DEPARTMENT OF HEALTH

A Community Engagement Model to Address African American Infant Mortality

COMMUNITY VOICES AND SOLUTIONS (CVAS)

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A Community Engagement Model to Address African American Infant Mortality

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I. Introduction

Community Engagement

Community engagement is "… the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people. It is a powerful vehicle for bringing about environmental and behavioral changes that will improve the health of the community and its members. It often involves partnerships and coalitions that help mobilize resources and influence systems, change relationships among partners, and serve as catalysts for changing policies, programs, and practices" (CDC, 1997). It has become an essential component of public health as new and more complex health challenges arise and as geographical boundaries become porous and permeable to the spread of diseases, leading to the search for innovative approaches beyond those offered by traditional medical models. Healthy equity approaches call for involving the populations most impacted by inequities in the entire process.

The size and composition of a "community" may vary. The extent of engagement can be limited or boundless, and the period can be short or long, depending on the purpose. Whatever form community engagement takes, there is general agreement that there has to be meaningful and authentic community participation for it to succeed. This means involvement is not merely physical; it must also include participation in the generation and deliberation of ideas, in decision making, and in the sharing of responsibilities. In CDC's community engagement continuum, the ultimate level of community engagement is "shared leadership"(CDC, 2011). This level is characterized by the presence of strong bidirectional relationship and trust, a strong partnership structure, and decision-making on broader health outcomes at the community level.

In 2015, the Center for Health Equity (CHE) at the Minnesota Department of Health (MDH) received a five-year grant from the Office of Minority Health (OMH) at the U.S. Department of Health and Human Services under the State Partnership Initiative to Address Health Disparities (SPI) grant program. The project is entitled *Addressing Infant Mortality and Developing a Health Profile on African American Mothers and their Infants Living in Hennepin County Using a Health Equity Analysis*. This report describes the community engagement model utilized in the project, the community leadership team, as well as the activities, events, and products developed under the team's leadership and guidance.

African American Infant Mortality Project

CHE's SPI grant project addressed the wide spectrum of factors that contribute to the high infant mortality rate among U.S.-born African Americans living in Hennepin County. Hennepin County has the largest concentration of African Americans in Minnesota, and African American babies in the county are three times more likely to die before their first birthday compared to white babies. The project acknowledged that differences in infant mortality rates could be explained by not only variations in maternal characteristics, behaviors, and access to health care, but also by social, economic and environmental conditions in which people live, work, and age. It utilized a community engagement model that brought together the perspectives and understandings of the community about the factors that create and sustain disparities, and activated it to create sustainable policy and systems changes.

Leading the project was Community Voices and Solutions (CVAS). CVAS members were from the African American community, represent various sectors, and have a strong passion for maternal and child health. CVAS was created to ensure that community voices are heard, that leadership from the community is valued and nurtured, that community assets are identified and leveraged, and to the greatest extent possible, community members set priorities and make decisions throughout the process. This ensures that strategies truly reflect the needs of the community as defined by those who represent it.

CVAS History

CVAS has undergone several configurations over the past 10 years. It was first formed in 2010 in response to a report entitled "Addressing Infant Mortality among African Americans: An Urgent Matter." The study, conducted by the Twin Cities-based Stairstep Foundation with funding from MDH's Office of Minority and Multicultural Health, examined the issue of infant mortality among African Americans in the metro area. It sought to understand the extent of the problem and perceptions around the contributing factors, and identify solutions from the perspective of the African American community. The findings and recommendations from the Stairstep report led to the creation of CVAS in 2010 as an advisory group for MDH's State Partnership grant program funded by OMH. The CVAS partnership brought together representatives from health clinics, social service agencies, schools, local health departments, professional associations, nonprofit organizations, community, and MDH. The 2010-2013 grant focused on building MDH's capacity to collect, analyze, and report on the health status of racial and ethnic communities in Minnesota.

CVAS again served as the advisory group in the next round of OMH grant from 2013-2015 that focused on building the U.S.-born African American community's capacity and action by increasing knowledge of evidence-based maternal child health and family home visiting (FHV) models of care. CVAS went into hiatus for almost two years beginning in 2013 due to personnel changes in the project. It briefly reconvened from May through July of 2015 to guide the project's remaining months.

When MDH received a new five-year grant starting in August 2015, CVAS was formed with completely new members that again represented different sectors, but with one change. It no longer served in an advisory capacity; rather, it became the project leadership team responsible for steering all planning and implementation of activities. Starting with 26 members in 2015 representing nine sectors, the current CVAS has 19 members representing seven sectors.

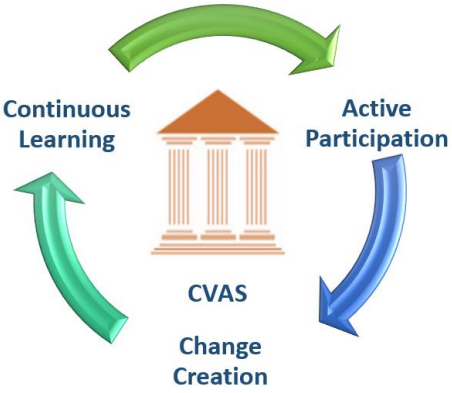
II. Role of CVAS

The project invested a generous amount of time to find the right people and build the relationships and trust. Despite changes in membership over the years, CVAS always embraced three important elements:

- Strength/Asset-based. Members had a strong passion for maternal and child health, but they also possessed other qualities that made them stand out in the community and that the project made sure were valued, amplified, and utilized.
- Shared leadership and decision-making. CVAS elected a Chair to serve as primary contact and liaison with project staff, but leadership and decision-making were equally shared among all members.
- Deep and authentic engagement. Members took the lead in all planning and implementation, including the development, creation, and dissemination of products.

Community engagement was not the end product. Rather, the project was an ongoing cycle of active participation, change creation, and continuous learning, with CVAS always serving as the strong center (Figure 1).

Figure 1. Cycle of CVAS engagement



III. Building the Foundation

Once CVAS was formed, the next step was to develop a shared understanding and a shared vision for the team; that is, a shared understanding of the African American infant mortality problem, the causes of the problem, what strategies could be used to address it, and a vision of what was possible, all rooted in CVAS values. This "level setting" was to get everybody on the same page. It required building a foundation to provide a firm ground and the stability on which the project could stand. This is an often-neglected step in community engagement. In many instances community teams are assembled and then get right to work; rarely do they take the time to ensure they gain a firm foothold beforehand. When individual members have different understandings, it makes it difficult to come to an agreement, to have a united front, and to make a strong impact.

CVAS's foundation-building evolved in three steps:

1. **Creating a team charter**

A team charter spells out a clear direction and purpose for the team and ways of working together. The CVAS Team Charter (Appendix A) embodied the shared decision-making and leadership model that guided their work in the project. It also reflected their shared vision for

the reduction in the African American infant mortality rate. Its contents included: purpose, approach, goals, time commitment, responsibilities and expectations, decision-making and conflict resolution processes, and core practices by which they abide. All new members who joined the team received a copy of the Charter.

2. Creating a guiding framework

The project reached a critical juncture where concrete steps to address African American infant mortality had to be developed. But a few questions lingered:

- A well-defined problem comes before solutions. How do we know we are addressing the root causes of the problem and not just treating the symptoms?
- Once we find these root causes, how do we address them? What policy levers can we use? What partnerships can we form?
- The community most impacted by the health inequities must be an active participant in the process of creating solutions and taking action. How do we ensure that everything we do reflects their beliefs, understandings, and lived experiences around the issue of African American infant mortality?

With CVAS and its charter firmly in place, the next steps were to develop a shared understanding of the root causes of the infant mortality issue at hand, and to embody these in a framework that would guide future activities. This led to the development of a Social Determinant of Health (SDOH) Framework for Addressing African American Infant Mortality (Appendix B).

The World Health Organization (WHO) conceptual framework for action on the social determinants of health served as basis for creating the guiding framework (Solar and Irwin, 2010). The project's rationale, that the conditions for health play a significant role in infant mortality, informed the choice of the WHO model. The conditions in which African American babies are born, live, work, play, worship and age, and the forces that shape their daily lives such as policies, systems, and cultural and societal norms, have more to do with their health and survival than people's behaviors or the medical care they receive.

According to the Prevention Institute, "community engagement efforts that provide space for identifying root causes of inequities build trust and foster long term relationships" (Prevention Institute, 2018). CVAS members participated in a Root Cause Mapping (RCM) activity as a preliminary step to building the guiding framework. Often used in quality improvement, RCM (also called Root Cause Analysis), is a systematic process for identifying the "root causes" of a problem and finding an approach for responding to them as defined by stakeholders.

The question posed to the group during the RCM activity was: *Why do African Americans in Hennepin County experience high rates of infant mortality disparities?* CVAS conducted the RCM on two separate days to allow as many members as possible to participate. At the end of the RCM activity, CVAS members came to the conclusion that the root cause governing all root causes was racism. It is a separate determinant, but everything else could be traced to racism. The RCM exercise uncovered CVAS members' shared beliefs around the root causes of infant mortality in the community, and paved the way for the development of the SDOH Framework.

The SDOH framework that resulted from the RCM is shown in Appendix B-Attachment 2. It embodies CVAS's beliefs around how structural and intermediary factors give rise to African American infant mortality. Similar to the WHO model, the Systems/Policies and Socioeconomic Position comprise the structural determinants; Community Conditions, Individual Circumstances, and the Health System comprise the intermediary determinants; Social Cohesion and Social Capital bridge the two main determinants; finally, all these factors influence birth outcomes. The logical sequence can also continue in the opposite direction. For example, if babies fail to thrive then this impacts their circumstances later in life, and then their socioeconomic position.

The early version of the SDOH Framework was widely used in planning project activities. As use increased, CVAS members saw the need to simplify the graphic to increase its applicability with a more general audience. The simplified framework is shown in Appendix B-Attachment 3.

Appendix B contains more information about the WHO model, the RCM activity, and the SDOH Framework.

3. Creating a New Narrative

A narrative is the way a group of people frame a shared understanding of an idea, an event, or a phenomenon. It conveys core ideas, values and beliefs. In the project's case, it is the African American community's (represented by CVAS) shared understanding, rooted in their values and beliefs, of what creates health for African American babies.

There were several reasons for creating a narrative for the project.

- To inform the public about CVAS's core values and beliefs regarding the issue of African American infant mortality
- To promote a new way of thinking about African American infant mortality
- To build public understanding and public will to support actions addressing African American infant mortality through a health equity lens

The dominant narrative around Infant mortality is one that focuses on individual behavior. For example, pregnant women who get early and regular prenatal care and engage in health-promoting behavior will deliver a healthy baby. But these alone are not enough to achieve optimal health outcomes and reduce health inequities. There was a need to shift the public narrative around infant mortality from one that focused on the individual's genes, behavioral choices, and health care access to one that focused on the living and working conditions into which babies are born; that is, current and historical landscapes of policies, systems, and environments that create structural inequities and limit opportunities for health. We needed to move away from "What's wrong with the mother?" to "How can she and the baby be healthy?"

Project staff conducted a narrative training with CVAS. CVAS worked on the narrative over twelve months. The final product, approved in November 2018, is shown in Appendix C.

A narrative has many uses. It can be used in hiring decisions to create job descriptions and expectations. It can be used to design and evaluate projects, programs or initiatives or strategies, to determine how they might look like when viewed through the narrative frames. A

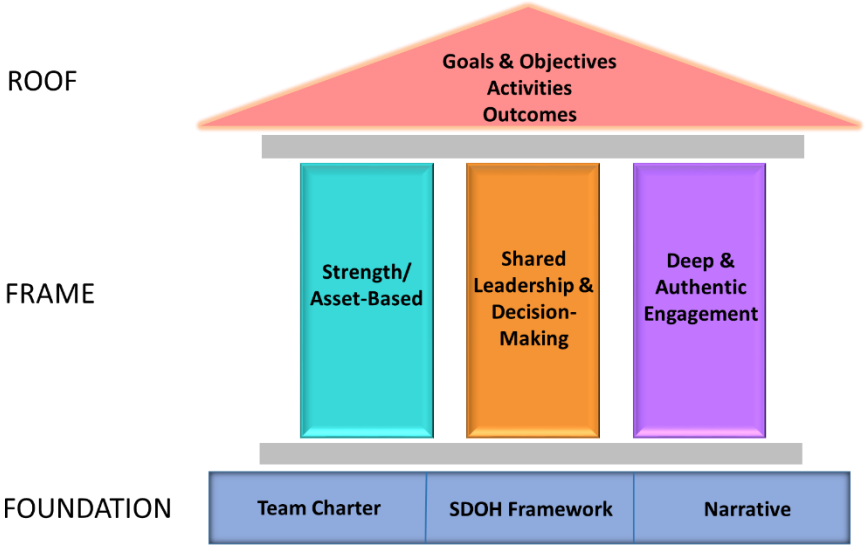
narrative can also guide policy or systems change decisions, as in: When one operates out of this narrative, how would the statement of need be written or how might the new policy look like? Lastly, the narrative can be used in advocacy. For example, to have conversations with funders regarding who, what, and how they fund; or, to discuss with agencies or institutions how conditions for families could be improved based on the narrative frames.

The project used the narrative to develop strategies for addressing African American infant mortality disparities and inequities, and it was used by the community co-learning participants to design their mini projects based on a chosen strategy (described in Section V).

IV. The CVAS House

Taken together, the project's components can be likened to a blueprint for a house (Figure 2).

Figure 2. Project blueprint



The team charter, SDOH framework, and narrative form the base or the foundation. It includes the team's vision, purpose and values. The three elements of CVAS, namely strength- or asset-based, shared leadership and decision-making, and deep and authentic engagement are the pillars that form the frame of the house. They characterize the actions that CVAS takes, which are intentional and bold because they lie on solid foundation. On the roof are the project goals, objectives, activities, and outcomes representing the results towards which all actions are directed. They envelope the project and protect it from going off-course.

V. CVAS Activities and Products

When the project brought a health equity lens into the issue of infant mortality, CVAS led the planning of, and took part in, a number of activities and events, as well as created several products that supported this approach. All the activities and products reflected their overall belief and vision that community must be a part of the solution, and that the solutions must

address the root causes of the problem, which necessitates change at the community, systems, and policy levels (the foundation). These guided their work throughout the five-year project.

The blueprint is reflected in the activities and events coordinated by CVAS:

1. Community co-learning: The goal of the Community Co-Learning was to deepen the community's understanding of the structural determinants of African American infant mortality, and to motivate participants to take action to change the policies and systems that perpetuate infant mortality rates and disparities. There were two rounds of co-learning, with two cohorts in each round. The 22 co-learning participants were community members with a passion for advocating for healthy babies in the community (three were CVAS members). They were community health workers (CHWs), doulas, social workers, health program administrators, moms, students, fathers and grandfathers. CVAS helped recruit participants and suggested topics and guest speakers. The cohorts attended education sessions where they learned about the social determinants of infant mortality, organizing for community power, and infant mortality programs around the country that have successfully used SDOH strategies; they brainstormed strategies targeting policy or systems change to address African American infant mortality; and from the strategies selected one that they implemented as a mini project. Co-learning participants implemented four mini projects.
2. Black Birth Summit: The idea to hold a Black Birth Summit (BBS) came from CVAS, after noting that there had been, and there were, numerous silo-*ed* efforts around black infant mortality. The BBS was held on September 17, 2019 with over a hundred attendees. The goal of the summit was to bring together community leaders and initiatives to connect, strengthen and amplify efforts around reducing African American infant mortality. CVAS designed the agenda for the event and led parts of it.
3. Restorative Talking Circle: The Restorative Talking Circle (RTC) was a follow-up to the BBS held on June 26, 2020. The purpose was to act on the suggestions and recommendations gathered at the summit, including providing a healing space for attendees to recognize the historical and intergenerational trauma that negatively impact how they go about their work at present. The RTC was held virtually due to COVID-19 restrictions. CVAS planned the agenda.

The blueprint is also reflected in products they created including:

1. Proposed Strategies for Addressing African American Infant Mortality: The list of 31 proposed strategies under nine issue areas resulted from brainstorming sessions in two rounds of community co-learning sessions held between September 2017 and March 2018. Participants targeted policies, systems and environments (PSE) that influenced the conditions for health (SDOH). In contrast to individual-level interventions, PSE changes in the conditions for health benefit the broader population, are more sustainable, and have longer lasting impacts. CVAS later provided input into the list of strategies.
2. Digital Stories: During the community co-learning sessions, several participants shared their personal experience with infant mortality and the part that health care systems and other institutions played in their story. CVAS and project staff felt it was important

to capture these stories so that they can serve as an education tool. Five stories were recorded, and the stories of three CVAS members are available on YouTube.

3. Co-learning documentary video: This 30-minute video documents the work of the community co-learning participants . It was created for two reasons: to determine the co-learning's impact on participants as part of the project evaluation, and to serve as an educational tool which was a recommendation of the 2013-2015 CVAS. The documentary addresses power imbalance as a root cause of health inequity. It aims to show that when power is handed over to community members, they can find solutions to a problem that impacts them disproportionately, create the change, and find success. It is undergoing final edits, and will be posted on YouTube upon completion.
4. Directories: Two directories were produced out of the BBS. The *Directory of African American Infant Mortality Efforts in Hennepin and Ramsey Counties* contains the names and contact information of individuals and groups in the two counties whose work touch on African American infant mortality. It is meant to serve as a starting point for them to connect with one another so they can marshal their collective strengths and resources to implement sustainable change. The *Directory of Black Birth Workers in Hennepin and Ramsey Counties* has the names and contact information of direct service providers who are either of African descent or work largely with people of African descent in these counties. The starting list was derived from the first directory, then CVAS and other partners added to it. The target end-user is any woman looking for a perinatal care provider who can deliver culturally competent care. Three organizations agreed to post the directories on their websites and to update them periodically: Integrated Care for High Risk Pregnancies (ICHRP), the Cultural Wellness Center, and the Minnesota Healing Justice Network.
5. Six-month Sustainability Plan: CVAS was the driving force behind the sustainability plan. They designed it for three reasons: to ensure that community voices continue to be part of future efforts to address African American infant mortality; to maintain the support of our stakeholders, most importantly the African American community, and leverage what has been accomplished by the project; and, to reiterate CHE's commitment to reducing inequities in African American birth outcomes.

V. Conclusions

This report described the community engagement model utilized in the project, the community leadership team CVAS, as well as the activities, events, and products developed under CVAS's leadership and guidance. What makes the model unique is that it required building a firm foundation on which to do the work. The three-part foundation included the team charter, guiding framework, and narrative. Together, they embody CVAS members' shared understanding of the African American infant mortality problem, its root causes, strategies that can be used to address it, and a vision of what is possible, all rooted in their common values. This is an often-neglected step in community engagement. In many instances community teams

are assembled and then get right to work; rarely do they take the time to ensure they gain a firm foothold beforehand. When individual members have different understandings, it makes it difficult to come to an agreement, to have a united front, and to make a strong impact.

With this foundation, and with a leadership team in CVAS that is asset/strength-based, with members sharing the leadership and decision-making responsibilities, and who are deeply and authentically engaged, much was accomplished in the project with the interests of the larger community always front and center. Co-learning participants successfully carried out four mini projects proving that they know the solutions to problems that directly affect them.

CVAS and co-learning participants gave positive feedback regarding their experience in the project. Based on data from two rounds of two surveys (Participant Survey and Network Development Survey), the majority said that they were genuinely engaged, they increased their knowledge of many infant mortality-related topics, enhanced their leadership skills, increased their participation in civic life, and strengthened their social and professional connections.

These assessments were confirmed by what CVAS members said in a reflection session at the end of the project. According to them, the most significant changes accomplished by the project were: forming new and deepening existing relationships, involving people from different sectors, being vocal and upfront about naming the root causes using the right language (health equity, systemic racism, race and ethnicity), using a community engagement model, building on strengths/assets while recognizing cultural traditions and history, putting community-based participatory research (CBPR) into action, and working on intentional and sustainable solutions.

Using CDC's definition of community engagement and its continuum (as referenced in the Introduction), it can be said that this project attained genuine community engagement at its highest level. That community engagement works was also demonstrated by the project's achievements. But it must stand on solid foundation and be supported with ample resources; efforts must be made to find the right people that have the passion for and commitment to the issues; and, there must be more trust and belief in communities most impacted by health inequities that they will find the right solutions.

Appendix A. CVAS Team Charter

(Approved March 21, 2017)

Purpose

The purpose of the Community Voices and Solutions (CVAS) is to provide leadership and guidance to the Minnesota Department of Health's (MDH) State Partnership Initiative Grant funded by the federal Office of Minority Health that is focused on reducing infant mortality disparities among U.S. born African American women living in Hennepin County. The community wisdom and expertise of CVAS members will inform the activities carried out by MDH and its partner organizations to create strategies and solutions to address the structural barriers that that lead to poor birth outcomes among the target population.

Approach

CVAS is a group of committed individuals representing various sectors that, using a shared leadership and decision making approach, works with MDH and its partners in utilizing a community engagement model that:

- Engages and activates the African American community in addressing the social determinants through a Health in All Policies approach to reduce the rate of infant mortality
- Builds, sustains and strengthens the community capacity to change key conditions contributing to health inequities
- Accesses and utilizes cultural assets and other available resources in community
- Includes behavioral health as part of the approach
- Supports and collaborates with the people that are doing the work in community and build on previous recommendations and work already done around African American infant mortality
- Includes fathers and young adults as community participants
- Sustainable and measurable activities that impacts infant mortality outcome

Goals

1. Ensure self-advocacy among community participants
2. Support and collaborate with the individuals and groups that are doing related infant mortality work
3. Review and seek opportunities to influence Hennepin County to change its policies that are detrimental to maternal and child health, and to implement policies that will improve key conditions for their health

Time Commitment

The CVAS commitment involves attending two-hour meetings every other month for 2017, after which we could move to quarterly meetings through the end of the project on July 31, 2020 depending on the work needed. MDH staff will ensure that meeting times and locations

best accommodate the majority of CVAS members' needs and availabilities, and will provide a conference call line if they are unable to join meetings in person.

CVAS members are expected to attend at least 75 percent of the scheduled meetings in person or by teleconference, or four out of the six meetings per year. If unable to attend in person or join by teleconference, a member may send a representative to the meeting and must inform MDH project staff of their intent to do so.

Responsibilities and Expectations

1. Attend regular meetings and following through on action items as needed
2. Provide input into the planning and implementation of various project activities
3. Review infant mortality recommendations from the Maternal and Child Health Section and other health equity materials as needed
4. Assist in recruiting community members to participate in co-learning sessions and focus groups
5. Advise on the development of the curriculum and assist in selecting speakers or contractors as needed for the co-learning sessions
6. Provide guidance to co-learning participants in the development of action plans for, and implementation of, their mini projects
7. Develop interventions and strategies for implementing the MDH statewide Infant Mortality Reduction Plan for the U.S. born African American population in Hennepin County
8. Assist in the development of data collection tools and methods
9. Review the project work plan, and evaluation plan, logic model and theory of change, and provide suggestions for improvement so that the documents are aligned with the goals of the project
10. Participate in the evaluation of the project

Decision Making

With the shared understanding that CVAS members are co-leading this project, in instances where CVAS has to make a decision, members will strive to reach agreement by consensus such that all members are willing to "live with" the proposed action. Members will strive to work expeditiously and avoid revising decisions once they are final.

Conflict Resolution

- Members will resolve issues within their power to resolve in a timely manner
- If it is necessary to redirect an issue to a larger group for resolution, CVAS will ensure the issue is resolved respectfully and the appropriate decision makers are at the table. If unable to have consensus, the co-chairs and project coordinator will make final decision.

Core Agreements

1. Everyone has a voice: practice active listening
2. Honor all voices: practice compassionate accountability and withhold judgment

3. Practice integrity be honest and put aside personal gain
4. Be transparent: share information and your own experiences to provide context, and share our work with others
5. Practice speaking up courageously, reach out to others
6. Embrace tension: practice addressing issues where there is not clear agreement; spend time ensuring everyone feels safe to discuss their point of view

Chair Responsibilities

1. Act as the liaison between project staff and CVAS members and serve as the primary contact for CVAS
2. Attend all CVAS bimonthly meetings *(time may be split with co-chair)*
3. Work with the Project Coordinator to plan meeting agendas and materials
4. Assist the Project Coordinator in monitoring the flow of meetings to ensure that all agenda items are covered, including prioritizing agenda items if time is running short
5. Bring to project staff's attention issues in the project that require consideration or decision
6. Provide counsel to the project staff on all aspects of decision-making
7. Assist project staff in identifying necessary tasks and reasonable timelines for completion
8. Be attentive to CVAS members' needs and concerns to ensure they remain valued and contributing members of the leadership team
9. Ensure CVAS members' satisfaction in the nature and extent of their participation
10. Ensure CVAS members carry out their responsibilities in a satisfactory manner
11. Represent CVAS in other infant mortality-focused advisory groups as needed

Appendix B. SDOH Framework for Addressing U.S.-Born African American Infant Mortality

Introduction

The Project

In 2015, the Center for Health Equity (CHE) at the Minnesota Department of Health (MDH) received a five-year grant from the Office of Minority Health, U.S. Department of Health and Human Services, under the State Partnership Initiative to Address Health Disparities program. The project, entitled *Addressing Infant Mortality and Developing a Health Profile on African American Mothers and their Infants Living in Hennepin County Using a Health Equity Analysis*, addressed the wide spectrum of factors that contribute to the high infant mortality rate among U.S.-born African Americans living in Hennepin County. Hennepin County has the largest concentration of African Americans in Minnesota, and African American babies in the county are three times more likely to die before their first birthday compared to white babies. The project acknowledged that differences in infant mortality rates could be explained by not only variations in maternal characteristics, behaviors, and access to health care, but also by social, economic and environmental conditions in which people live, work, and age. It utilized a community engagement model that brought together the perspectives and understandings of the community about the factors that create and sustain disparities, and activated it to create sustainable policy and systems changes.

Leading the project was Community Voices and Solutions (CVAS). CVAS members are from the African American community, represent various sectors, and have a strong passion for maternal and child health. CVAS created a Team Charter that spelled out the purpose of the team and the shared leadership and decision-making responsibilities. It also reflected members' values and vision for reducing the African American infant mortality rate.

The Need for a Guiding Framework

The project reached a critical juncture where concrete steps to address African American infant mortality had to be developed. A few questions lingered.

- A well-defined problem comes before solutions. How do we know we are addressing the root causes of the problem and not just treating the symptoms?
- Once we find these root causes, how do we address them? What policy levers can we use? What partnerships can we form?
- The community most impacted by the health inequities must be an active participant in the process of creating solutions and taking action. How do we ensure that everything we do reflects their beliefs, understandings, and lived experiences around the issue of African American infant mortality?

With CVAS and its charter firmly in place, the next steps were to develop a shared understanding of the infant mortality issue and its root causes, and to embody these in a framework that would guide future activities. The World Health Organization (WHO) conceptual framework for action on the social determinants of health (SDOH) served as basis for creating

the guiding framework of the project. The project's rationale, that the conditions for health play a significant role in infant mortality, informed the choice of the WHO model. The conditions in which African American babies are born, live, work, play, worship and age, and the forces that shape their daily lives such as policies, systems, and cultural and societal norms, have more to do with their health and survival than people's behaviors or the medical care they receive.

World Health Organization (WHO) Model

The WHO framework (Attachment 1) shows how social, economic and political mechanisms give rise to socioeconomic positions, which in turn shape specific determinants of people's health status that are reflective of their place within social hierarchies. Differences in social status leads to differences in exposure and vulnerability to health-compromising conditions.

In effect, it is saying that people are not randomly poor; rather, it is the institutions' policy decisions that create poverty for some groups and abundance for others.

The WHO framework categorizes health determinants into structural and intermediary. Bridging both areas are social cohesion and social capital.

- **Structural determinants** comprise the *socioeconomic and political contexts* in which a person is born and lives, which then dictate *socioeconomic position*.
- One's socioeconomic position sets the stage for the **intermediary determinants.** These are the *material circumstances* in which they find themselves (psychosocial, behavioral, or biological factors) and their interactions with the *health system*.
- Bridging the structural and intermediary determinants are **social cohesion and social capital**. Society can promote equity by developing systems that would facilitate cooperative relationships between the people and institutions that serve them.
- These three components influence one's **health and well-being**.

Illnesses can circle back to the structural determinants as shown by arrows going the opposite direction. For example, a person in a low wage job can only afford to live in a subpar housing that causes him to be ill, but a prolonged illness that led to loss of employment or income can also cause him to experience a lowering of his socioeconomic status.

To summarize, the WHO framework traces health inequities to these powerful forces that make up the socioeconomic and political contexts. It challenges public health to go into unfamiliar territory and to focus its efforts on policy changes that could have an impact on these factors.

Others have used the WHO model to create a conceptual framework for their infant mortality work, for example, Kim and Saada (2013).

Evolution Of The SDOH Framework

Root Cause Mapping

CVAS members participated in a Root Cause Mapping (RCM) activity as a preliminary step to building the guiding framework. Often used in quality improvement, RCM (also called Root Cause Analysis), is a systematic process for identifying the "root causes" of a problem and finding an approach for responding to them as defined by stakeholders.

The question posed to the group for the RCM activity was: **Why do African Americans in Hennepin County experience high rates of infant mortality disparities?** CVAS conducted the RCM on two separate days to allow as many members as possible to participate. In the first part of the activity, each person wrote a root cause on a sticky note, then went to the white board to post all their notes while explaining why they identified these as root causes. In the second part, CVAS members moved the sticky notes around in order to group root causes that were similar to each other. In the third and final step, they categorized the root causes based on the components of the WHO model.

Prior to the activity, the distinction between root cause and contributing factor was made clear to participants. Root causes are underlying process or system issues that led to the problem, and a problem can have several root causes. Contributing factors are not root causes, though two or more contributing factors can lead to the same root cause. The search for the root cause of a problem must continue even when contributing factors are found.

It is important to note that at the end of two days of RCM activity, CVAS members came to the conclusion that the root cause governing all root causes was *racism*. It is a separate structural determinant, but everything else boils down to racism.

The RCM exercise uncovered CVAS members' shared beliefs around the root causes of infant mortality in the community, and paved the way for the development of the SDOH Framework.

Resulting Framework

Attachment 2 shows the SDOH framework that resulted from the RCM activity. CVAS members discussed early drafts of the framework before approving the final version.

Similar to the WHO model, the Systems/Policies and Socioeconomic Position comprise the structural determinants; Community Conditions, Individual Circumstances, and the Health System comprise the intermediary determinants; Social Cohesion and Social Capital bridge the two main determinants; finally, all these factors influence birth outcomes. The logical sequence can also continue in the opposite direction. For example, if babies fail to thrive then this impacts their circumstances later in life, and then their socioeconomic position.

- The **Systems and Policies** include economic, social, public, and healthcare policies.
    - Economic policy issues identified by CVAS included redlining, capitalism, unequal resource distribution, and lack of funding. The county is still feeling the effects of decades of redlining practices by city planners, landlords, banks, and other

institutions that discriminated against residents on racial grounds. Residents have long suffered from the effects of capitalistic practices that valued private interests over the public good and channeled resources to the those holding the power. The community is caught in a vicious cycle in which discriminatory economic policies hinder development, which then acts as disincentive to invest resources that could improve the status of many.

  - The distribution of and access to resources also figure into the social policies that impact the well-being of African Americans in the county. CVAS specifically named labor policies that held back workforce development and fair wages, hiring policies that screen out black applicants, segregationist housing policies that have reduced access to safe and affordable housing, and gentrification that has led to neighborhood flight.
  - African American health has suffered from the effects of public policies that enable mass incarceration and the school-to-prison pipeline, and poor insurance coverage for care at African American-centered birth and wellness centers, including support from African American doulas and Community Health Workers.
  - The community has to lean more on cultural and societal norms and values that have served it well in the past. With urbanization comes cultural shifts and disconnect. No longer can one easily strike up a conversation with the neighborhood doctor, mailman, fireman, or policeman around the corner. The wisdom of elders and spiritual guidance from churches go untapped. These are the cultural assets that make the community healthier. (see also Social Cohesion and Social Capital)
  - Health-related policies named by CVAS include those that reduce access to care (insurance), the limited health education received by secondary and post-secondary students or education in medical schools that fail to acknowledge the role of structural racism and historical trauma in health inequities, and the lack of African Americans in the health care workforce.

- Experiences of racism, discrimination and community disempowerment dictate the **socioeconomic position** in society.
- The intermediary determinants include living and working conditions in the community, individual circumstances, and the health system.
  - **Community conditions** that African Americans are faced with include: crime, police brutality, lack of access to exercise, lack of neighborhood amenities, food insecurity, poverty, and short-term unsustainable programs.
  - **Individual circumstances** that impact birth outcomes include behaviors such as substance use or unhealthy eating, genetics, stress that leads to poor mental and emotional health, effects of adverse childhood experiences that carry well into adulthood, and low health literacy (capacity to obtain, process, and understand health information).

  - The **health system** as a social determinant encompasses:
    - Lack of or no access to health care
    - Lack of health education or complexities in the system that make it difficult to learn (e.g., health insurance materials that are inches thick can be very daunting to go through)
    - Sordid racist history with the health care system including medical experiments
    - Lack of culturally congruent care, with African American women not always given or having the choice of an African American health care provider

- Due to the lack of trust in the health care system, the values, beliefs, and attitudes that govern interactions between the system and the community are miles apart for these two entities. Additionally, because the supposed benefits from existing policies evade African Americans, these lead to segregation, social isolation, a diminished faith community, lack of adult mentors, unhealthy relationships, and no or lack of family support. As a result, **social cohesion and social capital** are low, minimizing their potential to improve community conditions and individual circumstances.

African American women's exposure to common protective and risk factors during their pregnancy are well-documented. But even when these are accounted for, there is still a racial gap in infant mortality that could not be explained. In the early 2000s the **life course perspective** began to offer an alternative explanation to the racial and ethnic disparities in birth outcomes.[1] It suggests that birth outcomes are the product of not only the mother's nine months of pregnancy, but also of her entire life course before the pregnancy. Events or factors experienced throughout the lifespan can shape the health trajectory of both mother and child. Differences in those experiences, therefore, lead to disparities in birth outcomes. The life course model as it relates to African American birth outcomes is depicted in the SDOH framework in Attachment 2 by the images showing progression from baby to adult.

Finally, as mentioned earlier, CVAS members firmly believed that one factor underlying all other factors is **racism**, both historical and present-day racism. Racism as the root cause is depicted in Attachment 2 at the bottom with an earthen ground backdrop.

Final Framework

The early version of the SDOH Framework was widely used in planning project activities. As use increased, CVAS members saw the need to simplify the graphic to increase its applicability with a more general audience. Attachment 3 shows the simplified SDOH Framework.

A fruit tree model was chosen because it was important to show that racism was at the very root of all the systemic factors influencing African American infant mortality.

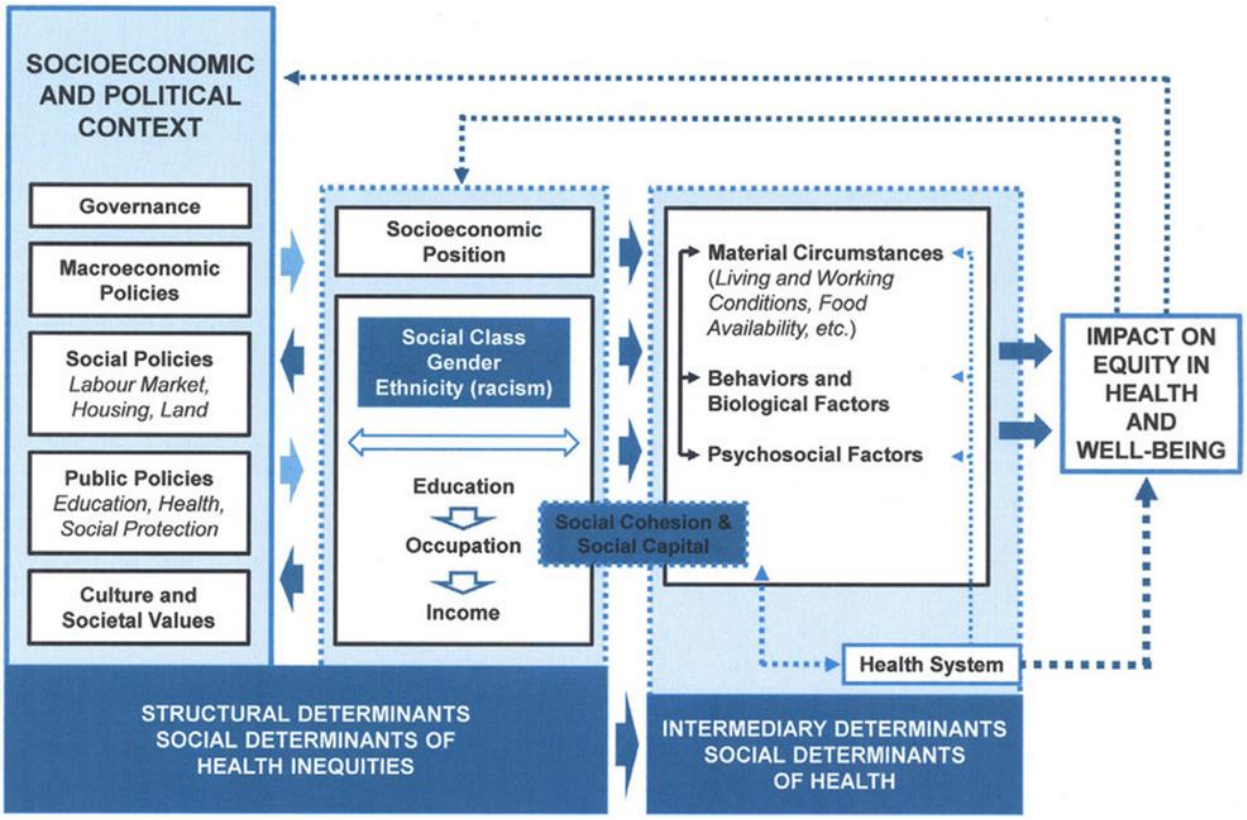
[1] Lu MC, Halfon N. Racial and ethnic disparities in birth outcomes: a life-course perspective. Maternal and Child Health Journal. 2003 Mar;7(1):13-30.

- Racism is at the tree roots in the ground.
- Nestled in the four main branches are the four components Systems and Policies, Socioeconomic Position, Living and Working Conditions, and Health System.
- The Structural and Intermediary Determinants are not as distinctly represented. However, in a similar way that the earlier version in Attachment 2 showed arrows going to the right and then circling back, the same effect can be represented by the flow of water and nutrients throughout the tree. While the movement of water is unidirectional (roots to trunks to stems to leaves to air), nutrients move up and down so they can be where they are needed. For example, down below if the tree needs to grow new roots, or up above when a fruit is developing on one of the branches.
- Social Capital as a bridging factor straddles the main branches.
- The fruit represents infant mortality as the outcome of the biological process.
- The different stages of growth, from seed to sapling to young tree to mature tree, represent the life course perspective.

Use Of The Framework

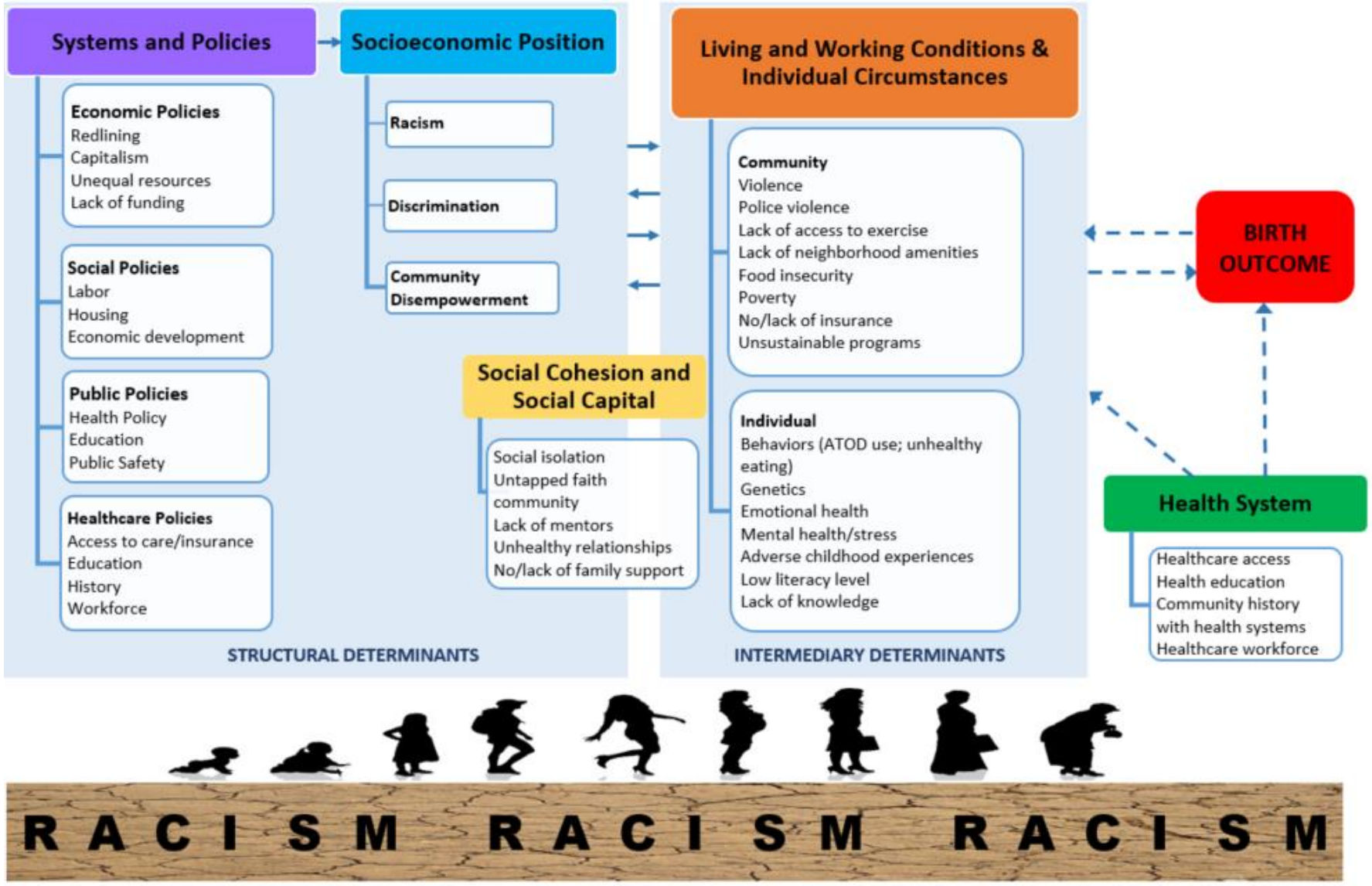
The SDOH framework embodies CVAS's beliefs around how structural and intermediary factors give rise to African American infant mortality. It served as the foundation of work in the project, guiding the design of activities and content of documents. Activities included the design of the community co-learning curriculum, development of the African American Infant Mortality Narrative, planning of the Black Birth Summit and follow-up event Restorative Talking Circle, development of proposed strategies to address African American infant mortality, and creation of a sustainability plan. CVAS is proud to say they are all consistent with the guiding framework.

Attachment 1: WHO Framework for Action on the SDOH

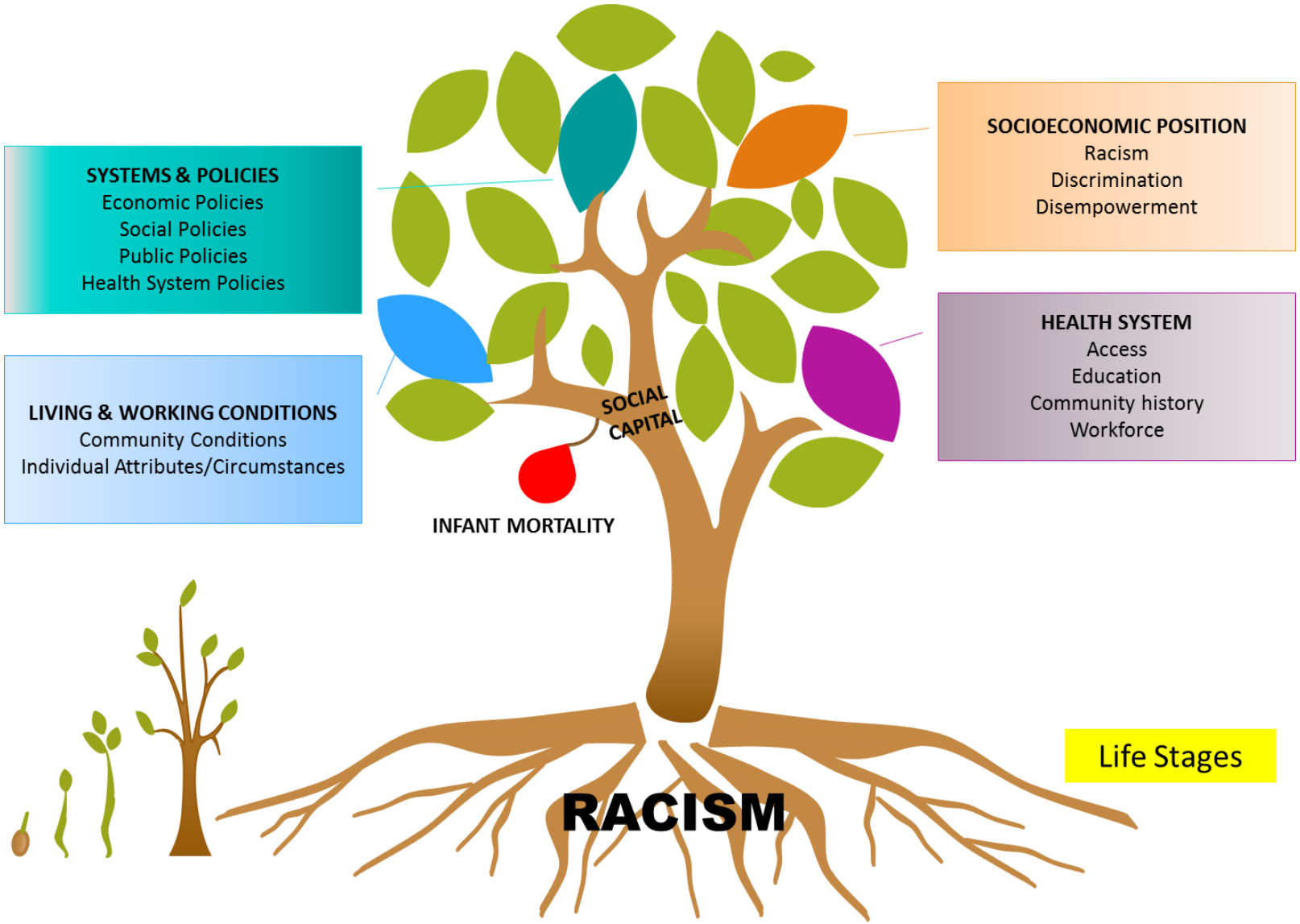


Source: Solar O, Irwin A. (2010). A conceptual framework for action on the social determinants of health. Social Determinants of Health Discussion Paper 2 (Policy and Practice). Geneva; World Health Organization.

Attachment 2: Project's SDOH Framework Based on WHO Model



Attachment 3: Simplified SDOH Framework



Appendix C. African American Infant Mortality Narrative

The Community Voices and Solutions Leadership (CVAS) team developed these narrative frames as part of the U.S.-Born African American Infant Mortality project. They embody CVAS's core values and beliefs regarding African American infant mortality in Minnesota. The narrative frames were developed primarily to help expand and improve policy conversations around infant mortality in African American families, to ensure that all efforts to address the issue are comprehensive and cultural appropriate. The narratives provide the foundation for messaging and for creating meaningful language for public discourse and future work in infant mortality.

1. **African American families have a clear understanding of their lived experience and this experience can inform solutions.**

    a. The unique history and trauma experienced by African Americans because of slavery and enduring racism means that trauma-informed and integrated holistic care are necessary to ensure healthy African American babies.

    b. African American families and communities have lived with inequitable social, economic and environmental conditions for generations. Addressing these conditions and the policies that shape them, including housing, employment, transportation, education, and more is essential for assuring that African American children can realize their full health potential.

2. **All African American children in every family deserve to have a healthy start, thrive, survive and develop to their fullest potential to become successful adults**

    a. For a healthy start and healthy life, African Americans families will have equitable economic and environmental conditions and opportunities as well as access to positive healthcare which includes medical, dental, mental and spiritual care prior to and especially during pregnancy.

    b. Promoting and supporting policies that contribute to healthy outcomes, such as good nutrition, is critical during a woman's reproductive years for a healthy pregnancy and intricately connected to her own maternal health and to positive birth outcomes.

3. **Harnessing the assets and strengths of African American families and communities is key to successfully reducing infant mortality. Our community knows and can identify cultural practices, community institutions, support systems, and other important community resources that are beneficial to them.**

    a. Programs, institutions, and community members will make decisions based on strengthening and amplifying community assets. In so doing, we create solutions that will work for our community.

b. We need to harness African American historical and cultural knowledge and experience with positive parenting.

c. African American men and fathers will be recognized and included in all efforts to support mothers and assure children have a healthy start.

4. **Fundamentally, people know what is important for their own health.**

   a. To create the best solutions possible, we need to affirm and harness the wisdom of our own community.

   b. To ensure their voices are heard, institutions, service providers, and policy makers will listen to and partner with African American families, when they identify or share that something is wrong.

   c. Traditional and cultural forms of support and practices will be encouraged in every system as preferred birth support; midwives, and paraprofessionals (perinatal educators, doulas, birth attendants, CHW, and peer support specialist).

5. **All families look different and can be, made up of many different biological and non-biological connections. People are free to define and identify which people they consider as part of their family.**

   a. A community strength-based and family-centered approach will involve fathers and other family members (however these are defined) to encourage and strengthen social connectedness.

6. **Communities are the best messengers of their own story. Our stories of suffering and endurance give us a sense of belonging and create hope for the future.**

   a. We will work with African American elders and other community members to preserve the stories about what our people have done to support healthy births, and to provide avenues for these stories to be shared, with others in our own communities.

7. **To ensure healthy African American infants, the city, county, and state policy makers and community have a role and responsibilities to create and enforce policies that will achieve this goal.**

   a. A commitment to implement policies that promote systemic change will be required of policy makers at all levels of government to ensure barriers to reproductive justice are removed and infant and maternal health are improved.

8. **Regardless of race, faith tradition, economic status, or social status, African American families deserve to experience and are entitled to experience comprehensive and quality care.**

9. **Advocacy, training, guidance and support are critical in the vision for creating a path for changes in practices, policies, systems and the environment for healthy outcomes in infant and maternal health.**