ISSUE BRIEF

Black Infant Health Intervention

JANUARY 2016

The Black Infant Health Program (BIH) has evolved since its inception in 1989 when the intervention was narrowly focused on ensuring that women received prenatal care. Today, the program is moving forward with an intervention strategy emphasizing social support, stress reduction and empowerment. This report provides an overview of the BIH implementation.

BIH INTERVENTION PURPOSE & RATIONALE

African-American mothers and babies continue to face challenges to their optimal health and well-being. The California Black Infant Health (BIH) program is intended to address the problem of poor birth outcomes and health disparities that affect African-American women and their babies. BIH aims to improve health among African-American mothers and babies and to reduce the Black:White disparities in maternal and infant health by helping women become empowered to make healthy choices for themselves, their families and their communities.

Intervention Summary

Within a culturally affirming environment and honoring the unique history of African-American women, the BIH program uses a group-based approach with complementary participant-centered case management to help pregnant and parenting women develop life skills, set and attain health goals, learn strategies for managing stress and build social support. Each BIH participant attends weekly group sessions and works individually with BIH staff to set and make progress toward meeting personal goals, to connect with other community and social services to meet her needs, and to develop a longer-term life plan that can guide her continued progress after BIH.

Scientific Rationale

The health of African-American mothers and infants can be improved and health disparities reduced through an empowerment-based approach that focuses on strengthening life skills, building resilience, reducing/managing stress, and promoting healthy behaviors and relationships to help women create healthier lives for themselves and their children.[1,2,3]

Addressing stress among African-American women — including stress due to experiences of racial discrimination, trans-generational poverty, and associated powerlessness and lack of self-esteem — is crucial to reducing the Black:White disparities in maternal and infant health. When Black women become empowered with skills to help them manage and reduce stress in their lives, they are more likely to be healthy, have healthy babies, and raise healthy children.[4,5] Having more social support can also help them and their families become healthier, in part by buffering the health-harming effects of stress and by increasing access to health-promoting resources.[6,7,8]

The BIH intervention builds on the following evidence-informed assumptions:

- Group approaches are more effective than one-on-one approaches in accomplishing behavior change
- Most pregnant African-American women can participate in and benefit from groups when those groups are accessible, and effectively and enthusiastically facilitated

GOVERNING CONCEPTS

- **Culturally relevant:** Providing culturally relevant information that honors the unique history and traditions of people of African descent
- **Participant-centered:** Placing the participants' own needs, values, priorities and goals at the core of every interaction and activity
- **Strength-based:** Building on each woman's strengths by empowering her to make healthy decisions
- **Cognitive skill-building:** Encouraging each woman to think differently about her behaviors and to act on what she has learned

PROGRAM OUTCOMES & IMPACTS

Shorter-Term Outcomes

Participant Outcome	Outcome Measure
Improved ability to set and make progress toward meeting personal goals	Goal setting, confidence in goal achievement, and progress toward stated goal(s) in the areas of health, relationships, and finances
Improved ability to manage stress	Change relative to baseline in self-reported use of stress management techniques
Improved social support	Change relative to baseline in (a) self-reported emotional and practical support and (b) Social Provisions Scale (Cutrona, C.E. & Russell, D. 1987)
Increased mastery	Change relative to baseline in Pearlin Mastery Scale (Pearlin, L. & Schooler, C. 1978)
Increased self-esteem	Change relative to baseline in Rosenberg's Self-esteem Scale(Rosenberg, 1965)
Increased resiliency	Change relative to baseline in Brief Resiliency Scale (Smith et al. 2008)
Healthier eating and decreased cigarette smoking	Changes relative to baseline in fruit and vegetable intake; consumption of sugary beverages; fast food consumption; compliance with recommended use of multivitamin with folate; and cigarette smoking among women who smoke
Increase health knowledge	Change relative to baseline in knowledge about appropriate timing of delivery, infant sleep practices, and shaken baby syndrome
Greater physical activity	Change relative to baseline in reported level of physical activity
Increased breastfeeding	Self-reported breastfeeding initiation and duration, relative to initial intent

Longer-Term Impacts

Impact	Impact Measure
Increased proportion of term deliveries among African American women	Proportion of live births to BIH participants that occur at or after 39 completed weeks of gestation, relative to (a) other African American women who have not participated in BIH and (b) white women
Increased proportion of normal birth weight deliveries among African American women	Proportion of singleton live births to BIH participants with birth weighs between 2500 and 4000 grams for singleton deliveries, relative to (a) other African American women who have not participated in BIH and (b) white women

REFERENCES

1 Rising S. Centering Pregnancy: An interdisciplinary model of empowerment. Journal of Nurse Midwifery 1998; 43(1):46-54.

2 Wallerstein N. Powerlessness, empowerment, and health: implications for health promotion programs. Am J Health Promot 1992;6(3):197-205.

3 Wallerstein N. Empowerment to reduce health disparities. Scand J Public Health 2002;30:72-77.

4 Ickovics J. Group prenatal care and perinatal outcomes. Obstetrics & Gynecology 2007;110(2 Pt 1): 330-339.

5 Braveman P, Egerter S, Barclay C. Issue Brief 3: Stress and Health. Princeton, NJ: Robert Wood Johnson Foundation 2011.

6 Giesbrecht G, Poole J, Letourneau N, Campbell T, Kaplan B. The buffering effect of social support on hypothalamic-pituitary-adrenal axis function during pregnancy. Psychosom Med 2013;75(9):856-62.

7 Orr S. Social support and pregnancy outcome: a review of literature. Clinical Obstetrics and Gynecology 2004;47(4):842-855.

8 Berkman LF. The role of social relations in health promotion. Psychosom Med 1995;57:245-254.

California Department of Public Health

1615 Capitol Avenue
Building 173
Sacramento, CA 95814
916 650 0300
BlackInfantHealth@cdph.ca.gov