

ENGAGING THE POWER OF TITLE V FOR
EQUITY IN PRETERM BIRTH PREVENTION

The Oregon Preterm Birth Rate in Context: Zooming in Spatially and Racially

This issue brief is part of a four-part series that explores the unique power of the Title V Maternal and Child Health (MCH) Services Block Grant to support anti-racist strategies and intentionally address the roots of racial injustice in maternal and infant health, including the prevention of preterm birth. Each issue brief describes how MCH programs can disrupt structural and institutional racism and shift power toward the expertise of people who birth, communities, and the organizations a community trusts to implement solutions. The series was produced with the support of the Pritzker Children's Initiative.

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In November 2019, the March of Dimes released their annual Report Cards, which describe progress on key indicators and actions to improve the health of moms and babies in the United States. Oregon is the only state that received a grade in the “A” category (“A-”). This grade prompted public health and policy stakeholders to ask: *What is unique about Oregon’s approach to curbing preterm birth in the state?*

This issue brief explores statewide efforts to improve maternal and infant health in Oregon. It considers the way Oregon’s racialized past influences the disproportionately high preterm birth rates for Black and Native American infants across and within counties in the state. The March of Dimes Report Card shows that disaggregated by race, the preterm birth rate is 22 percent higher for Black births (9.4 percent) and 34 percent higher for American Indian/Alaska Native births (10.3 percent) compared to 7.7 percent for White births.¹ The authors discuss the need to offer comprehensive

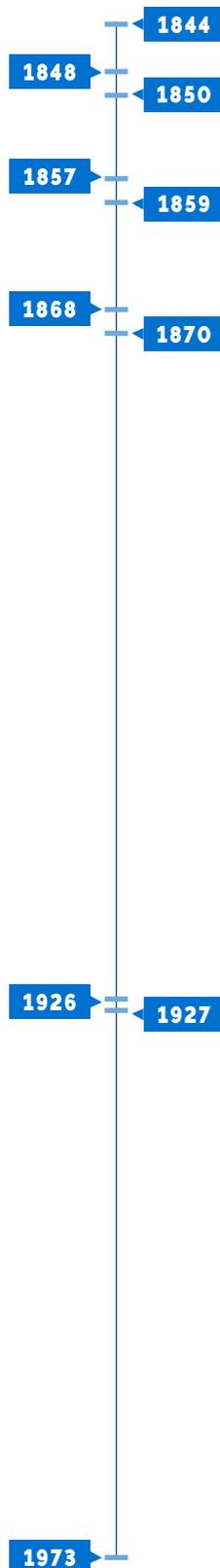
and community-based support to communities oppressed by structural inequities created by racism. The need applies even in states that have the lowest overall preterm birth rates. This issue brief integrates observations from the Oregon Health Authority and two Healthy Start programs. It reflects on Oregon’s gains (such as increased access to reproductive healthcare and Medicaid expansion), while specifically discussing persistent structural inequities. These inequities in affordable housing, economic access, transportation, health care, and support for rural communities date back to the state’s founding and continue to influence birth outcomes of future generations.

State and territory MCH programs should study their own racial histories and how they influence the current context for preterm birth and other perinatal health disparities. The authors provide recommendations for states and territories that are prepared to engage with community partners to eliminate disparities in preterm birth.

Acknowledging Racial History in Oregon

For thousands of years before White settlers arrived, Oregon was home to more than 60 Native American tribes. Their land was forcibly stolen from them by settlers who arrived on the Oregon Trail. The Oregon Trail established a route to the Pacific Northwest, which encouraged White American settlers to migrate in large numbers in the 1840s.² Before Oregon became a state in 1859, Peter Burnett, a former slaveholder, led a provisional government that stayed in place for 15 years. Through "exclusion laws" implemented during the time of the provisional government, the territory forced the removal of Black people, Native American people, and immigrants of color.³ Here is a timeline of key laws that provide important historical context for Oregon's current outcomes.

These actions over centuries created a system of advantage that benefited White people at the expense of Native people and people of color. These histories for every state and territory in the United States form the foundation on which our government was built. Government structures mirror the social context of their time. For this reason, an exploration of the racial disparities for any health outcome, including preterm birth, must include an historical, multigenerational, and place-based analysis of the systems of advantage and disadvantage in place.



1844: The "Lash Law," although quickly repealed, allowed slaveholders to keep their slaves for up to three years, after which the slaves had to leave the Oregon territory or face severe whippings of up to 39 lashes.

1848: The provisional government passed a law that made it illegal for any Black person or person with parents of different races to live in Oregon.⁴

1850: The Oregon Donation Land Act excluded Black people from owning land and offered 320 acres to White immigrants. Eventually, these White immigrants claimed 2.8 million acres of Native American land over a 5-year period. Continued theft of Native American land by White settlers in Oregon set the stage for a White majority of settlers to impose the series of state laws that would further remove Native Americans, Black people, and other people of color and effectively establish Oregon as a White only state.⁵

1857: The state's constitution passed, which made it illegal for Black people to own any real estate, make any contracts, or file any lawsuits.

1859: Oregon joined the union. When this happened, it was illegal for any non-White person to live in the state.

1868: Oregon rescinded its ratification of the 14th Amendment of the Constitution, which granted all people born or naturalized in the United States the right to citizenship and equal protection of the laws.

1870: Oregon refused to ratify the 15th Amendment of the Constitution, which allowed citizenship for any persons born in the U.S. and any man to vote regardless of race, color, or previous condition of servitude.⁶

1926: Oregon officially repealed the exclusion law that banned Black people from living in the state.

1927: Oregon removed a clause that excluded Black people and Chinese people from having the right to vote.⁷

1973: Oregon re-ratified the 14th Amendment, 105 years after its introduction.⁸

Oregon Today and Statewide Efforts to Improve Maternal and Infant Health

As part of the legacy of its founding as a “White-only” state, the vast majority of the state’s population identifies as White (83.6 percent), according to the 2010 Census. Nearly 12 percent (11.7 percent) of residents in the state are of Hispanic origin, followed by 3.7 percent Asian, 1.8 percent African American, and 1.4 percent American Indian/Alaska Native. There are nine federally recognized Native American tribes in Oregon.⁹

Although intracommunity efforts to rebuild civic power are abundant in Oregon, populations that are marginalized from centuries of systemic racism continue to face unequal access to opportunity. Especially in Portland, rising rental and home sale prices in recent years have displaced many residents, disproportionately affecting people of color and individuals with lower incomes. The next chapter in housing inequities is about displacement that began 100 years ago and was formalized through racist land use policies in the mid-1900s. These policies had far-reaching impacts documented through the 1990s.¹⁰ The population in the state is predominantly White; thus, the effects of institutional racism in various systems (e.g., economic access) on critical MCH indicators may be obscured. This reality holds true when reviewing

the 2019 March of Dimes Report Card. March of Dimes gave Oregon an A- grade, with an overall preterm birth rate of 7.8 percent. The breakdown of these numbers is more telling than the aggregate. Oregon reported a preterm birth rate of 7.7 percent for White births in the state, compared to preterm birth rates of 8.1 percent for Asian Pacific Islanders, 8.5 percent for Hispanic births, 9.4 percent for Black births, and 10.3 percent for Native American births. The preterm birth rate among Black births is 22 percent higher than for White births and is 34 percent higher for Native American births than for White births.¹¹ The experience of racism in all its forms is a leading risk factor for preterm birth, but this experience is not shared by the majority of the state’s population.

To address the root causes of inequities in health across the state of Oregon, the Oregon Health Authority’s State Health Improvement Plan (SHIP) identifies the following priorities: institutional bias; adversity, trauma, and toxic stress; economic drivers of health (including issues related to housing, living wage, food security and transportation); access to equitable preventative health care; and behavioral health (including mental health and substance abuse).¹²



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Within the Oregon Health Authority, the state MCH program that administers the Title V MCH Services Block Grant identified the following key and universal services, policies, and transformations in the state that have contributed to its overall low preterm birth rate:

- **Expanded access to high quality care for women:** Oregon policymakers prioritize health care services and supports for women, including reproductive health care. The state began a health care transformation in 2011 that included Medicaid expansion; in 2012, the state introduced coordinated care organizations (CCOs). CCOs provide person-centered coordination of physical, mental, and dental health care for Medicaid clients. CCOs focus on advancing health equity and preventing and managing chronic disease. The 15 CCOs operating in the state track quarterly progress toward incentive metrics and progress is shared publicly. CCOs maintain community advisory councils; at least 51 percent of the council membership consists of Medicaid clients or their families. CCOs are required to have a community health improvement plan that extends its impact beyond the population of people enrolled in Medicaid. CCOs track incentive metrics, which include measures such as contraception use, early prenatal care, and postpartum care. Soon, they will include efforts to support families experiencing negative social determinants of health.¹³
- **Reproductive Health Equity Act (HB 3391):** The passing of significant reproductive health legislation is viewed as an achievement toward being able to provide necessary services to those who need them most. The Reproductive Health Equity Act, signed into law in August 2017, removes barriers to many reproductive health services, including abortion and contraception. It also eliminates out-of-pocket costs, removes gaps in coverage due to citizenship status, and prohibits discrimination in the provision of reproductive health services

based on self-identified gender identity.¹⁴ Community members and lawmakers collaborated to garner the support that was needed for this legislation to pass. The bill demonstrates that Oregonians are committed to prioritizing reproductive health care for all women, including undocumented women.

- **Statewide Commitment to Home Visiting:** The Oregon Health Authority and the Oregon Department of Education's Early Learning Division collaborate closely on an extensive network of home visiting programs available in nearly every county in the state to comprise a statewide home visiting system.¹⁵ Home visiting programs include the following:
 - Healthy Families Oregon, a free family support and parent education home visiting program coordinated by the Early Learning Division
 - Three evidence-based home visiting models funded through the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, which covers 13 counties
 - Numerous locally-developed public health nurse visiting programs
 - The newly launched Family Connects Oregon, a universally offered nurse home visiting program that will soon be available to any family with a newborn.

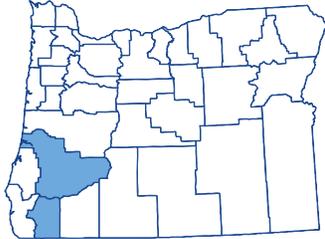
Together, these transformations in the health system in Oregon are foundational for accessing health care and support for people who birth and their families. They partially explain why fewer babies are born preterm in Oregon compared to other states. However, structural inequities will continue to produce disproportionate risk for poorer birth outcomes for specific geographic areas and racial groups. Communities hold the answers to disrupting this risk.

Learning from Healthy Start in Oregon

The federal Healthy Start program funds 101 projects across the United States, Washington, DC, and Puerto Rico. The program aims to improve infant and maternal health in communities where the infant mortality rate is at least 1.5 times greater than the national average. Although individual Healthy Start grantees vary in their program elements and design, their defining characteristics make them critical thought leaders in a journey toward achieving equitable birth outcomes. These characteristics include a focus on African American, Native American, and Hispanic women of reproductive age, pregnant people, new moms, and families with a child up to 2 years of age; ensuring access to comprehensive, community-based, and culturally-reflective health and social services with a focus on outreach and home visiting; and mobilizing a Community Action Network (CAN), a consortium of neighborhood residents, clients,

health care and social service organizations, local businesses, and faith leaders collaborating to combat disparities in perinatal outcomes.¹⁶

Oregon has two Healthy Start grantees in its state borders: Healthy Birth Initiatives located in the Portland metropolitan area and Healthy Start of Southern Oregon. The latter serves two rural southern counties. Together, these programs ensure that the counties receive access to high quality, coordinated, and equitable pregnancy, childbirth, and postpartum care and support. For both programs, the statewide birth outcomes data do not fully represent clients' experiences on-the-ground. Healthy Start grantees discuss the programs and services they provide to support their clients' daily battle against systemic inequities. They contributed ideas for a path forward to advance a community-centered, anti-racist agenda for preventing preterm births.

HEALTHY START PROGRAM	COUNTIES SERVED	PRETERM BIRTH RATES ¹⁷ (PERCENT) ¹	CLIENTS SERVED
Healthy Birth Initiatives , situated in the Multnomah County Health Department, established in 1997	Multnomah County 	Overall: 7.99 Non-Hispanic American Indian/Alaska Native: 13.58 Hispanic: 8.76 Non-Hispanic Asian: 7.75 Non-Hispanic Pacific Islander: 10.96 Non-Hispanic Black: 10.96 Non-Hispanic White: 7.28	Urban, women who identify as Black or African American
Healthy Start of Southern Oregon , situated in the Health Care Coalition of Southern Oregon, established in 1988	Douglas and Josephine Counties 	Overall: 8.51 Non-Hispanic American Indian/Alaska Native: 6.86 Hispanic: 11.08 Non-Hispanic Asian: 10.58 Non-Hispanic Pacific Islander: 8.33 Non-Hispanic Black: 16.67 Non-Hispanic White: 8.27	Rural service population, which includes White, Hispanic/Latinx, Native American, and Black or African American (This region includes a growing population of women who speak English as a second language as well as undocumented women.)

¹ These are the racial categories as reported by state level data source for years 2014-2018.

Strengths of Oregon Healthy Start Grantees

Structural inequities have a pervasive impact on the Oregon Healthy Start grantees' clients, including a housing crisis that extends from urban to rural settings and hits communities of color the hardest. In Portland, a community input-gathering process that began five years ago enabled the Healthy Birth Initiatives to develop a specific goal of impacting the effects of racism on disparities in birth outcomes, with a specific focus on family unity, housing, and economic security. In Douglas and Josephine counties, social isolation, lack of public transportation and affordable housing, and failures to invest in equitable access to higher-risk pregnancy care centers create barriers for meeting basic needs for the clients served by Healthy Start of Southern Oregon. To overcome these entrenched barriers, both Healthy Start programs rely on two key program features:

- Both programs emphasize the need to employ staff that resemble the demographics of the population they serve. Doing this is essential for building trust and ensuring services are culturally specific. Healthy Birth Initiatives has made it a priority to hire nurse home visitors that "look like you" when they come to a client's door.
- Through partnerships with their CANs and local service providers, the Healthy Start grantees develop community-centered and codesigned initiatives to complement their respective outreach, clinical, and home visiting programs that are the backbone of services they offer. The community is able to bring its leadership and wisdom together to identify innovations and implement solutions that will be most effective for them. Set out below are descriptions of unique programs and strategies implemented or supported through the Healthy Start grantees.

EXAMPLES OF INNOVATIVE STRATEGIES	
HEALTHY BIRTH INITIATIVES (HBI)	<ul style="list-style-type: none">• Tackling Racism in Hospital Systems: HBI established a formal relationship with a large hospital system in Portland to have difficult conversations about racial bias that HBI clients experience in the hospital and the impact of the stress of these experiences. HBI and the Portland hospital system are collaborating to identify opportunities to center the needs of Black birthing patients.• Ensuring Housing Stability: HBI joined a memorandum of understanding with Transition Projects, a housing assistance program in Portland, to ensure HBI clients received priority for housing assistance. HBI also works with the Baby Booster initiative through a community development corporation to ensure HBI families are given preference to access the family housing units under development, as well as to other open units. Additionally, HBI receives flexible funding from the local health department to help HBI families with emergency financial support, if they need it, for electricity, water, or rent payments, so that families remain in housing.• Providing Transformative Cash Transfers: The county health department partnered with HBI to provide \$1,000, with no strings attached, to a subset of HBI clients. Families received financial literacy education and shared information about how they used the funds. Clients reported buying new uniforms for work or textbooks for school, or using the funds to help pay for rent. In a few cases, the funding was transformative because it allowed the client to purchase a home. Families that participated in the program experienced improved health outcomes. Unfortunately, funding cuts from the local health department eliminated the program.

**HEALTHY
START OF
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(HSSO)**

- **Providing Professional Development Opportunities for Local Stakeholders and Community Members:** Each of the two service counties (Douglas and Josephine) launched a perinatal task force (as part of the CAN) with annual strategic maps to identify priority areas and activities. On a monthly basis, participants in each cross-sector task force make a presentation to each other and engage in shared training and skills-building on topics that include health equity, maternal mental health, or motivational interviewing. HSSO also invites outside experts to train community members and offer professional development. In addition, HSSO works to align learning resources and priorities with professional development areas of focus for home visiting, public health agencies, and the local Early Learning Hub.
- **Ensuring Access for Families in Remote Areas:** The CANs in both counties have experienced success hosting annual Welcome, Baby! Community Baby Showers and Resource Fairs. These events help families learn about several topics related to healthy pregnancy, birth, and infant care; gain access to available resources; and receive items needed to support the health and well-being of parents and infants. These events are held in different communities across the region each year to reach families who live in areas most remote from opportunities. In 2019, these events reached more than 500 individuals in rural areas, which made a significant impact in connecting families to resources.
- **Guaranteeing No Family is Disconnected from Services:** In Douglas County, all stakeholders providing perinatal and early learning supportive services participate in a coordinated referral system. This system connects families with available services and tracks the outcomes of these referrals. Agencies and organizations that provide services meet regularly to review coordinated referrals and ensure that no family goes without support.

Next Steps: Opportunities for Title V to Advance an Equitable Agenda for Preterm Birth Prevention

To transform systemic inequities that drive racial and geographic disparities in birth outcomes, stakeholders must approach the work in a hyper-local manner. This requires funneling a disproportionate investment of data and resources into those communities marginalized through state-sanctioned programs and policies over centuries. The Oregon Health Authority recently took specific strides to begin this work:

- **Developing New State Performance**

- **Measures (SPMs) that Address Title V Priority**

- **Needs:** In FY 2018, the Oregon Title V program began developing state-specific performance measures to address two priority needs that were identified through Oregon's 2015 Title V Needs Assessment: (1) safe and nurturing relationships and stable, attached families and (2) improved health equity and reduced MCH disparities. To address these priority needs, the Title V program developed the following state performance measures (SPMs) under the Cross-Cutting/Systems Building Domain.

- **SPM 1:** A) Percentage of new mothers who experienced stressful life events before or during pregnancy B) Percentage of mothers of 2-year-olds who have adequate social support. Examples of strategies supported under this measure include the promotion of family-friendly policies that decrease toxic stress and adversity and the development of a trauma-informed workforce, workplaces, systems and services.

- **SPM 2:** A) Percentage of households experiencing food insecurity B) Percentage of households with children <18 years of age experiencing food insecurity. Examples of strategies supported under this measure include increasing access to healthy, affordable food, including access to food assistance safety net programs, and screening clients for food insecurity and providing referrals for food assistance. As a result of the 2020 Needs Assessment, Oregon will remove part A of this SPM. Food insecurity, housing, and poverty will be components of a new social determinants of health (SDOH) SPM.

- **SPM 3:** A) Percentage of children age 0 - 17 years who have a healthcare provider who is sensitive to their family's values and customs B) Percentage of new mothers who have ever experienced discrimination while getting any type of health or medical care. An example of a strategy supported under this measure is providing effective, equitable, understandable, and culturally responsive services.¹⁸

- **Strengthening Community Partnerships:** For the 2020 Title V Needs Assessment cycle, the MCH program has committed to amplifying the community voice in a new way. Oregon's MCH program provided funding to community-based organizations to conduct smaller needs assessments. These assessments

generated insight into the needs of their communities. Moreover, the MCH program specifically engaged historically marginalized communities, including transgender youth and tribal citizens, to learn about their unique needs and provide more support.

These efforts complement the existing state commitment to health care transformation, reproductive health equity, and home visiting. Exploring additional opportunities and expanding partnerships will advance an equitable agenda to improve birth outcomes in Title V programs. Lessons learned from the activities of Healthy Start programs are abundant. They include the following:

- **Be intentional about "going to the tables" of community organizations:** Due to staff time and resource constraints in community organizations, including the distance required to travel, Title V programs may need to invest more effort and time engaging with organizations that serve marginalized communities. Staff should initiate travel to these communities to communicate face to face about critical initiatives, such as the statewide maternal mortality review committee or the perinatal quality collaborative. Equally important, staff must hear the collective voice of the community.
- **Fund scaling of innovations:** Healthy Start grantees and community-rooted organizations know the people they serve. The Title V Block Grant program has the flexibility to invest in communities' wisdom and knowledge to

do transformative work that addresses root causes of disparities, thereby disrupting racial inequities in birth outcomes. Title V programs can support cash transfer programs and share accountability by collaborating with partners to ensure no family in the MCH network of services is without safe and stable food access, for example.

- **Advocate for community voice:** Healthy Birth Initiatives acknowledged that the Healthy Start program *"can do so much advocacy and work with our clients in the community, arming them with support and information, but if you go into the hospital...it can all go out the window because one person didn't take the time to learn, speak, think in a different way."* Title V should advocate for Healthy Start programs and community-rooted organizations to ensure the voices of those they serve are centered in efforts to transform health systems.

Title V programs should implement the specific steps and strategies described above to reach out intentionally to community organizations, invest in innovative solutions that are working in communities, and actively advocate for what local communities need to transform health systems. This is the way forward to disrupting structural inequities. This brief puts into context the reasons for Oregon's overall low preterm birth rate: its history of racism factors into the statistics. Sharing power and acknowledging the state's or territory's history and ongoing legacy of racism is a key element of Title V efforts to advance health equity.

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