depression and anxiety ranking among students' mental health concerns. Further, among nearly 180,000 students across 152 institutions seeking mental health services over the 2017–2018 school year, 40.3% reported experiencing "a traumatic event

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that caused them to feel intense fear, helplessness, or horror."[7] Though it is not specified the percentage related to partner violence, clinicians perceived that 20% of clients struggled with relationship problems in the 2017–2018 school year. Consistently, relationship problems rank third among the most common concern of clients, as noted by their clinicians, behind anxiety and depression. Data for nearly 70,000 students in the 2017–2018 school year indicate that 24.2% sought care for a specific relationship problem, 8.9% sought care for sexual abuse/assault, 6.4% sought care for harassment and emotional abuse, 3.5% sought care for physical abuse, and 0.4% sought care for stalking.[7] Given that it is common for IPV victims to not report to formal outlets, it is likely these percentages are actually higher.[8]

Collecting and reporting IPV data on college campuses

The (CDC) recommends focusing not only on individual risk factors, but on the larger social environment as well, recommending improving school climate and safety to address IPV. Among evidence cited for addressing school climate includes promoting awareness and reporting of dating violence to school personnel. IPV is recognized as a public health issue, but preventing said issue through a public health approach requires issue data collection, analysis, and subsequent communication of findings and recommendation. However, IPV identification and subsequent response is only as informed as the assessment tool utilized.[9]

Colleges and universities in the United States receiving Title IX funding are required to collect and annually report on campus crime statistics and information related to campus security as part of the 1990 Jeanne Clery Disclosure of Campus Security Policy and Campus Crime Statistics Act ("Clery Act").[10] However, universities are not limited to Clery Reporting when collecting partner violence data. The 2017 White House Task Force to Protect Students from Sexual Assault supported the use of Campus Climate Surveys (CCS) to collect information pertaining to gender-based violence on college campuses, including perpetrator information, students' access of services, and barriers to these services.[11] However, this tool is largely focused on sexual violence as opposed to the broader scope of IPV.

For instance, data pertaining to gender-based violence on the large University in a Western U.S. campus is collected via the University's Campus Climate Survey (CCS), which only contained three questions related to intimate partner or domestic violence (DV).[12] Each institution can tailor the CCS, making direct comparisons difficult. For this University, questions were "… has a partner controlled or tried to control you? Examples of controlling behavior could be when a partner: kept you from going to classes or pursuing your educational goals, did not allow you to see or talk with friends or family, made decisions for you such as, where you go or what you wear or eat, threatened to "out" you to others"; "… has a partner threatened to physically harm you, someone you love, or themselves?"; and "… has a partner used any kind of non-consensual physical force against you? Examples could be when someone: bent your fingers or bit you strangled, slapped, punched or kicked you, hit you with something other than a fist, attacked you with a weapon, or otherwise physically hurt or injured you." Here, the operationalization of IPV is limited to psychological and physical forms of violence, neglecting other forms of IPV including reproductive coercion, financial abuse, and digital abuse.[13] Even with a limited focus on IPV, more than 10% of undergraduates and 7% of graduate students who responded reported experiencing IPV at the university.[12] Of those students, more than 40% did not contact any university offices for assistance because they did not think their incident was serious enough or they did not know where to go [for assistance] or who to tell (nearly 20%).[12] By not formally reporting, these students then would have been missed in Clery Report numbers.

Issues in present data collection efforts

The way IPV is operationalized and assessed affects prevalence and incidence rates, subsequently impacting how resources are allocated to address it. A limited definition of IPV contributes to a lack of awareness and reporting on university-based surveys such as the CCS, while also potentially hindering students' ability to report to appropriate authorities. Similar to universities, across research studies, researchers do not adhere to the same terminology when assessing sexual violence tied to intimate partner relationships and, due to inconsistent operationalization, what is left is an inconsistent understanding of IPV's ramifications and consequences.[14]

Utilizing Clery Act reporting as a marker to identify IPV incidents is limited in that only reports that have been deemed IPV by a university's Title IX office are captured. This is especially problematic considering that students are more likely to report to peers than to formal university administration.[8] Further, tools like the Campus Climate Survey are typically deployed every two years and focus more on sexual violence than other IPV victimization types. Further, universities tailor these surveys, resulting in datasets that cannot be accurately compared. As a result, data captured is not current and results cannot be generalized across universities.

Common measures used to assess for presence of IPV include the Hit, Insult, Threaten, Screen (HITS), the Woman Abuse Screening Tool (WAST), and the Partner Violence Screen (PVS). Further, the Danger Assessment can be used to determine if a current or former intimate partner is at risk for perpetrating homicide. However, when psychometrically tested, soundness of the HITS, WAST, and PVS varied.[15] Further, these tools focus on some, but not all forms of IPV, neglecting reproductive coercion, digital abuse, and financial abuse, among other victimization types.

Conclusion and call to action

Tremendous work remains to be done on college campuses to assess for, prevent, and intervene in instances of IPV. If university actions for supporting and protecting students and employees are based on incomplete and non-generalizable data generated by assessments that do not capture the full scope of IPV, programing and intervention efforts will be ineffective. Universities can signify administrative buy-in to address this issue by undertaking their own annual assessments to screen for IPV, including newer forms of abuse perpetration, which can subsequently inform prevention and intervention programing. Further, universities can use their data to inform a national collaboration on developing a standardized and validated tool for use across universities specifically for college students experiencing a range of victimizations. The efforts needed to make these changes are substantial, and funding and collaboration are needed for them to be successful. However, it's clear this is the route that needs to be taken in light of IPV-related homicides at institutions of higher education.

Conflict of interest disclosure

The authors have no conflicts of interest to report. The authors confirm that the research presented in this article met the ethical guidelines, including adherence to the legal requirements, of United States and received approval from the University of Utah.

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