1. Is there a correlation between infant mortality rates and maternal mortality rates?
   a. Yes, there is a correlation between state-level infant and maternal mortality rates. They have some unique causes (e.g., safe sleep and SUID) but similar structural and social determinants. Maternal and infant health are inextricably linked and we hope that efforts to improve both will be synergistic.

2. Is there a plan to disaggregate Asian/Pacific Islanders? Pacific Islanders have higher mortality rates and poor health outcomes as compared to other Asian subpopulations. Due to these differences, I was wondering if there was a plan to measure IMR/MMR for Pacific Islanders?
   a. Yes, all states can now examine this detail and disaggregated data has been reported by NCHS for the past two years (https://www.cdc.gov/nchs/nvss/linked-birth.htm). Because of the need to use 3 years of data for stable county estimates, bridged race was used where Asian/PI are consolidated for this analysis. With the release of the 2019 linked file, it is possible to disaggregate 3 years and examine this detail.
   b. It is important to disaggregate and get as granular as possible in terms of data for several populations. For Asian American, Native Hawaiian, and Pacific Islander populations (AANHPI) specifically, there are large disparities within the group itself and the richness of that information is lost upon aggregation. It severely limits programs’ abilities to meet the health needs of specific populations who are experiencing worse outcomes, especially in a way that is culturally significant and effective. Aggregated data erases the voices, needs, cultural uniqueness, and identities of people who are racialized as AANHPI. There is also an element of justice involved in the conversation of data disaggregation, especially around the Model Minority Myth. What is usually termed “Asian” in the US is actually an incredibly diverse population and it would be in all of our best interests to collect disaggregated information!
   c. We recognize that often, in terms of data, sample size presents a challenge for reporting needs of some populations. However, the needs in each community persist. As health professionals, we must find a way to collect that information in different or new ways and report it so that populations are not erased from our equity work. Qualitative information can be a goldmine.
   d. Multnomah County, Oregon is working on decolonizing their data (and data collection methods), especially for Pacific Islander populations.
   e. The California Health Interview Survey (CHIS) is another example of a very intentional effort to collect granular data for Black and Brown populations. Their surveys can be found on their website through UCLA’s Center for Health Policy.

3. Could you please clarify how this CoIIN connects to the state IM COIIN, or is it strictly for Healthy Start?
   a. This is a webinar series to assist Region V states to improve birth outcomes, and Healthy Starts play a key role in this.
4. Which local and state organizations do you think have the best chance of combatting infant mortality rates?
   a. This will vary from community to community, state to state. The needs and priorities of each will vary, and it will be **important to have people at the table who can speak to those needs**. It should, necessarily, **include members of the community/public whose lived experience can inform and guide the work and help keep professionals accountable**.
   b. Also, think of non-traditional partners and other non-health sectors. Examples: housing, transportation, parks and rec, sororities/fraternities, local businesses, policy folks, etc. The important thing to note is no one organization is going to do this alone. Eliminating disparities in infant mortality and other outcomes requires a collaborative approach including working with those outside of usual partners.

5. Are there any particularly promising models or pilots of inter-disciplinary collaborative efforts at the state and local levels between infant mortality reduction initiatives and early childhood programs such as Part-C, MIECHV and Head Start and Early Head Start?
   a. Promising practices and successful strategies will be shared over the course of this webinar series. Stay tuned for more information.

6. In regards to African-American infant mortality rates, could it be attributable more to seeking pre-natal care later than sooner?
   a. The disparity is still more than two-fold among those with early prenatal care (within the first three months): [https://wonder.cdc.gov/controller/saved/D69/D124F819](https://wonder.cdc.gov/controller/saved/D69/D124F819). Addressing preconception health, access to quality care, and new models of care are critical to move the needle on both infant and maternal morbidity and mortality.
   b. Thinking upstream, many societal and systemic factors contribute to infant mortality and disproportionately affect Black and Brown communities. Historic, racist policies continue to have contemporary impacts. For example, zip codes that show poorer health, education, economic, etc. outcomes can be almost exactly overlaid with redlining maps. Governments and businesses did not (and arguably, still do not) invest in formerly redlined neighborhoods, which means a dearth of quality education, healthy food, and social service programs readily available to constituents in those neighborhoods. There have also been US policies that enabled some populations, not all, to create generational wealth (e.g. through purchasing land, free higher education for higher paying careers) that continue to promote better outcomes to this day. More economic resources can mean higher health literacy, more access to health services, insurance, transportation, etc. This is why CityMatCH stresses the importance of working upstream – to identify and mitigate impacts of policies that negatively affect Black and Brown populations.
   c. There is also an element of toxic stress and potentially, toxic financial stress, from being in redlined neighborhoods or not being able to access care that people know they need. This stress can be magnified before, during, and after pregnancy and can negatively affect the pregnant person’s
pregnancy/birthing experience. Stress often manifests itself physically, for example, in the form of hypertension and can contribute ultimately to poorer birth outcomes.

d. Clinical attitudes such as racism among healthcare providers and systems have also resulted in poorer health outcomes for both parents and children. Research has shown that some clinical providers do not believe Black and Brown women when they express feeling pain. Patients' concerns can be dismissed, wrongly sent home from the ER, or not given proper treatment due to racism and bias among providers, whether or not it is conscious or intentional.

7. Can you describe Transitions of Care in the list of Acceleration activities?
   a. "Transition" work often describes work related to children and youth with special healthcare needs and helping them transition successfully from pediatric to adult care. Their needs are often complex and it is important to have a coordinated approach in transitioning them to adult providers. But all children need to successfully transition from pediatric to adult care, to support optimal health across the life course. Assuring access to medical homes and preventive care is important to assure that people arrive at pregnancy in an optimal health status.

8. Have we looked at requiring additional data required such as country of origin and primary language?
   a. Country of origin is on the birth certificate and can definitely be examined.

9. How does immigration status figure into the data?
   a. There is usually an immigrant advantage that deteriorates over time and that was not considered in the context of this webinar, but we know that MN still has a large African immigrant population that explains lower overall Black IMRs. They still have high rates of US-born Black infant mortality.

10. Can you speak to any analysis of paternal health on infant health?
    a. Some states/cities have done Perinatal Periods of Risk (PPOR) analysis, and CityMatCH can provide more information on that. One of the striking things is that in many cases, a large driver of infant mortality--especially related to very preterm/low birth weight babies--is related to preconception health--mom's health before she ever becomes pregnant. PPOR can be a helpful tool to analyze key drivers of infant mortality in your community. Paternal health should be examined, but there is currently more evidence on the impact of maternal health and paternal involvement and support. Check out this link for more information regarding paternal involvement: https://pubmed.ncbi.nlm.nih.gov/29370258/
    b. PPOR Articles can be found on the CityMatCH website here: https://www.citymatch.org/ppor-journal-articles/
    c. Paternal health is important and there is a need to better understand the impact of men’s health on birth outcomes. CDC’s Division of Reproductive Health has partnered with others to conduct formative research on the possibility of conducting a PRAMS-like survey with new fathers. This research is
ongoing. See the CDC webpage to learn more about the PRAMS for Dads special project (https://www.cdc.gov/prams/special-projects/index.htm#dads). Additionally, see article discussing the need for a formal surveillance system for fathers linked here: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6137775/.

11. Through my work in MI and throughout the region, I know that American Indians/Alaska Natives are often misclassified based solely on the shade of their skin. How do you account for racial misclassification in relation to your data specifically in MI?
   a. AI/AN race may not be very accurate on the death certificate since it's not self-reported. However, this data is using linked data in which maternal race from the birth certificate is self-reported and accurate.

12. We have noted an association between breastfeeding and infant mortality reduction. How can we ensure that infant mortality reduction initiatives include the promotion and support of breastfeeding?
   a. Breastfeeding is definitely important! Connect with the Title V program in your state to find out how they are moving forward with this work, and let them know you'd like to be connected to it! States can find contact information for their Title V leaders at: https://mchb.tvisdata.hrsa.gov/Home/StateContacts

13. How much are MCH programs in all the Region V states working with health department STD programs on preventing congenital syphilis?
   a. You can explore Region V states’ action plans for their MCH Block Grant at: https://mchb.tvisdata.hrsa.gov/ . Those action plans and the grant narratives have information about what the states are doing across a variety of topics.

14. April is National Minority Health Month. Do you have any resources or planned events pertaining to infant mortality that will represent minorities to include Black infants?
   a. HRSA is on four social media platforms. We encourage you to follow along and share their content on Twitter, Facebook, LinkedIn and Instagram to stay up-to-date on the latest HRSA news. The account/handle on each platform is @HRSAGov.
   b. CityMatCH can also be found on social media platforms. Please follow for our content and information shared from partners. The handle for each platform is as follows: Facebook - @CityMatCH; Instagram - @CityMCH; Twitter - @CityMCH.
15. For states who are in the <1 deaths needed to avoid a month, what have been successful for them? Can you share any ideas or programs that have been helpful?
   a. This is a good question. Those with <1 death are states with very small Black populations, not necessarily lower disparities. We are definitely looking at states/counties where disparities and Black IMRs are lower to help learn from and extend those successes.

16. How much money is being allocated to address the political and structural barriers at the federal and state levels to help reduce these measures?
   a. We do not have this information at this time.

17. Hello! I just recently started as an epidemiologist for a local health department focusing on infant mortality. If you have any advice for someone new starting out in this field, that would be great!
   a. Please continue to join this webinar series for additional information.
   b. CityMatCH also offers an annual MCH Epidemiology Training Course. Applications just closed for this cycle but be on the lookout for future announcements! Courses take place each summer and are divided into “Beginner/Intermediate” and “Intermediate/Advanced” years, alternating yearly. You can join our mailing list via our website (www.citymatch.org). CityMatCH’s youtube page also contains recordings of previous years’ courses!
   c. Another resource for MCH professionals is a site called the “MCH Navigator.” It has a plethora of information and training modules regarding various aspects of MCH. Some of the information focuses on state-level work but can be a good starting place for someone new to MCH nonetheless.