J038 Proceedings of Winning the Fight
Against Infant Mortality: A National
Summit on Community and Corporate Initiatives

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Proceedings of

WINNING THE FIGHT AGAINST INFANT MORTALITY:
A National Summit on Community and Corporate Initiatives

Johnson & Johnson
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Despite the recent gains in reducing infant deaths in the United States, infant mortality remains a serious and tragic problem that can be solved only if all stakeholders—community leaders, corporations, health care professionals, and policymakers—work together to find answers.

The future of the United States will be greatly affected by what all of us do to improve maternal and child health. Now is the time to find solutions to infant mortality.

To help find these solutions, and put them into practice across the country, on September 18, 1996, the Maternal and Child Health Bureau and Johnson & Johnson cohosted Winning the Fight Against Infant Mortality: A National Summit on Corporate and Community Initiatives. This one-day summit examined the impact of infant mortality on our nation and how the problem affects both communities and businesses. The conference focused on effective community and corporate models and their adaptation by other communities, employers, and corporations across the United States.

The summit was inspiring. Information was openly shared and many new networks are now in place at all levels. We share the summit proceedings to inform you of the problems that mothers, infants, and families contend with on a daily basis, and of the many existing solutions to these problems. We hope that in reading these proceedings, you are filled with the momentum and spirit that pervaded the summit. We hope that the proceedings spur you to work with us to ensure a legacy of health for our children—our country’s future.

Sincerely yours,

Audrey H. Nora, M.D.
Director, Maternal and Child Health Bureau
Health Resources and Services Administration

Ralph S. Larsen
Chairman and Chief Executive Officer
Johnson & Johnson
Acknowledgments

Johnson & Johnson was the first corporate partner of Healthy Start, co-chairing the Healthy Start Private Sector Steering Group, conducting a national advertising campaign in support of the Healthy Start Initiative in 1991, and sponsoring media roundtables that highlighted Healthy Start programs. Johnson & Johnson, as a company whose history is linked to the health and well-being of mothers and babies, has been a leader in raising public awareness of the diverse health needs of women and infants and their families, and encouraging public policy that supports programs to address these needs. Johnson & Johnson was a cosponsor of this summit, which brought together business and community leaders as well as the nonprofit and public agencies as partners in Healthy Start's mission to improve the health of women, infants, and families.

Our gratitude and appreciation are also extended to the Washington Business Group on Health (WBGH) for its active participation in the Healthy Start Private Sector Steering Group over the past five years, and for its contribution in planning this summit. WBGH represents large employers in promoting performance-driven health care systems and competitive markets that improve the health and productivity of companies and communities.

A special thanks is made to each speaker who donated time and expertise to share knowledge and encourage future efforts in the fight against infant mortality. Also, we are especially grateful to those private-sector partners who have supported Healthy Start over the past five years. They are listed on page 46.

A final thank-you to all of the Healthy Start projects and their community partners who continue to work tirelessly to ensure that babies born in their communities across the United States have a Healthy Start.
Foreword

The Healthy Start Initiative was first developed as a national demonstration program that uses a community-driven, systems development approach to reduce infant mortality and improve the health and well-being of women, infants, children, and families. During its upcoming replication phase, Healthy Start hopes to fulfill its commitment to disseminating its lessons to those who can put them into practice.

"We cannot rest—we must not rest—until all parents have the tools they need to bring healthy children into this world.”

Kevin L. Thurm
Deputy Secretary
U.S. Department of Health and Human Services

Applicants for Healthy Start demonstration grants were sought among urban and rural communities with infant mortality rates at least 1.5 times the national average. In late 1991, 15 applicants (13 urban and 2 rural) were awarded planning grants. The initial grants supported year-long comprehensive planning activities through fiscal year 1992; the projects began serving clients in fiscal year 1993. The overall goal was to reduce infant mortality in the project areas by 50 percent over a five-year period, focusing on five principles that would assure early prenatal care and appropriate supports for families: innovation, community commitment and involvement, increased access to health care, service integration, and personal responsibility.

In late 1994, seven additional communities (five urban and two rural) received Healthy Start demonstration Special Project grants. These communities also had infant mortality rates greater than 1.5 times the national average for infant mortality. The goal for these projects was to significantly reduce infant mortality rates in the target areas over a two-year period.
These projects are implementing innovative approaches to develop coordinated, comprehensive, culturally competent models of health and other support.

*Therma McCann Goldman, M.D., M.P.H.*

*Director*

*Division of Healthy Start*

*Maternal and Child Health Bureau*
Statement of Purpose

Although our spending on health care is greater than in any other country, the United States has higher infant mortality rates than 21 other industrialized nations—Spain, Singapore, and Ireland, for example. This means mounting costs for both the government and the business sector for largely preventable problems.

To change this situation, in 1991 the U.S. Department of Health and Human Services (DHHS) launched a federal demonstration program with the goal of reducing infant mortality in those communities with the highest rates in the United States. Called Healthy Start, this initiative has funded 22 urban and rural communities that, over the past five years, have pioneered new ways to provide comprehensive services to at-risk pregnant women as well as infant care for their babies.

Now in the final year of this demonstration program, Healthy Start is working to turn the lessons learned by these projects into helpful information for replication that can be shared widely with communities, businesses, and the maternal and child health community. Accordingly, Healthy Start enlisted the help of Johnson & Johnson, a corporation that has been a major supporter of the Healthy Start Initiative, to host a one-day summit in Washington, DC, that not only elevated infant mortality as a priority issue, but also presented the lessons learned through the Healthy Start program.

Within this context, the summit addressed the costs to the nation of infant mortality and how the problem affects communities and the business sector. The conference also focused on effective community and corporate models and how these models can be adopted by other communities, employers, and corporations across the country.

Ultimately, the goal of this national summit was to focus on the future. Although significant progress has been made toward reducing infant death, infant mortality remains a very serious and tragic problem that must be addressed. Despite a century of work, African-American infants still die at a rate nearly three times that of white infants.

It is hoped that through this national summit community leaders, corporations, health professionals, and policymakers will commit themselves to winning the fight against infant mortality, and that they will provide the resources and innovative thinking needed to achieve success. As a new millennium nears, it is time to give this investment in the health of mothers and babies the attention it deserves.
Introduction and Overview

America’s future will be determined by what all of us do to improve maternal and child health. The best marker of a healthy society is how well it does in saving the lives of babies. Despite the recent gains in reducing infant deaths, infant mortality remains a serious and tragic problem that can be solved only if all stakeholders—community leaders, businesses, health care professionals, and policymakers—work together to find answers. To this end, Winning the Fight Against Infant Mortality: A National Summit on Community and Corporate Initiatives was convened on September 18, 1996, in Washington, DC. The summit was sponsored jointly by the federal Healthy Start Initiative and Johnson & Johnson.

The summit’s threefold purpose was to:

1. Share the findings of the Healthy Start Initiative with business and community leaders;

2. Teach strategies to continue the current progress toward healthy women, infants, and children, with special attention to those populations without full access to health care; and

3. Encourage the continued involvement of community and business leaders in supporting national, state, and local efforts to reduce infant mortality.

“Our aim is to make the battle against infant mortality a top national priority and to agree on new directions for future actions against this problem.”

Audrey H. Nora, M.D., M.P.H.
Assistant Surgeon General
Director, Maternal and Child Health Bureau
Health Resources and Services Administration
Public Health Service
U.S. Department of Health and Human Services

Figure 1.
Leading causes of infant death: United States, 1994
(percentage of total infant deaths)

This summit examined the impact of infant mortality on our nation, our communities, and our businesses. The conference focused on effective community and corporate models and how they can be adapted by other communities, employers, and businesses. Solutions have been found and they must be shared.

Many diverse factors contribute to our national infant mortality rate (see Figure 1). Considerable progress has been made in identifying these factors and meeting the challenges they present. Through the years of the Healthy Start Initiative, disparities—racial, economic, and geographic—in access to early prenatal care have been reduced, resulting in a trend toward healthier birth outcomes. The 22 Healthy Start communities have identified community-based strategies that can significantly and effectively reduce infant mortality, increasing our knowledge of successful approaches to guarding the health of both mother and infant.

In joining together to create this summit, the federal Healthy Start Initiative and Johnson & Johnson hoped to model the innovative public-private partnerships that are needed to move our nation ahead in its efforts to save babies' lives.
The summit’s keynote address was presented by Kevin L. Thurm, Deputy Secretary, U.S. Department of Health and Human Services. An adaptation of his remarks appears below.

To all of you, I bring greetings from Secretary Donna Shalala who joins me today in thanking you for your tireless commitment to our children and our families. I’ve been with this administration since day one, and I must say, I’ve learned quite a bit over the last four years. I’ve learned about the power of grassroots leadership; about what can be accomplished when government teams up with parents, businesses, and community leaders to tackle some of the greatest challenges facing our families. And I’ve learned something else. From my personal experience as a husband and father, I’ve learned that there is nothing more rewarding, more demanding, or more humbling than raising a child.

My two sons agree. In fact, when I asked them what I should say to you today, they responded in their usual fashion. My one-year-old, Jason, offered his opinion by sticking his tongue out at me. And my four-year-old, Eric, managed to turn away from a Winnie the Pooh video just long enough to say, “Dad, it’s the part with Beyonce and Tigger; I’m busy.”

So even though I come here today without any clear guidance from the next generation, I come with a very personal commitment to improving the lives of all children in every community—now and into the future.

And I come with a great deal of pride—pride because I have been privileged to serve with a secretary and a president who have fought every step of the way to give all children the right start in life. We don’t just talk about valuing young children. We have done it—by putting children first. And it’s paid off.

Today, infant immunization rates are at their highest levels in history. And childhood infectious diseases are at an all-time low. The United States’ death rate from sudden infant death syndrome (SIDS) has dropped dramatically. Head Start, which now serves children 0–3 years through Early Head Start, is better and stronger than ever. More parents have access to reliable and affordable child care. And because we’ve cracked down on child support enforcement, more parents are taking financial responsibility for the children they bring into this world. With our historic children’s tobacco initiative, we are kicking Joe Camel and the Marlboro Man out of the lives of young people. We’re helping young people say “no” to premarital sex, drugs, and
violence, and "yes" to their education and their futures.

And thanks to your help, we're lowering infant mortality rates and finding new ways to do even better. As parents and as leaders committed to the health of children, we must discuss the subject of infant mortality. No parent should ever have to endure the heartache and pain of losing a child. No family should have to be torn apart in grief. Yet, every year 33,000 babies die in the United States before they've celebrated their first birthday.

There is only one thing worse than tragedies that afflict our children: tragedies that could have been prevented. Infant mortality is in that category. That's why our administration has made it a national priority.

We know a great deal today about the causes of infant mortality, from congenital disabilities to SIDS to low birthweight. We know the constellation of risks babies face when pregnant women smoke, abuse drugs and alcohol, don't gain enough weight during pregnancy, or become pregnant in their adolescence. But we also know that early and regular prenatal care can make a huge difference, especially in the case of low birthweight—the most preventable cause of infant mortality.

Now we must get this lifesaving information out to every family in America. But that's not all. We need to knock down the barriers that keep women from getting proper prenatal care. That's exactly what we've done, with your leadership and hard work, by expanding our Healthy Start Initiative. With more clinical services and resource centers, with better transportation and child care, with unique initiatives to reach young people early, we're all helping parents and communities prevent tragedies.

And do you know what? It's working. In Healthy Start communities across the country, more women are getting early and regular prenatal care. Smoking among pregnant women is down, the incidence of low birthweight is down, and most important, infant mortality is down.

Should we be proud of these accomplishments? You bet. Have we done enough? No, not by a long shot. We cannot—we must not—rest until all parents have the tools they need to bring healthy children into this world. And that's why we're all here today. Because we know that government can't do it alone.

From community leaders to clergy, from parents to teachers, from health care providers to corporations like Johnson & Johnson, it will take all of
us working together to do right by our children and our families, to reach parents where they read, work, and live, to reach them in their homes and at their jobs, on buses and in the streets, to reach across boundaries of culture and geography, race and income, providing hope and healing for all parents, all families, all Americans.

If we do that, if we continue to stand together and work together, I know that we can win the fight against infant mortality—the fight for the future of our children and our country.
The business community needs to be concerned about the quality of the future work force, to take steps to ensure that children reach their potential as adults in an increasingly complex workplace. The reduction of infant mortality not only improves the health of the nation, it makes good business sense. Employees of businesses that provide prenatal care services are healthier and more likely to be productive, stay on the job, and spend less on health care. The benefits of corporate-sponsored prenatal care greatly outweigh the costs. Consider the following statistics:

- Fifty-seven percent of all employees in the nation's work force are women, and 80 percent of these employed women will become pregnant during their careers. More than 38 million women in the work force are of childbearing age (18–44 years), and they give birth to 1 million babies each year. Many employees continue to work during pregnancy, and few leave the work force after having their babies. In 1992, more than 50 percent of all women with children ages one year or younger were working.

“We realize the public sector certainly cannot assure and promote good maternal and child health in this country alone and that business has a very important part to play."

Martha Naismith
Director of Federal Relations
Office of Government Affairs
Johnson & Johnson

“The more time off you give women before birth to visit doctors, the more likely they are to stay with the company after birth.”

Dana E. Friedman
Senior Vice President
Corporate Family Solutions

- Pregnancy and birth-related procedures are the fifth largest medical expenditure in the United States. For most employers, childbirth and its related costs absorb the majority of the company's health care budget. Furthermore, only a third of the $34 billion spent annually on maternity costs is due to normal deliveries. The remaining costs are for cesarean sections, premature births, home care, diagnostic testing, and medicines.
• A National Insurance Research survey estimated that in 1992 American businesses and their employees paid $5.6 billion through their health benefits programs for unhealthy birth outcomes for mothers and infants. The same study also found that in 1992 companies paid more than $4 billion in higher taxes, medical fees, and insurance premiums to cover uncompensated maternal and infant care costs. Medicaid reimbursement of these expenses averaged only 78 percent. These costs substantially increase if the baby is born too soon (preterm) or too small (low birthweight), thus requiring intensive care and specialized medical treatment.

• Even after the maternity and delivery costs are paid, companies incur additional medical and social costs associated with low birthweight babies. Pregnancy will take a woman out of the job market for a short time, but caring for a baby with physical or developmental disabilities caused by prematurity or low birthweight may affect the productivity of both parents for years.

Currently, the private sector endeavors to address the many and varied issues surrounding infant mortality through a variety of workplace and community initiatives. The following are some examples:

• ConAgra Refrigerated Foods Companies/Monfort Inc. has developed a partnership with the local health department to design and implement the preconception health promotion program Healthy Moms, Babies, and Families. This program is designed to ensure healthy birth outcomes for all employees.

• To encourage other corporations to become involved in reducing infant deaths, Johnson & Johnson launched a five-year, $15 million effort called the Johnson & Johnson Maternal and Child Health Initiative. One activity included the development of a nationwide television advertising campaign to help Healthy Start promote the need for early prenatal care. The advertisement addresses the issues of smoking, alcohol consumption, and drug abuse, and of timely and adequate prenatal care. This advertising campaign also heightens awareness among adolescent mothers and low-income women of risks that could affect their babies’ health.

“Our Healthy Moms, Babies, and Families program has saved families a lot of heartache and our company a lot of money.”

Lucille Gallagher, A.R.M.
Vice President of Risk Management
ConAgra Refrigerated Foods Companies/Monfort Inc.
"We all need to be better informed about what this country is paying for by neglecting children in those early years of life. Every single one of us has a responsibility to educate our legislators, our public officials, everyone that we talk to."

Judith E. Jones, M.Sc.
Clinical Professor of Public Health
Columbia University School of Public Health
Senior Advisor, Carnegie Corporation of New York
National Resource Center for Children in Poverty, Free to Grow Program

- The Carnegie Corporation of New York, a private foundation, has developed the publication *Starting Points: Meeting the Needs of Our Youngest Children* to educate all Americans on four essential aspects of healthy child development: responsible parenthood, quality child care, good health and protection, and community mobilization to support young children and their families, including a heavy investment by the corporate and philanthropic sectors.

- After reviewing Healthy Start’s materials, the National Association of Retail Druggists joined in promoting Healthy Start’s message by publishing an article in the National Association of Retail Druggists Journal that highlighted the alarming U.S. infant mortality statistics. The article generated calls to Healthy Start from local community pharmacists who were eager to help spread the word by distributing Healthy Start public information materials.

At the local level, other corporations and organizations have been involved in Healthy Start program activities. The following are examples of how businesses partner with the Healthy Start site within their local communities.

- In Washington, the DC Healthy Start project, Bell Atlantic, the Corporation for Public Broadcasting, and George Washington University are collaborating to enhance community job skills such as computer literacy.

- In the Pee Dee region of South Carolina, corporations including Sara Lee Hosiery/Hanes and Tupperware Manufacturing are exploring creative ways of working with Healthy Start. In fact, Tupperware underwrote the production of a Healthy Start public awareness brochure that is distributed to plant employees. The company even credits Healthy Start’s successful community development initiatives as a factor in its decision to keep a major production facility in the area.
• In Northwest Indiana, a major pharmaceutical company is donating vitamins to the Healthy Start project. The local Healthy Start site also works closely with the Northwest Indiana Forum, a group of business leaders actively engaged in promoting economic development while alleviating the impact of poverty on infant mortality. Figure 2 illustrates the relationship between poverty and infant mortality rates.

• In Pittsburgh, the NBC affiliate WPXI-TV is coproducing a weekly Healthy Start public affairs television program for the station’s new cable channel. The program features physicians, fitness experts, dietitians, and others discussing the prenatal needs of expectant mothers and the health care of newborns.

Businesses and foundations can build on the successes of Healthy Start by collaborating with existing Healthy Start projects, replicating Healthy Start models of intervention, and educating communities on the benefits of prenatal care.

“It is important to learn from previous examples of successful community-based interventions. We need to disseminate this useful information, to replicate these interventions in other environments, and to pursue alternative resources to win the battle against infant death.”

Thurma McCann Goldman, M.D., M.P.H.
Director, Division of Healthy Start
Maternal and Child Health Bureau
Infant Mortality: The Problem That Won’t Go Away

It seems irreconcilable that, compared with newborns in other countries, so many more American infants die. The United States has one of the most advanced medical care systems in the world, superbly trained medical care providers, and affordable medical care available to nearly all pregnant women. Yet, in international comparisons, the infant mortality rate for the United States remains among the highest for industrialized nations (7.9 deaths per 1,000 infants).

Infant mortality is exponentially related to low birthweight. Low birthweight (less than 2,500 grams or 5.5 pounds) is the result of premature birth (less than 37 weeks’ gestation), impaired growth in utero, or a combination of the two. Low birthweight infants are at much greater risk for mortality and long-term disability than other babies. They are 20 times more likely than other infants to die during the first year of life. Low birthweight babies account for 7 percent of live births but for 60 percent of infant deaths. Furthermore, very low birthweight babies (less than 1,500 grams or 3.25 pounds) account for only 1 percent of live births but account for 66 percent of all neonatal deaths.

Three main themes define the contributing factors for infant mortality: timing, low birthweight, and epidemiology. The overwhelming majority of infant deaths occur in the first month after birth; of those babies dying in the first month, most die in the first week. Furthermore, of those infants dying in the first week, most die on the first day and near the time of birth. Deaths occurring during the first day of life are those that are most preventable with prenatal care.

“Birthweight is the strongest biological factor in predicting infant mortality and is really the thing we ought to concern ourselves about regarding prenatal care.”

John Kiely, Ph.D.
Chief, Infant and Child Health Studies Branch
National Center for Health Statistics
Centers for Disease Control and Prevention

Nearly 100 years ago, the 20th century was considered the century of the child. The nation felt great optimism in technology to eradicate poverty. There was also a sense of optimism and belief in the power of new medical technology, with immunizations, to eradicate childhood illness and initiate a new era for the life of the child. The goal of reducing infant mortality over the past 100 years can claim some victories but also many defeats.

In studying the problem of low birthweight (see Figure 3) in the United States, epidemiologists
have described a disturbing, and as yet unexplained, phenomenon. African-American babies are more than twice as likely as white infants to be born low birthweight, to be born preterm, and to die at birth. Only 17 percent of all births are to African-American families, yet 33 percent of all low birthweight births and 38 percent of all very low birthweight births are to African-American families. Little is known about why African-American infants are at such high risk for adverse birth outcomes. However, factors such as poverty and preterm birth are known to be major contributors.

National Center for Health Statistics data also reveal that important risk factors for infant mortality—such as low birthweight and inadequate prenatal care—show no recent decline. The following statistics serve as examples:

- On a national level, about 20 percent of mothers receive no prenatal care during the first trimester of pregnancy. However, government statistics reveal that approximately one-third of African-American, Hispanic, and Native American women receive no prenatal care at all or do not obtain prenatal care until the last trimester of pregnancy.

- Low birthweight is the third leading cause of infant death, but it’s the leading cause of death for black infants. Babies born with low birthweight are 40 times more likely to die in their first month of life than other babies. Those who do survive are likely to develop future health problems.

- Large racial disparities exist in the number of low birthweight babies. Over 13 percent of African-American babies are born with low birthweight—more than any other minority population and over twice the rate of white babies.

- The incidence of low birthweight has continued to rise steadily since the mid-1980s.
"The Healthy Start program has undertaken an approach to families that is both inclusive and preventative, that really uses the strengths of the family and the culture to develop an alliance among the clinician, the family, and the community."

J. Kevin Nugent, Ph.D.
Director, Brazelton Center for Infants and Parents
Children's Hospital of Boston
Harvard Medical School

- Initial hospitalization costs for each very low birthweight baby is more than $26,000 with a total national cost estimate to care for all low birthweight babies equaling more than $4 billion a year.

What makes these statistics even more disturbing is the fact that the problems they represent are largely avoidable. In 1989, a White House Task Force on Infant Mortality determined that one in four of all U.S. infant deaths and disabilities is preventable with cost-effective health measures such as adequate prenatal care for pregnant women. Further, numerous government reports have documented disturbing trends in lifestyle behaviors with a direct impact on infant death, such as smoking and substance abuse. One result is an increasing number of infants born with HIV. Today, an estimated 7,000 infants are born to HIV-infected women each year. As a result, AIDS has become one of the leading causes of death among very young children.

In response to statistics such as these, the public health community and several voluntary organizations, including the United Way of America and March of Dimes, are conducting public education programs and are pressing for more federal and state resources for maternal and child health programs. The information developed by these organizations is also being used by a host of child advocacy groups to escalate the importance of children's issues with policymakers.

The activities of government agencies and nonprofit groups are helping to focus public attention on the issues. Still, the problems associated with inadequate maternal and child health programs also require the attention of the corporate sector. Currently, mothers with young children are the fastest growing segment of the workforce. Thus, healthier children would directly benefit industry through reduced parental absenteeism, tardiness, and inattention—all factors that affect productivity. Further, the business community needs to be concerned about the quality of the future workforce, taking steps to ensure children reach their potential as adults in an increasingly complex workplace.
Barriers to Prenatal Care

Several national commissions have convened experts from many disciplines to determine how to prevent low birthweight and infant mortality. These commissions have focused on one promising area—prenatal care. Early comprehensive prenatal care promotes healthier pregnancies by detecting and managing pre-existing medical conditions, providing health behavior advice, and assessing the risk of complications such as low birthweight and preterm birth. Prenatal care, crucial to maternal and child health, may serve as a gateway to the health care system, especially for socially disadvantaged women.

Although prenatal care varies, it usually includes a package of medical care services in a defined schedule of visits. In addition to medical care, prenatal care programs often include comprehensive health education, social, and nutrition services. At times, prenatal care is an adult woman’s first contact with the medical care system, and the screening she receives may uncover manageable conditions and/or treatable diseases that could affect the baby’s life and her own. The education a woman receives about pregnancy, labor and delivery, and caring for the newborn is crucial, particularly for first-time mothers. Prenatal care is also valuable for women who are impoverished because it links them with needed social services. The legacy of prenatal care continues after the birth of a child—women who receive this care have been shown to be more likely to get preventive care for their infants.

Figure 4 (left) shows the percentages of women in the United States in 1994 who initiated prena-

"As we look at ways in which our population can be served, let us not forget that cultural barriers and challenges, and the backgrounds of these communities, are equally important as any strategy, program, or funding initiative."

Eunice Diaz, Ph.D., M.P.H.
Health Care Consultant
tal care during the first trimester of pregnancy. Despite gains in women receiving adequate prenatal care, nearly 800,000 women who gave birth in 1994 did not receive prenatal care in the first trimester of pregnancy. Pregnant women must overcome many barriers to obtain adequate prenatal care: lack of access to care, unaffordable care, poor health-seeking behaviors, lack of adequate knowledge of the need for care, and the fact that health care is not considered a "right" for all children born in the United States.

Women who get inadequate amounts of prenatal care do so for a variety of reasons related to characteristics of the health care system, provider practices, and their own individual and social characteristics. More than 80 years ago health professionals identified key reasons why some pregnant women received medical attention late or not at all. Many of these same obstacles exist today: Poverty and the lack of good health care are primary reasons why pregnant women do not receive prenatal care. Limited access to care, substance abuse, cultural differences, fear, denial, and lack of emotional support are additional barriers.

In a national study of low-income women, 71 percent of the women experienced a problem receiving prenatal care. Those who received the least prenatal care cited finances as the most important reason for not getting prenatal care sooner or more often. However, as these women were more likely to cite multiple access problems, improving prenatal care access may require more than overcoming financial barriers of the health care system. Women also cited lack of transportation and child care as additional barriers to prenatal care access.

Women whose pregnancies are unwanted, who have negative attitudes about being pregnant, or who unintentionally become pregnant are more likely to delay prenatal care or to miss health care appointments. It is, therefore, crucial to emphasize the importance of reducing unwanted pregnancies. Women and men must receive help to achieve only those pregnancies that they want and desire. They need help in planning for pregnancy and information about how to reduce risks to ensure a more healthy birth outcome.

Denial and depression have been associated with poor use of prenatal care, especially among ado-
lescents. The woman’s partner and family social support network have also been associated with the use of adequate care. A woman living with the baby’s father or with a sexual partner was more likely to receive adequate prenatal care visits than a woman living with adult relatives. However, conflicts or problems with the father of the baby have been found to be deterrents to early and continuous prenatal care.

Women who are satisfied with their care and view their physicians as competent and concerned about their welfare are more likely to receive adequate care. On the other hand, negative attitudes toward health care and health care providers may lead women to reject the importance of prenatal care and to seek it less often.

Women who disagree with their physicians regarding health risks are less likely to get care. Having a baby too soon or one that is too small is of concern to most women, but their perceptions of when is too soon, what is too small, and what is a problem all vary.

Clearly, the determinants of prenatal care use are varied and range from obvious financial, geographic, and support barriers to more subtle cultural and attitudinal characteristics. Through the expansion of Medicaid eligibility, nationwide efforts to reduce the financial barriers to prenatal care access have been under way for some years. Preliminary reports indicate that these efforts have, in fact, begun to increase prenatal care use. Nevertheless, between 1981 and 1991, the incidence of low birthweight in the United States increased, as did the proportion of women receiving no care or starting prenatal care in the third trimester.

At the summit, Jimmie Brown, a mother of six from New York City, shared her personal story of overcoming a variety of barriers with the help of her community’s Healthy Start site. Ms. Brown discussed how Healthy Start was able to link her to various services and agencies that helped guarantee she and her children received adequate and timely health care.

Reform of the health care system offers an opportunity to shape a future that promotes the health of infants and women, facilitates reproductive choice, and assures access and availability of comprehensive health care and ancillary services—all of which are needed to reduce the risks of low birthweight. However, it is important to

“I was fortunate enough to enter the Healthy Start program when it first began. It has changed my life.”

Jimmie Brown
Consumer Representative
"If the reason you get out of bed in the morning is to improve the welfare of children, families, and pregnant women, one—not the only, but one—of your activities must involve helping men and women reduce unintended and high-risk pregnancy."

Sarah Brown, M.P.H.
Director, The National Campaign to Prevent Teen Pregnancy

recognize that while adequate, comprehensive prenatal care is a necessary and important part of the solution, it may not be sufficient to effect the dramatic reduction in low birthweight that is needed in the United States.

The ultimate success of prenatal care in reducing current low birthweight percentages in the United States may hinge on the development of a much broader and more unified conception of prenatal care than currently prevails. It is now necessary to undertake the difficult task of re-educating policymakers and the public regarding the value of prenatal care and the importance of universal access. In addition, other avenues to reduce low birthweight and preterm delivery must be explored.

To help remove the barriers preventing pregnant women from receiving prenatal care, the United States must seek a national consensus proclaiming that child health is paramount. Social, political, and corporate policies must be consistent with this consensus. Financial, professional, and personal commitment to the health of children must become a priority.
Healthy Start Solutions

The mission of the Healthy Start Initiative is to identify and implement a broad range of community-based strategies and interventions that could successfully and significantly reduce both infant mortality and low birthweight rates among high-risk populations. Healthy Start focuses the power of collaboration on combating infant mortality. At the start of the initiative, a great deal was already understood about the chief causes of infant mortality, including congenital anomalies, complications from low birthweight, and SIDS. It was also known that early and regular prenatal care is important for healthy pregnancies and birth outcomes. But what was not well understood were the approaches that would break down barriers to care that were already apparent, such as limited availability of health care providers to some urban and rural communities.

Applicants for Healthy Start demonstration grants were sought among urban and rural communities with infant mortality rates at least 1.5 times the national average. In late 1991, 15 applicants (13 urban and 2 rural) were awarded planning grants. The initial grants supported year-long comprehensive planning activities through fiscal year 1992; the projects began serving clients in fiscal year 1993. The overall goal was to reduce infant mortality in the project areas by 50 percent over a five-year period, focusing on five principles that would assure early prenatal care and appropriate supports for families: innovation, community commitment and involvement, increased access to health care, service integration, and personal responsibility.

In late 1994, seven additional communities (five urban and two rural) received Healthy Start Demonstration Special Project grants. These communities also had infant mortality rates greater than 1.5 times the national average. The goal for these projects was to significantly reduce infant mortality rates in the target areas over a two-year period.

During the initiative's demonstration phase, the 22 Healthy Start communities contributed enormously to the knowledge base of what works to combat infant mortality in communities, what the communities need, and what resources communities have in designing approaches. Each Healthy Start community examined what contributed to infant mortality in its community, what its needs were, and what resources it had in designing community-based approaches to reduce its infant mortality rate. The results are nine models of intervention and a host of lessons learned about successfully implementing the interventions.
The Healthy Start models all focus on the same goal: community-based infant mortality reduction. The models accomplish this through community-based services integration, especially for those clients at highest risk. The goals of these community interventions are:

- Reduced infant mortality
- Reduced rates of low birthweight and pre-term births
- Increased access to perinatal care (e.g., prenatal, postpartum, well-baby, and interconceptional care)

The nine Healthy Start models are:

- Community-Based Consortia
- Care Coordination/Case Management
- Outreach and Client Recruitment
- Family Resource Centers
- Enhanced Clinical Services
- Risk Prevention
- Facilitating Services
- Training and Education
- Adolescent Programs

At the summit, the directors from three projects—Boston, Dallas, and Baltimore—presented examples of how they and other projects have put these models into practice.

**Healthy Start Model 1: Community-Based Consortia**

At the heart of the Healthy Start Initiative is the belief that, guided by consortia of families, community leaders, and organizations from the private, public, and nonprofit sectors, communities can design and implement services needed by families. Programs designed by local communities will best address the unique needs and mobilize the resources of that community. Advised by the consortia, the Healthy Start communities focus the power of collaboration on the problem of infant mortality.

*We work with the community and educate them so that when the Boston Healthy Start project demonstration ends, our consortium can continue to contribute to the communities as they have been.*

Dianna Christmas, M.Ed.
Project Director, Boston Healthy Start
Boston Healthy Start is a partnership between the Boston Department of Health and Hospitals and a consortium of community residents and service providers. This structure places the power for change directly into the hands of families and communities. To establish and maintain programs, policies, and services appropriate to the needs of the target audience, Boston Healthy Start collaborates with such organizations as the March of Dimes, the Boston Housing Authority, the Massachusetts Department of Public Health, the Latino Health Institute, the Alliance for Young Families, and Community Health Education Centers.

**Healthy Start Model 2: Care Coordination/Case Management**

The coordination of the total care of pregnant and parenting women and their families is a cornerstone of Healthy Start. Relying on direct relationships between case managers and families, care coordination facilitates women’s access to and use of the perinatal health care and social services they need. Client empowerment is important; case managers realize that individualized needs assessments and service plans developed with the woman are more likely to be followed. The case manager’s ongoing close contact with the family to coordinate care and services provides continuity that increases both client and provider satisfaction. The case management model includes home visits, client assessment, health care coordination, and client education in breastfeeding, infant care, and family planning.

Case management is the foundation of Boston Healthy Start’s efforts to expand access to prenatal, postnatal, and infant health care for at-risk populations, including adolescents and the homeless. Fourteen case management programs are currently operating at a grassroots level. The case managers for Health Care for the Homeless make contact with pregnant homeless women who enter a shelter. Once a woman is recruited into Healthy Start, the case manager advocates for her placement in a location near medical care, then schedules and monitors prenatal care appointments. In conjunction with the school system and local health care providers, case managers offer health and social services to pregnant and parenting adolescents in five Boston high schools.

**Healthy Start Model 3: Outreach and Client Recruitment**

Healthy Start projects reach out to locate and actively recruit pregnant and parenting women, especially women and their families who have been underserved by the health and social service systems. Specially trained community residents
go door-to-door and to other community locations to find women and promote the importance and availability of Healthy Start services. Such resourceful efforts help to remind and encourage these women to obtain the care they need. Birmingham Healthy Start in Alabama employs both novel and conventional strategies to recruit clients and facilitate service delivery. Outreach and tracking play a key role in the program. Activities include door-to-door canvassing, computer database management, referrals, telephone inquiries, home visits, and the distribution of flyers and calendars.

To help Birmingham women access prenatal care, family planning, and child health services, Birmingham Healthy Start employs several residents as community outreach workers (CORWs) in each of the project’s 12 service areas. Selected by the consortium in each area, the CORWs help provide approximately 35 services including health education, nutritional counseling, and referrals to social services and nursing. The CORWs visit clients at home and follow up to ensure that the clients are keeping health care appointments. CORWs also recruit clients, manage cases, offer transportation assistance, and help clients apply for entitlement programs. During one project year, Resource Mothers and CORWs completed 810 home assessments during visits to expectant mothers.

Intercession Ministries provide outreach services for Birmingham Healthy Start through the Rough Riders Pregnant Males Initiative (PMI). The purpose of the church-based PMI program is to enhance the involvement of high-risk young males in the prenatal and infant stages. Clients identified through door-to-door canvassing and flyer distribution are offered GED tutoring, job placement assistance, counseling, training in parenting and social skills, and referrals to Birmingham Healthy Start for further help.

Through the Resource Mother’s program, at-risk pregnant adolescents receive social support and prenatal education during prenatal appointments and support in the home once the baby is delivered. Resource Mothers work one-on-one with clients to bridge the gap of isolation often experienced by these young women.

"If we are going to get women to come into our prenatal care clinics in the first trimester, if we are going to get women to come during the entire pregnancy for prenatal visits, they have to like the places they are going."

Thomas P. Coyle
Project Director, Baltimore Healthy Start
Healthy Start Model 4: Family Resource Centers

Healthy Start communities have demonstrated the positive impact of providing multiple services in a single and accessible community location. Commonly called one-stop shopping, the Family Resource Center concept encompasses collocating existing maternal and pediatric primary health care with on-site Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and/or Medicaid eligibility processing, health education programs, counseling and support services, employment, and other programs. Minimizing the number of places to go and forms to complete increases the chance that clients will have access to and make use of the care and services they need.

Baltimore Healthy Start has two Neighborhood Healthy Start Centers, each with a satellite location, serving nearly 1,400 women annually. One of the centers reaches more than 80 percent of pregnant women in its target area. Baltimore Healthy Start’s approach is to employ neighborhood residents as Neighborhood Health Advocates. The advocates aggressively identify pregnant and postpartum women and promote enrollment in Healthy Start. Case managers then work with each woman to develop an individual care plan addressing her specific needs (e.g., basic medical and prenatal care, substance abuse counseling, employment assistance).

Centralized one-stop resources facilitate continued care and nurturing of healthy lifestyles. Among the offerings are GED classes, on-site links to Medicaid, WIC, income assistance and food stamps, health education, and life planning.

Healthy Start Model 5: Enhanced Clinical Services

In many of the Healthy Start communities, existing services were not adequate for meeting the needs of the community. The Healthy Start communities developed strategies to enhance both the availability and user-friendliness of services to increase their use and quality. Depending on community needs, these strategies have included hiring more providers, expanding clinic hours, creating clinic atmospheres and protocols that are more welcoming and more greatly involve fathers and male partners, and conducting cultural sensitivity training for providers. Enhancing cultural understanding improves the climate of care and, in turn, pregnant and parenting women are more likely to follow provider recommendations.

The Detroit Healthy Start staff have devoted considerable effort to the enhanced clinical service integration and the enhancement of clinics that
now offer increased access to primary health care for those in greatest need. Such core services as family planning, sexually transmitted disease prevention and identification, laboratory and pharmacy services, parenting classes, social work, obstetric and gynecologic care, and well-baby care are crucial for the residents of this project area.

These clinics serve as community hubs offering a full spectrum of support services to vulnerable families by providing comprehensive, community-based care for women of childbearing age, adolescents, and infants. Each client receives a complete health-risk appraisal. Clients visiting the enhanced health centers can enroll in WIC and other food supplement programs, participate in smoking cessation programs, learn about congenital anomalies, have children immunized or tested for tuberculosis or lead poisoning, and be referred for alcohol/drug abuse and domestic violence interventions.

"The community must designate the kind of services that will work for it. The city and the state must understand and respect the fact that the people who need these services, who use these services, do have the capabilities of knowing what these services should be."

Dianna Christmas, M.Ed.
Project Director, Boston Healthy Start

Healthy Start Model 6: Risk Prevention and Reduction

The Healthy Start communities have documented that there is more to giving babies a healthy start in life than just providing prenatal medical care to pregnant women. Low birthweight and infant mortality are also influenced by other factors such as smoking, alcohol and other substance abuse, unemployment, homelessness, and neighborhood violence. Therefore, Healthy Start communities provide specialized services such as nutrition counseling, parenting education, mental health counseling, self-esteem enhancement programs, support groups, referrals to smoking cessation and substance abuse programs, violence prevention, GED programs, and employment training. Recognizing the support needs of these families, many communities target these programs to pregnant women, their male partners, and other significant family members.

Great Expectations Healthy Start in New Orleans, LA, is licensed to provide case management for people in high-risk environments: women who are unlikely to seek regular health checkups, or who abuse alcohol or other substances during pregnancy; Hispanics; and males. Once identified, a client benefits from a range of services and programs including the assignment of a community health nurse and nutrition education
for herself and her baby. Great Expectations provides specialized services to pregnant women involved in substance abuse. Spanish-speaking case managers continue to be effective in identifying Hispanic clients and facilitating their involvement through language translation during classes in all programs.

Great Expectations brings supportive males into the maternal and prenatal care loop through such activities as the Fourth Annual Male Involvement Week and a citywide male involvement conference focusing on how to build and sustain positive relationships.

**Healthy Start Model 7: Facilitating Services**

Due to dwindling community and family resources, health and enabling services are becoming more difficult to access even when they are available. For example, services may be located in areas that women—particularly those with young children/toddlers and with limited or no transportation—cannot easily access. By facilitating access to existing and new services, Healthy Start projects are able to capitalize on community resources and achieve greater use of care services. In some communities, mobile vans to transport women and their children to services, or to transport medical services to accessible neighborhood locations, have been put into service. On-site child care facilities have been added in some projects so that the woman's children are cared for while she attends her perinatal appointment or parenting class. Other services, such as more bilingual staff, have made a difference in facilitating both clients' and providers' understanding, concerns, and future plans regarding care.

Dallas Healthy Start operates three Mom Mobile vans (with two more on the way) providing free rides for women and children from their homes to health appointments, WIC services, parenting education classes, and related maternal and child care services. As word of this transportation has spread, the number of people using the vans has increased steadily. This service is greatly improving the comprehensive nature of services to women and families. Seventy-seven percent of the funds for this service come from local foundations and corporations. The program is but one illustration of the benefits of community collaboration.

In the near future, Dallas Healthy Start will also take its services on the road using a mobile medical van funded by Mattel and Exxon. The mobile clinic will serve five Head Start sites, providing immunizations, prenatal and postnatal care, health assessments and physical exams for
women and children, health and parenting education, and health referrals in the most underserved areas. Several community partners, including the Texas Woman's University School of Nursing and Head Start, are helping to make this clinic possible.

Healthy Start Model 8: Education and Training

Raising awareness of infant mortality as a problem is a prerequisite to convincing people to become involved in its solutions. Increasing a community's awareness of infant mortality, contributing factors, and strategies for combating it is essential groundwork for a Healthy Start project to achieve its goals. Every Healthy Start community conducts extensive efforts to reach residents with information about the problem and resources in the community for tackling it. Creative events, media outreach, and other strategies have been extremely important.

As the health care system evolves, projects are aware that the knowledge base of their health system's workforce needs to be expanded and updated. During the demonstration period, many Healthy Start projects focused some of their attention on developing and refining curricula on a variety of perinatal service components including outreach worker training manuals; male support group curricula and training manuals; childbirth education and parenting education curricula; a paraprofessional case manager training manual; safety precautions for home visiting; guides for managed care; and other audiovisual training and marketing aids.

In Washington, DC, Healthy Start activities are aimed at increasing support for reduced infant mortality and informing females of childbearing age and their families and other supporters about the importance of appropriate health care and how to access it. DC Healthy Start's public information and public education efforts are extensive and multifaceted. They include regular public service announcements on at least four local radio stations and three local commercial TV stations, and in six local minority print outlets; outreach in the local schools and prisons; and health quizzes and incentives aired over the radio. Other incentives include free tickets to nationally televised boxing matches, a Mother's Day shopping spree through the supermarket to select healthy products, and special coupons toward the purchase of food items distributed to expectant mothers who attend public health clinics during the first trimester of pregnancy.

The DC Healthy Start project also hosts a local art contest to encourage high school students to create original works of art that depict good health habits during pregnancy and the positive
support of a pregnant woman and her unborn child. An adolescent peer educator has been showcased at the National Urban League conference and on Black Entertainment Television. The project has also developed numerous informational tip sheets, fact sheets, and brochures.

**Healthy Start Model 9: Adolescent Programs**

A significant percentage of low birthweight babies are born to adolescents, and the infant mortality rate for babies born to adolescents is high. Healthy Start communities make a special effort to target female and male adolescents with information and activities that encourage healthy behaviors, self-esteem, and sexual abstinence; and that help them understand the risks of pregnancy as well as the challenges of parenting. Young people need support and services to encourage sexual abstinence and to feel involved in social interactions while empowered to postpone having babies.

A priority of Dallas Healthy Start is to stimulate community ownership of Healthy Start strategies. Adolescents are crucial to this effort. The Dallas Teen Advisory Committee, comprising 31 adolescents of both sexes, assesses the needs of its own age group and devises ways for adolescents to respond to those needs. The committee’s mission is to increase adolescent awareness of factors harmful to health and encourage role modeling of healthy behaviors. These adolescents meet monthly to plan an ambitious calendar of events, programs, and recruiting efforts, including health fairs, workshops on healthy behaviors, pregnancy-prevention services at community sites and schools, teen court (a conflict-resolution method that empowers adolescents to make wise decisions), and dramas and panel presentations about appropriate health behaviors.

As Healthy Start looks to the future, new goals include sustaining successful strategies in currently funded demonstration communities while implementing successful strategies in new communities. With the benefit of experience, existing sites will mentor new communities in their efforts to reduce infant mortality. These nine models of intervention will guide communities and others as they seek to replicate or adapt programs and strategies to address their unique circumstances.

*"We as adults want to, and need to, hear from our teens exactly what needs to be done to help them in their future."

Elizabeth H. Cowles, M.A.I.S.
Project Director, Dallas Healthy Start
Call to Action: Putting It All Together

Despite the recent gains in reducing infant deaths, infant mortality remains a serious and tragic problem that can be solved only if all stakeholders—community leaders, businesses, health care professionals, and policymakers—work together to find answers. To this end, Winning the Fight Against Infant Mortality: A National Summit on Community and Corporate Initiatives highlighted how philanthropy and enlightened self-interest can work together to overcome infant mortality. Businesses and other institutions help to form values in their surrounding communities. If businesses treat their employees and customers with respect and compassion, the stage is set for a nurturing society. If social profit is just as much of a motive as economic profit, the stage is set for a caring culture. If businesses promote understanding of differences (racial, religious, or personality), then the stage is set for social, mental, and physical harmony and health. Many businesses and corporations have pioneered initiatives that encourage such positive changes.

This summit examined the impact of infant mortality on our nation and how the problem affects both communities and the business sector. More importantly, the conference focused on effective community and corporate models and how they can be adapted by other communities, employers, and businesses. There are solutions and they must be shared.

Winning the Fight Against Infant Mortality: A National Summit on Community and Corporate Initiatives highlighted how philanthropy and enlightened self-interest can work together to overcome infant mortality. Businesses and other institutions help to form values in their surrounding communities. If businesses treat their employees and customers with respect and compassion, the stage is set for a nurturing society. If social profit is just as much of a motive as economic profit, the stage is set for a caring culture. If businesses promote understanding of differences (racial, religious, or personality), then the stage is set for social, mental, and physical harmony and health. Many businesses and corporations have pioneered initiatives that encourage such positive changes.

The federal Healthy Start Initiative recognizes the role that many businesses and corporations already play in the fight against infant mortality. The initiative encourages the private sector to join these organizations as partners in the national and local effort to make our country’s children healthy. No matter how large or how small,

"We are devolving back into a time where there is less federal influence in both funding and decision making. This has particular importance for the reduction of infant mortality and the improvement of health. It will be increasingly more important that local community involvement is developed and local identity of needs and gaps are made and local efforts are made in regards to their resolution."
every corporation can play a unique role in reducing the rate of infant mortality.

Corporations should examine in what ways they can reduce these rates in partnership with their customers and employees and through their marketing plans, products, and services. From internal programs and local information dissemination to national workplace initiatives, the possibilities are varied and endless. Activities do not necessarily require a major monetary commitment, but all make a difference. A business can help enhance and sustain existing Healthy Start program components, or adapt parts or all of a program in its community or other areas of the country with high rates of infant mortality.

Although one cannot put a price on the value of a healthy birth, real costs are incurred from medical complications in newborns. These costs plague not only health care organizations, but all businesses. At least 25 percent of the complications resulting in infant deaths could be prevented if the women received adequate and timely prenatal care. The lack of prenatal care in this country is taking a toll on our families, our businesses, and our society. Programs like Healthy Start are finding solutions through innovative strategies to reach pregnant women and their families. Healthy Start can help organizations be part of the solution to improving America's infant mortality crisis.

Every organization can partner with one or more of the 22 existing Healthy Start projects that have served in the federal demonstration and developed unique and successful approaches to reducing infant deaths in their inner-city or rural communities. These projects have established resources and networks of providers in their areas, upon which pregnant and parenting women and their families depend. The following are some ways an organization can become involved as a partner in the fight against infant mortality:

- Join a local Healthy Start consortium and help the project network with the community's business sector. The consortium can develop a successful marketing plan to sustain a project beyond its federal funding.
- Donate products, services, volunteers, meeting

"One of the things that the corporate industry can do is to host many programs at the local level in an effort to raise awareness and inform our communities about the needs of maternal and child health."

Ezra Davidson, Jr., M.D. Chair, Department of Obstetrics and Gynecology Charles R. Drew University of Medicine and Science
space, and/or supplies to help the Healthy Start projects continue their work.

- Provide funding for a specific program component such as adolescent pregnancy prevention, substance abuse counseling, or home visiting outreach.

- Contract with a Healthy Start project to provide services, using its existing network of resources and providers in the local communities.

- Provide training classes to equip Healthy Start parents for the job market.

- Provide stipends or scholarships to encourage Healthy Start clients to continue their education and job training.

- Provide a job to a man or woman who enrolls in Healthy Start to improve their life and that of their newborn in addition to spurring economic development in the community.

- Become involved in a mentoring program, where employees are matched with young Healthy Start clients that need positive role models.

Another way that an organization can help Healthy Start is to replicate one or more Healthy Start strategies in other communities or in a workplace setting. Replication of a Healthy Start project can spread the benefits of what the program has learned over the past five years to other communities struggling with the same challenges and issues. This is a particularly viable option for organizations wishing to target resources to a specific city, state, or region.

Each Healthy Start project has numerous strategies that have been designed and shown to meet the needs of specific target populations—inner-city youth, the rural unemployed, Spanish-speaking women, Native Americans, and many others. Examine the organization's goals and match a Healthy Start model with the target groups you want to reach in a community that needs help.

Data from the National Center for Health Statistics indicate that more than 80 counties in the United States have infant mortality rates greater than 150 percent of the national rate (1991–93 data). Also, more than 100 large cities have a higher infant mortality rate than the national average and more than 30 of these cities have an infant mortality rate greater than 150 percent of the national average (e.g., Wichita, KS; San Bernardino, CA; St. Louis, MO; Bridgeport, CT). These high infant death rates in large pockets of the country are also compounded by enormous racial disparity of
infant deaths between white and minority populations.

Healthy Start projects can come together with businesses, foundations, and other organizations to give rise to a new site in one of these areas of the country that needs attention. One piece of a program or a whole system can be replicated. Projects have developed different approaches to overcome barriers and are eager to help others benefit from their experiences. Some ideas for replication include:

- Pursue a partnership where a Healthy Start project mentors a new program that the company or organization helps create. Healthy Start can share lessons learned and teach part or all of the models that have flourished in the communities.

- Arrange for Healthy Start staff to host an orientation or conduct a workshop about model services to an interested organization or community. Healthy Start staff can serve as advisors to establish new initiatives such as a transportation system, a well-baby tracking system, or a fatherhood involvement program.

- Convene a task force of local businesses to identify and secure resources to replicate a Healthy Start program.

- Consult with a Healthy Start project to help develop materials and services for a hard-to-reach population among the company's or organization's work force or consumers. Many Healthy Start sites have developed an expertise in overcoming cultural and language barriers and encouraging pregnant women who speak a different language to be more comfortable in using available prenatal care services.

- Solicit the help of a Healthy Start project in developing appropriate materials that will increase awareness and use of health care services available in the workplace.

- Help the Healthy Start sites extend their public education efforts beyond their target areas by reprinting and distributing existing materials, or sponsoring the development of new ones, that educate about ways to reduce highly preventable conditions such as low birthweight, prematurity, and fetal alcohol syndrome.

Whether the organization partners with the national effort by replicating or sustaining a Healthy Start project, it will contribute to the betterment of the community, the organization, and its future. Healthy Start projects have paved the way: They offer businesses, foundations, and other organizations a new avenue for supporting
Healthy Start works with corporations and organizations to develop public education activities that will greatly extend the reach, impact, and sustainability of the Healthy Start campaign. The most effective partnerships—and the most mutually beneficial—are those in which a company gets involved in a hands-on manner, such as sponsoring a health fair or distributing prenatal care information to employees.

Corporations can make a difference. The business community can rise to the challenge to become a Healthy Start partner and to improve the health of women, infants, and their families. For more information on how corporations can become part of the solution, call the Federal Maternal and Child Health Bureau's Division of Healthy Start at (301) 443-0543, or contact a Healthy Start community directly. Contact information is listed in the appendix.

Getting useful, positive, and relevant information into the hands of pregnant women and their families promises to be the best way to help solve the problem of infant mortality in this country. To spread the prenatal care message as widely as possible, Healthy
Luncheon Keynote Address

The luncheon keynote address was presented by Louis Sullivan, M.D. Dr. Sullivan is currently the president of Morehouse School of Medicine and served as the secretary of the U.S. Department of Health and Human Services for President George Bush. An adaptation of Dr. Sullivan's remarks appears below.

Nelson Mandela, on the day of his inauguration as president of a new South Africa, said, "Today, all of us do, by our presence here . . . confer glory and hope to newborn liberty. Out of the experience of an extraordinary human disaster that lasted too long, must be born a society of which all humanity will be proud."

The infant mortality rate in our country is shockingly high, a sober statement about our inability to craft a harmonious and healthy society. Today, by your presence, you "confer hope" that we can address the many complex factors that lead to unnecessary illness, disability, and death among our newest citizens. Just as President Mandela has provided profound and extraordinary leadership in healing the enormous wounds in South African society, so we too can provide dynamic and lasting leadership in our own communities.

Today I would like to talk about crafting a culture that places a premium on our children and their good health. I will begin by explaining my vision of such a culture, and then I will outline a few of the many steps we must take to make a culture of character a reality.

Our culture must reinforce the value of human life and the importance of free choice. As secretary, I often spoke of the need for a culture of character—a culture that works for a stronger sense of personal responsibility and community service. Each of us has a given set of possibilities, different actions we can undertake, opportunities we can use, and various roads that we can travel. I want to create a culture where our individual stamp, the way that we shape our lives, the engraving of our actions will reflect a high level of personal responsibility and service to others. I stress personal responsibility because we must highlight the freedom of choice, and the importance of positive decisions in shaping our own lives, and I stress community service to underline the central truth that we are all in this together.

In a culture of character, we must begin with a strong perinatal program for all Americans, but especially for those most in need.

I have just returned from a trip to England, Denmark, and Sweden, where the infant mortal-
ity rate is one-half as high as ours. I have learned there, as well as here, that three factors are indispensable in lowering infant mortality rates: access to care, targeted programs for our low-income and minority populations, and a high priority on prenatal care.

One powerful example of a successful effort in our country is the Healthy Start program, a federally funded, locally administered program that works! In 1991, during my tenure as secretary, the U.S. Department of Health and Human Services funded demonstration programs in 15 communities across the nation to find ways to reduce infant mortality. We now are beginning to see positive results from these demonstration projects. Although a five-year study to evaluate the success of Healthy Start has not been completed, the available local data from some of the communities indicate that the program has been very effective in reducing infant mortality and other pregnancy problems. As you know, in the areas of Chicago participating in the Healthy Start program, infant mortality dropped 28.6 percent from 1990 to 1994. By way of comparison, the State of Illinois lowered infant mortality by only 16 percent during the same period. I am certain that we will see similar success stories across the country, as more data become available.

The resources devoted to this program repay the nation many times over. Healthy Start is a sound investment to promote good health of our citizens and better use of our economic resources. According to the Office of Technology Assessment, every time low birthweight is prevented through proper prenatal care, the U.S. health care system saves between $14,000 and $30,000 in health care costs. In fact, for every dollar spent on routine prenatal care for high-risk women, more than three dollars are saved in after-delivery costs. There are long-term savings in other areas, too. Proper prenatal and postnatal care are strongly linked in later life to improved earning capacity and educational attainment, and to less dependence on welfare and other safety net programs.

In general, we must expand health promotion/disease prevention efforts. And we surely don't hear enough about prevention programs in our low-income and minority communities, which have been left behind in prevention efforts. That is why, as Secretary of Health and Human Services, I published Healthy People 2000, which outlined almost 300 health prevention goals for the nation during the 1990s, with special emphasis on reducing preventable illness and injury in our underserved communities by the year 2000.
And, if we are to achieve significant cost savings and improved health outcomes in our health care system, we must greatly reduce the use of tobacco by the American public.

Prevention must be a visible and central part of health system reform. So I support the American Public Health Association and other groups that are working for a significantly greater investment in prevention. Currently, federal spending on prevention and public health is about $5 billion—less than 1 percent of national health care expenditures. But we surely could support a much higher figure of $50 billion, or almost 5 percent of national health care expenditures.

Another answer is to provide needed primary care services to our citizens, especially in medically underserved communities. According to a report in 1990 from the Council on Graduate Medical Education, by the year 2000, more than half of our nation's physicians should be primary care providers for the optimal delivery of appropriate health care. To achieve that goal means that the nation's training rate for primary care physicians must more than double the rate in 1990.

There is much we can do if we place a priority on training in primary care. The National Resident Matching Program has recently found that, for the third year in a row, 51 percent of seniors picked generalist specialties. According to a recent *AMA News*, this change is being driven by market considerations and vigorous efforts by medical schools and the American Academy of Family Physicians. I can testify from my own experience that an emphasis on primary care in the medical school setting can make a difference. In 1993, the Association of American Medical Colleges reported that the Morehouse School of Medicine was the number one school in the nation in the percentage of our medical graduates who are practicing as primary care physicians. At Morehouse almost 75 percent of the physicians we have graduated have chosen primary care, and more than 66 percent of our graduates practice in underserved areas.

But short-term gains are not enough. We need to place a priority on primary care well into the next century. We need to give a greater national emphasis to the National Health Services Corps. We need to promote medicine as a serving profession, rather than a ticket to financial gain. And we need to make our physicians "renaissance practitioners"—armed with a variety of professional, communication, and cultural skills for our nation's changing health care environment.
We must also more effectively extend the health care system beyond the four walls of the hospital or the health professional’s office. We must interact more closely with our patients through such activities as communitywide nutrition programs, outreach services to our low-income and minority communities, placement of clinics in housing projects and other underserved areas, special efforts to address HIV infection and tuberculosis, health partnerships with businesses and schools, health fairs and career counseling, mobile services in vans and trailers, helplines and radio programs, and establishment of patient information services with telecommunications networks.

The health care system must be more accessible if we are to reach our low-income and minority populations. Currently, the health care system is virtually nonexistent for millions of our citizens. There are serious and sustained disparities between the general population and our low-income and minority communities in every health status category: cancer, AIDS, lupus, injuries, violence—these and other barometers of health status tell the same story. For example, half a million African Americans die every year from heart disease, at rates much higher than for other Americans: cardiovascular disease is 46 percent higher for black men and 69 percent higher for black women. Strokes are 98 percent higher for black men and 77 percent higher for black women.

We witness these disparities in Harlem, in Watts, in Northeast Washington, DC, on the West Side of Chicago, in the barrios of Texas, in the rural areas of Virginia, and in many of your own neighborhoods. I have concluded that our nation has a two-tiered health care system—one for the general population and one for our low-income and minority citizens.

One reason is that, for our low-income and minority citizens, services are harder to get. A recent study from the Health Care Financing Administration indicated that there are serious disparities between African Americans and the general population in utilization of preventive, surgical, and other health services provided under the Medicare program. There was considerable evidence to indicate that African Americans wait longer to use the services for which they are already eligible.

So we must take the health care system where it will do the most good—to the ghetto, the barrio, housing projects, migrant farms, rural areas, our schools, and even our churches. We must explore every avenue to end the callous disparities that reflect an uncaring, fragmented culture.
Now, I would like to take a moment to speak to the business leaders here today. Thank you for coming. I believe that our greatest and most successful companies stand for something; they have a set of corporate values that reflect a deep interest in their customers, their employees, and the surrounding community. They have a relationship with their customers—reflected in honesty, loyalty, and respect.

So how can business help reduce infant mortality? First, our corporations, churches, universities, and other institutions have to realize that they help to form the values and beliefs of the surrounding community. If you treat your customers and employees callously, then you set the stage for a callous culture. If the profit motive is your sole reason for existence, then you help craft a cold, disinterested culture. I urge you to make the work environment a place of racial harmony, economic justice, and social responsibility.

Second, I urge you to promote healthy diets and good health as part of the work environment. When I was secretary, I had the cafeteria menu revamped and upgraded, to offer healthy choices to employees. Of course, the old greasy burgers, death dogs, and gut-buster chili were still available. But we noticed that most employees preferred the healthy menu. Employee exercise is important. So is a good health care plan that provides strong incentives for prenatal care, adequate maternity leave, and affordable child care.

Third, I urge you to support targeted programs for our low-income and minority communities. The Healthy Start program has demonstrated the powerful impact of targeted, focused, and sustained programs that receive a high community and national priority. When you sponsor sports teams or community events, also consider becoming a partner to a neighborhood clinic or community outreach program. This is another way you can help to shape the values in our communities and to help our newborn babies be healthy and stay healthy.

I began by recalling the courage, persistence, and compassion of Nelson Mandela. He has led an inspiring life, filled with defeat and victory. Yet, his optimistic vision has inspired a nation and the entire world. He has shown that an infinite number of obstacles can be overcome.

He concluded his recent autobiography with these words: "I have walked that long road to freedom. I have tried not to falter; I have made missteps along the way. But I have discovered the secret that after climbing a great hill, one finds that there are many more hills to climb . . ."
for with freedom comes responsibilities, and I
dare not linger, for my long walk is not yet
ended."

Our long journey has not ended. We linger here
in this place to review our accomplishments and
to see the many hills we must still climb togeth-
er. But, like President Mandela, we recognize
that our responsibility, our duty, and our human-
ity propel us ahead to tackle the formidable
obstacles that are still in the way. We can—we
will—reduce infant deaths. We will drive down
the infant mortality rate. If we work in unison; if
we carry a common vision; if we provide sus-
tained leadership; if we target those most in
need; and if we make our health care system
more affordable, more accessible, more just, and
more compassionate, then we too will have
walked the long road to freedom.
References


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Miller H, Kelly W. Impact of Uncompensated Maternity and Infant Care Costs on Employers—Summary Highlights. Prepared by the Center for Health Policy Studies, Columbia, MD.


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Winning the Fight Against Infant Mortality:  
A National Summit on Community and Corporate Initiatives

Wednesday, September 18, 1996  
Renaissance Washington, DC Hotel

8:30–9:15  Registration and Continental Breakfast

9:15–9:30  Welcome: Compelling Reasons for Corporations to Care  
Audrey H. Nora, M.D., M.P.H., Assistant Surgeon General; Director, Maternal  
and Child Health Bureau  
Nancy Lane, Director of Corporate Affairs, Johnson & Johnson  
Healthy Start Video

9:30–10:15  Opening Keynote Address: Infant Mortality—The Problem That Won’t Go Away  
Kevin L. Thurm, Deputy Secretary, U.S. Department of Health and Human Services  
Introduction by Ciro V. Sumaya, M.D., Administrator, Health Resources  
and Services Administration

10:15–11:00  Panel Session: Infant Mortality—A Closer Look  
Moderator: Kathy Buskin, Director of Editorial Administration, U.S. News and World Report

Who and How Many Are Affected  
John Kiely, Ph.D., Chief, Infant and Child Health Studies Branch,  
National Center for Health Statistics

Risk Factors  
J. Kevin Nugent, Ph.D., Director, Brazelton Center for Infants and Parents

Unintended Pregnancy—A Growing Problem  
Sarah Brown, Director, The National Campaign to Prevent Teen Pregnancy
11:00–11:15  Break

11:15–12:00  Panel Session: Barriers to Prenatal Care
Moderator: Maxine D. Hayes, M.D., President, Association of Maternal
and Child Health Programs; Assistant Secretary, Washington State Department
of Health, Community and Family Health

The Access Question
Clyde Oden, M.D., President and CEO, United Health Plan

A View from the Community
Jimmie Brown, Consumer Representative, Healthy Start/New York City

Cultural Obstacles and Family Breakdown
Eunice Diaz, Ph.D., Health Care Consultant

12:00–1:15  Luncheon Keynote Address
Louis Sullivan, M.D., Former Secretary of the U.S. Department of Health
and Human Services; President, Morehouse School of Medicine

Introduction by Antoinette Parisi Eaton, M.D., Past President, American Academy
of Pediatrics; Chair, Secretary's Advisory Committee on Infant Mortality; Professor
of Pediatrics and Preventive Medicine (Emerita), The Ohio State University

1:15–2:15  Panel Session: Healthy Start Models and Overview
Moderator: Thurma McCann Goldman, M.D., M.P.H., Director, Division
of Healthy Start, Maternal and Child Health Bureau

Thomas P. Coyle, Project Director, Baltimore Healthy Start
Dianna Christmas, Project Director, Boston Healthy Start
Elizabeth H. Cowles, Project Director, Dallas Healthy Start
2:15–2:30  Break

2:30–3:30  Panel Session: The Private Sector Role—Babies, Business, and the Bottom Line
Moderator Mary Jane England, M.D., President, Washington Business Group on Health; Immediate Past President, American Psychiatric Association

Overview
Dana Friedman, Senior Vice President, Corporate Family Solutions

Healthy Start Private Sector Partnerships
Judith E. Jones, Senior Advisor, Carnegie Corporation of New York

Employer Initiatives
Lucille Gallagher, Vice President, Risk Management, ConAgra Refrigerated Foods Companies/Monfort Inc.

Johnson & Johnson Maternal and Child Health Initiative
Martha Naismith, Director of Federal Relations, Office of Government Affairs, Johnson & Johnson

3:30–4:00  Call to Action: Putting It All Together
Ezra Davidson, M.D., Chair, Obstetrics Department, Charles Drew Medical School

Introduced by Thurma McCann Goldman, M.D., M.P.H., Director, Division of Healthy Start, Maternal and Child Health Bureau

4:00–5:30  Networking Reception
List of Speakers

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Abell Foundation, Inc.
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New Orleans Dietetic Association
New Orleans Saints
New York Botanical Gardens
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Patrick Outdoor Advertising
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PrimeCare HMO
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Tiger Foundation
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University of The District of Columbia (UDC)
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WABC-TV
Walt Disney Productions
Washington Metropolitan Area Transit Authority (METRO)
Wendy’s International, Inc.
Wildlife Conservation Society
WOL/WMMJ Radio
Woodland Avenue Presbyterian Church
WPXI Television
WQUE radio (New Orleans)
WZAK radio (Oakland)
Young’s Memorial Church of Christ Holiness
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and many more . . .
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Winning the Fight
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