A-Kins Newsletter 2019

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A-KINS ANALYSTS AND PROJECT MANAGERS

Mission:

To build a network of international workforce, mobilizing communities to be self-sufficient, executing effective and efficient assessments, feasibility studies, and implementing projects for the complete physical, mental and social wellbeing of all.
–Optimal Wellbeing.

What do we do?

A-Kins Analysts and Project Managers, a minority woman owned community based small business, is a specialty provider of Health Consulting Services including:

- Health Care Advisory & Support Services
- Health Care Strategic Plans/Project Management
- Business Plan Development/Financial Resource Planning/Analysis

…….Health Care Systems Development; Research; Analytics; and community based social determinants of health -Economics

"Successfully implementing challenging projects in challenging places"

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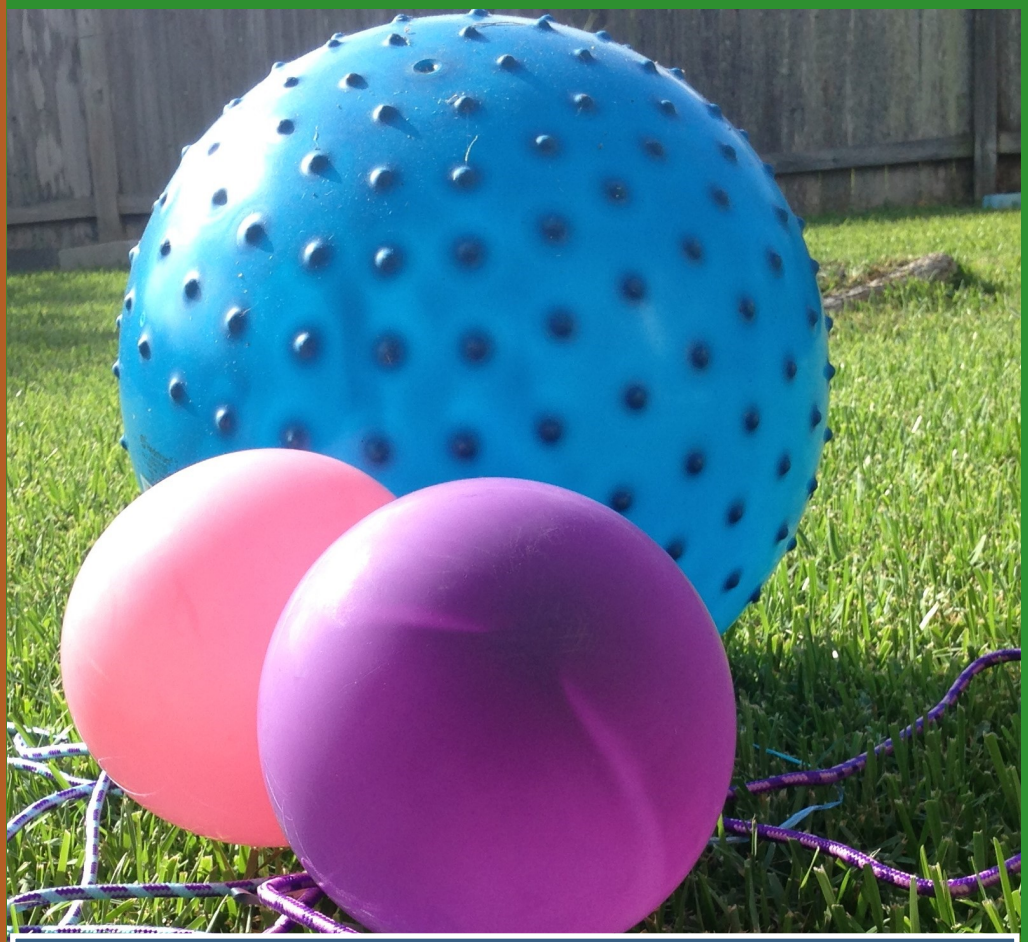

US: MATERNAL AND CHILD HEALTH

US –Health Care in Reform……continued

US Health Care in Reform

Maternal and Child Health Care Status

The United States of America (US) spends 17.1% of its GDP -Gross Domestic Product on Health. US is second (2nd) only to the Marshal Islands, out of 192 nations (2014) in the world. In order to be accountable, US has set up various departments and agencies, and with meaningful use of data available, one can track the progress of health outcomes in US. For US maternal and child health -MCH purposes, this newsletter has been created as a part of accountability review by citizens of the United States of America. That is, accountability - *by the people, for the people!*

US ranks 139th out of 184 countries in the world in Maternal Mortality, at a rate of 14 deaths per 100,000 live births (2015). **That is, for every random selection of 200,000 US live birth population, 28 mothers die from causes related to or aggravated by pregnancy or its management, excluding accidental or incidental causes**. These are deaths during pregnancy, child birth, or within 42 days of termination of pregnancy, irrespective of duration and site of the pregnancy, for a specific year.

US ranks 170th out of 224 countries in the world in Infant Mortality, at a rate of 5.7 deaths per 1,000 live births (2018). **That is, for every random 200,000 US live birth population, 1,140 children under the age of one die.**

US, though one nation, is made up of peoples from all over the world, who arrived via ship in waters, land, or by air in planes, to join the American Indian/ Alaskan Natives in the land. Each population brings its own cultural background, food, believes and ways to the land. This makes America the most diverse country in the free world. This is the heritage Americans are all so proud being a part of. This is our American Dream, where all men and women are created equal and are promised equal freedom, liberty and justice. Health Care Systems we have created are however yet to embrace this heritage of diversity in an equal/ equitable manner. There are different genes that come to play in healthcare diversity. The peoples of US are exposed to the same kinds of environment, yet manifest into different phenotypical" out-show" of what dwells within, diversity in health outcomes.

In order to explain the lack of equality/equity among US maternal and child health population health outcomes, one must explore the various hypothesis that may explain the unusual increase in maternal and infant death among different races/ ethnicities. **Imagine a table set for US peoples, with chefs employed to cook nutritious meals, and invitations to dinner sent out to all US maternal and child health population, by the government. What happens at the dinner table?**

US Health Care in Reform

Maternal and Child Health Care Status

Hypothesis #1 Equality

In health care, one knows that genes are not dished-out in an equal fashion, but that the makeup of genes are based on evolutional needs of our varied ancestors and their environments. The only thing "Man" has control over, when it comes to the out-show of genes phenotype, is the environment. If all peoples of US are brought to the dinner table and are exposed to the same "environment" i.e. a meal for instance, the various out-show of the effect of the food in the same environment to each of the peoples of US brought to the table would be different. Hence, the health outcomes for each of the peoples at the table will be far-from-expected, even though the environment has been "controlled by man".

All things being equal and held at equal standard assumptions, the US government has tried to bring all US peoples to the dinner table, and the healthcare dinner has been served. For those who have, they are given a right to buy extra nutrients, as this is a capitalist nation. For those who do not have much, a balanced diet is placed at the table -equally, for all at the table who are eligible to be helped to the table –equity, Medicaid/Children's Health Insurance Program -CHIP and Maternal and Child Health Block Grant -Title V. Even though the table has been set and dinner has been served, one needs to remember that some people are still not able to get to the dinner table and others cannot meet eligibility for the nutritious meal served. Others who are eligible cannot afford what it takes to be dressed for dinner –co-pay. In this light, US has provided various poverty scales to help those who are eligible to access healthcare, expecting a good health outcome in those who herness these nutritious provisions. Those who cannot afford the co-pay too, also decide not to show up for dinner. Others just never got the invite and so never showed up. Even though there is a dinner table and nutritious food has been provided, the measures of the health outcome of the maternal and child health peoples in US is still found wanting. In light of this, "EQUALITY OF THE OFFERING" is in question, since each of the peoples not only have varying genes, but also have varying dietary needs, and are found to thrive in varying environments.

Hypothesis #2 Equity

All things being equable and held at equal standard assumptions, assuming US recognizes that its peoples are diverse in culture, ways and believes; there is however still unexplained alarming disparity in health outcomes.

Taking a look at the equality, "Man Controlled Environment" at the Dinner table, Equal meals with Equal nutrition have been offered without adequate research about the US peoples at the table; so, the right amount of the right nutrition is prepared for each of the US Peoples at the table, according to a predictable genetic phenotypic outcome formula based on genetic predisposition and the right dinning environmental situation for predictable expected good healthcare outcomes.

US Health Care in Reform

Maternal and Child Health Care Status

These predictable favorable outcomes come with "RESEARCH and COMMUNITY ENGAGEMENT" to understand the right controlled environment for thriving to take place.

Hypothesis #3

Equality Versus Equity in the measure of Disparity by Natural Migration and Un-natural Settlements. If we measure the expected US Maternal and Child Health Outcomes based on the number of migrants from various parts of the world; we expect the number of US maternal and infant deaths to mirror the number peoples and percentage of migrants from various parts of the world. In this case, those of European origin, who comprise 61% of the US population, should in fact have the most amount of maternal and infant deaths. This is however not the case. **Randomly selecting 200,000 US live birth population, based on the race and ethnicity and percentage of total US migration distribution from all over the world; a measure of the MCH health outcomes shows, the expected number of maternal and infant deaths and the actual number of deaths do not correlate** (see table 1. below).

1. US Race/Ethnicity Distribution	Expected Number of Maternal Deaths by Race/Ethnicity Distribution (2015)	Expected Number of Infant Deaths by Race/Ethnicity Distribution (2018)
US American Indian/Alaskan Native Race/Ethnicity Population **1%** Distribution	0	15
US African American Race/Ethnicity Population **14%** Distribution	4	159
US Hispanic Race/Ethnicity Population **18%** Distribution	5	206
US Native Hawaiian/Asian Pacific Islander Race/Ethnicity Population **0.2%** Distribution	0	2
US White Race/Ethnicity Population **61%** Distribution	17	691
US Asian/Other Pacific Islander Race/Ethnicity Population **6%** Distribution	2	66
Total US Population 100% Distribution	**28**	**1140**

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If we decide to control for percentage (%) of immigrants from all nations (above), we take an equal amount of each of the race populations. By taking an equal amount of population of peoples by race/ethnicity i.e. 200,000 people from each race/ethnicity and measure the health outcomes of those who get to the table and eat, the healthcare outcomes are still not equal or equitable.

Randomly selecting 200,000 US live birth population from each of the US race and ethnicity distribution, irrespective of the percentage of the migrant US population; a measure the MCH health outcomes show, the expected number of maternal and infant deaths and the actual number of deaths do not correlate (see table 2. below).

In fact, the stratification by race introduces the greatest difference between expected and actual outcomes in deaths. It is then clear that equality and equity do not exist when it comes to the distribution of maternal and child healthcare outcomes in US.

In medicine, one does not manage people like cans of tomato on a con-

2. US Equal Distribution of Race/Ethnicity MCH Population Live Births	Actual Number of Maternal Deaths by Equal Race/Ethnicity Distribution (2007-2016)	Actual Number of Infant Deaths by Equal Race/ Ethnicity Distribution (2007-2016)
US American Indian/Alaskan Native **200,000 Equal** MCH Population of Live Births (...and Mothers)	3 (Rate =1.5)	1,762 (Rate =8.8)
US African American **200,000 Equal** MCH Population of Live Births (...and Mothers)	3 (Rate =1.5)	2,242 (Rate =11.2)
US Hispanic **200,000 Equal** MCH Population of Live Births (...and Mothers)	2 (Rate =0.9)	940 (Rate =4.7)
US Native Hawaiian/Asian Pacific Islander **200,000 Equal** MCH Population of Live Births (...and Mothers)	1 (Rate =0.5)	1,340 (Rate =6.7)
US White **200,000 Equal** MCH Population of Live Births (...and Mothers)	1 (Rate =0.5)	974 (Rate =4.9)
US Asian/Other Pacific Islander **200,000 Equal** MCH Population of Live Births (...and Mothers)	1 (Rate =0.5)	766 (Rate =3.8)
Total US Population 100% Distribution	**2 (Rate =0.8)**	**1,174 (Rate =5.9)**

US Health Care in Reform

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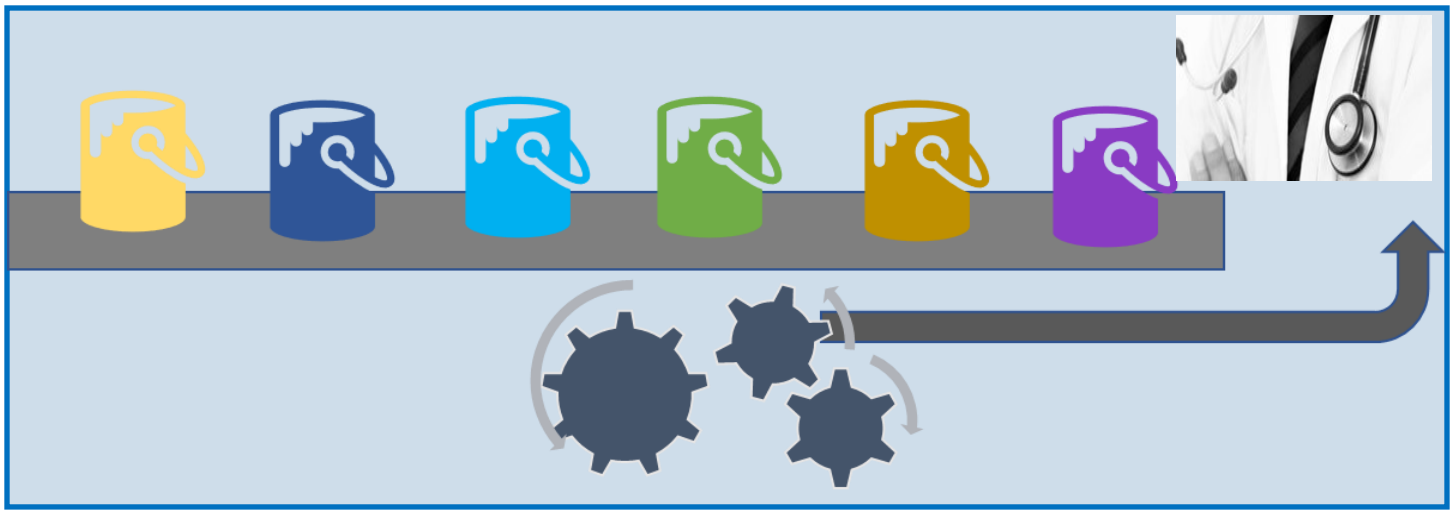
veyor belt. Each individual race is a tin can of tomato- mixing-of-genes that would taste and cook differently. Each is treated in a different way based on its genetic content. Although we all have genes, the gene mixing phenotypic "out-shows" are different. Hence, you have different products at the end of the line. Different healthcare needs and different health outcomes, no matter the equal and equitable treatment on the conveyor belt. Hence, Business mastery, does not literally translate in health care systems into good measurable health outcomes.

If we now decide to go where the races migrate to and see how they form a community, taking care of each other *-in numbers*, we look for the 4th quartile of each race/ethnicity population in census data, and follow the highest amount of migration/settlement by race/ethnicity to various states, we find that similar races migrate to the same areas on the US map.

Randomly selecting 200,000 US live birth population for each race/ethnicity, by state, based on the natural 4th quartile migration/settlements of the highest number of the same races, in maps; a measure the MCH health outcomes show, the expected number of maternal and infant deaths and the actual number of deaths do not correlate. In fact, the health outcomes are worse for populations at risk i.e. American Indian/Alaskan Natives and African American/Blacks living and settling in the same high population areas. This migrant/settlement population distribution however works with positive outcomes for Hispanic, Hawaiian/Pacific Islanders, White, and Asian peoples of US (see table 3. above).

So, what is missing at the funds table? US maternal and child health population's attempt on equality and equity? Information on minority race/ethnicity nutrition needs, based on genetic predisposition and environments for favorable health outcomes? This information needs to be researched and handed over to the chefs'



US Health Care in Reform

Maternal and Child Health Care Status

3. US Race/Ethnicity Natural Migration/Settlements	US Migratory States by Race/Ethnicity	Actual Maternal Death Per 200,000 Live Births (1999-2016)	Actual Infant Deaths Per 200,000 Live Births (2007-2016)
US American Indian/Alaskan Native (States/Communities with >1.7%-15.3% White Population)	Alaska; Oregon; Montana; Wyoming; North Dakota, South Dakota; Oklahoma	6 (Rate =3.0)	2,000 (Rate =10)
US African American (States/Communities with >17.7%-47.1% White Population)	Louisiana; Mississippi; Alabama; George; South Carolina; North Carolina; Virginia; Maryland Delaware	3 (Rate =1.5)	2,400 (Rate =12)
US Hispanic (States/Communities with >17.3%-99% White Population)	California; Nevada; Arizona; Utah; New Mexico; Colorado; Texas; Florida; New Jersey; New York; New Hampshire	2 (Rate =0.9)	1000 (Rate =5)
US Native Hawaiian/ Asian Pacific Islander (States/Communities with >9%-12% White Population)	Hawaii; West Virginia; New Hampshire; Vermont; Maine	1 (Rate =0.6)	1,000 (Rate =5)
US White (States/Communities with >82%-93.3% White Population)	Montana; Wyoming; North Dakota, South Dakota; Iowa; Kentucky; Virginia; New Hampshire; Vermont; Maine	1 (Rate =0.5)	1,000 (Rate =5)
US Asian/Other Pacific Islander (States/Communities with >5.7%-37.8%White Population)	California; Nevada; Washington; New York; West Virginia; New Jersey; Connecticut; Massachusetts	1 (Rate =0.5)	800 (Rate =4)

US Health Care in Reform

Maternal and Child Health Care System Funding

creating the menu, while working with each race/ethnic community. This should be performed before the table is set, and all are invited to partake equally. This is the only form of true equality/equity.

Equality is all being given the same dinner at the table.

Systemic Systematic Bias: is thinking "equal nutrition" at the table, means "equal health outcomes ".

Institutional Bias: is the closed-minded chefs who do not want to research or be informed of the nutritional needs and restrictions of each race/ethnicity at the table.

Social Bias: Others at the table feeling dissatisfied with the feeding

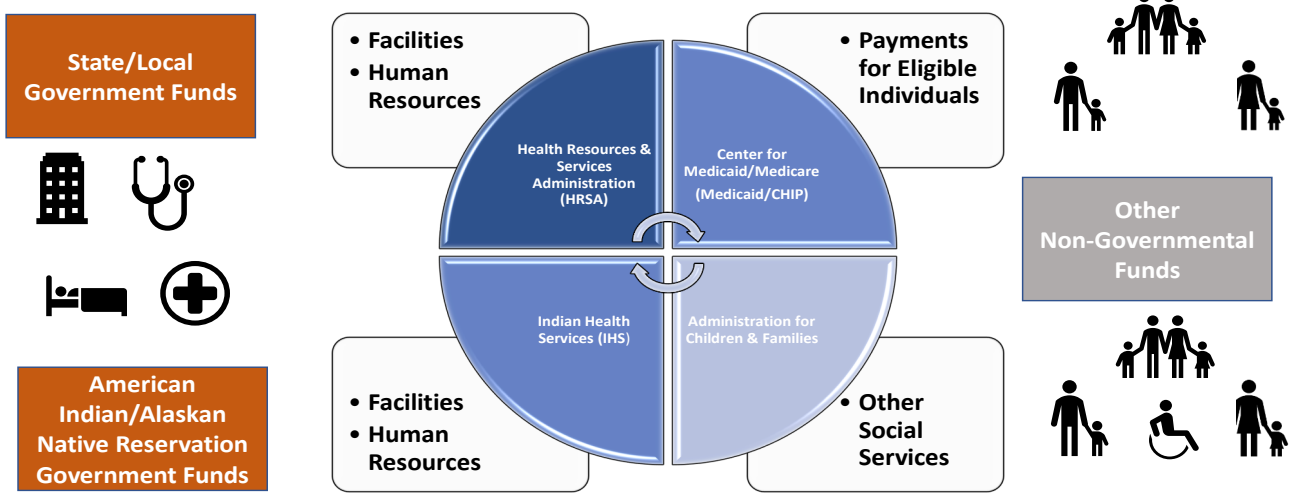
Equity is all being invited to the table and helped to get to the dinner table.

capabilities of different races/ethnicity at the table.

Inclusion/Omission Bias: Who was invited to the table? Who got the invitation, and Who came to partake of the dinner?.....and Why/Why Not? These are questions to be researched and answered for more inclusiveness.

Design Bias: The MCH funds were created to meet certain needs, just like the dinner table and the meals were created to meet the right nutrition needs to "effect a positive Maternal and Child Health Outcome". The question to ask is "Which Race/Ethnicity was the meal design and the outcome create around?". i.e. Nutrition design for one race /ethnicity may not meet the nutrition needs of another race/

US Maternal and Child Health Population Fund



US Health Care in Reform

Maternal and Child Health Care System Funds

.....Where we are.

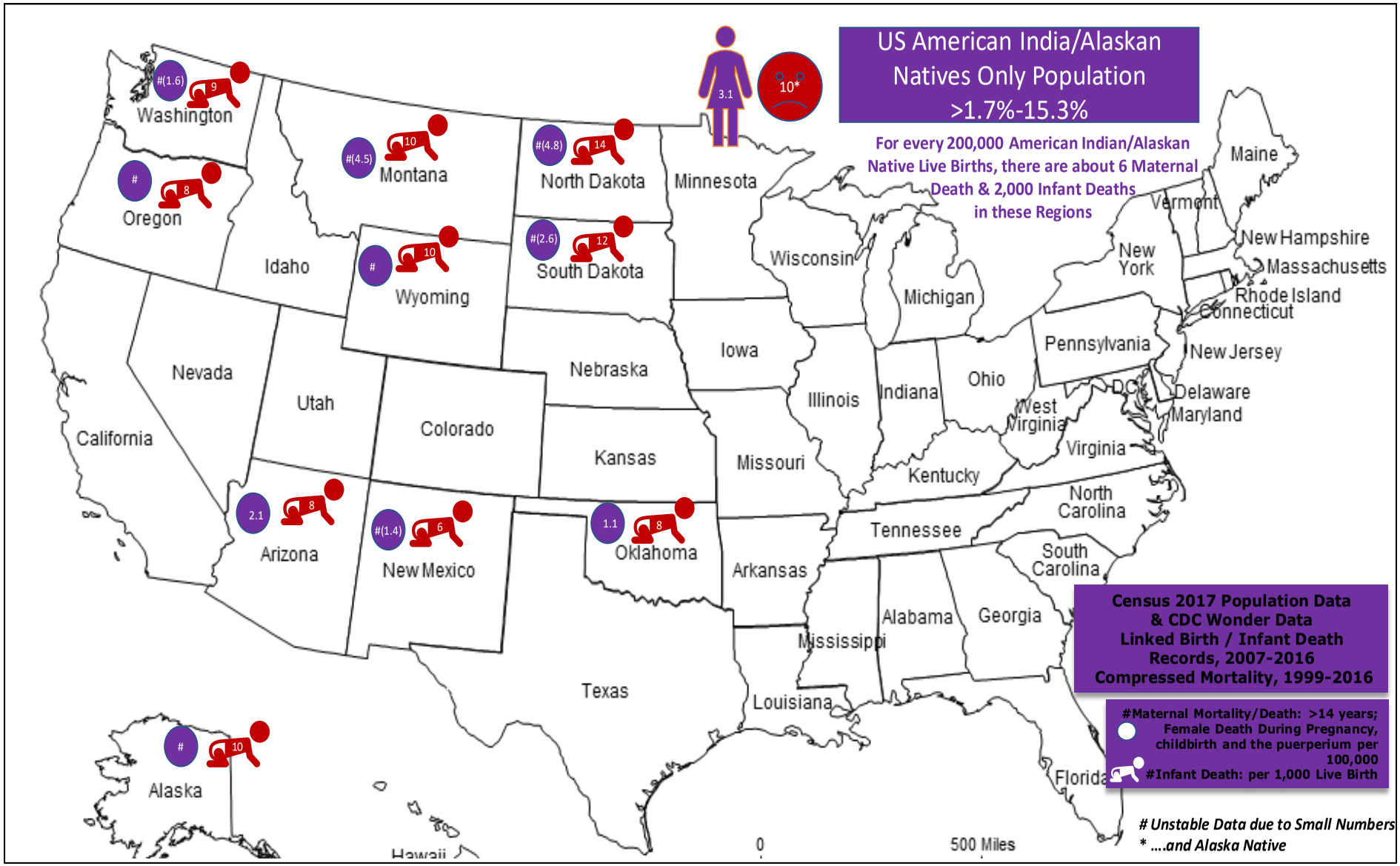
The Power is in the Market

Major Functions of the Health Care System	The People	The Government	Health Care Regulatory Agencies	Health Care Market	Government Administrative Agencies
Power	X	√	√	√	X
Policy	X	√	√	√	X
Funds	X	√	√	X	√
Market	X	X	X	√	X
Price	√	X	X	√	X
Cost Savings	X	X	X	X	√
Health Care Status	X	√	X	X	X
Customer Selection	X	X	X	√	X

The Power is in the Market

US Health Care in Reform

Maternal and Child Health Care Status



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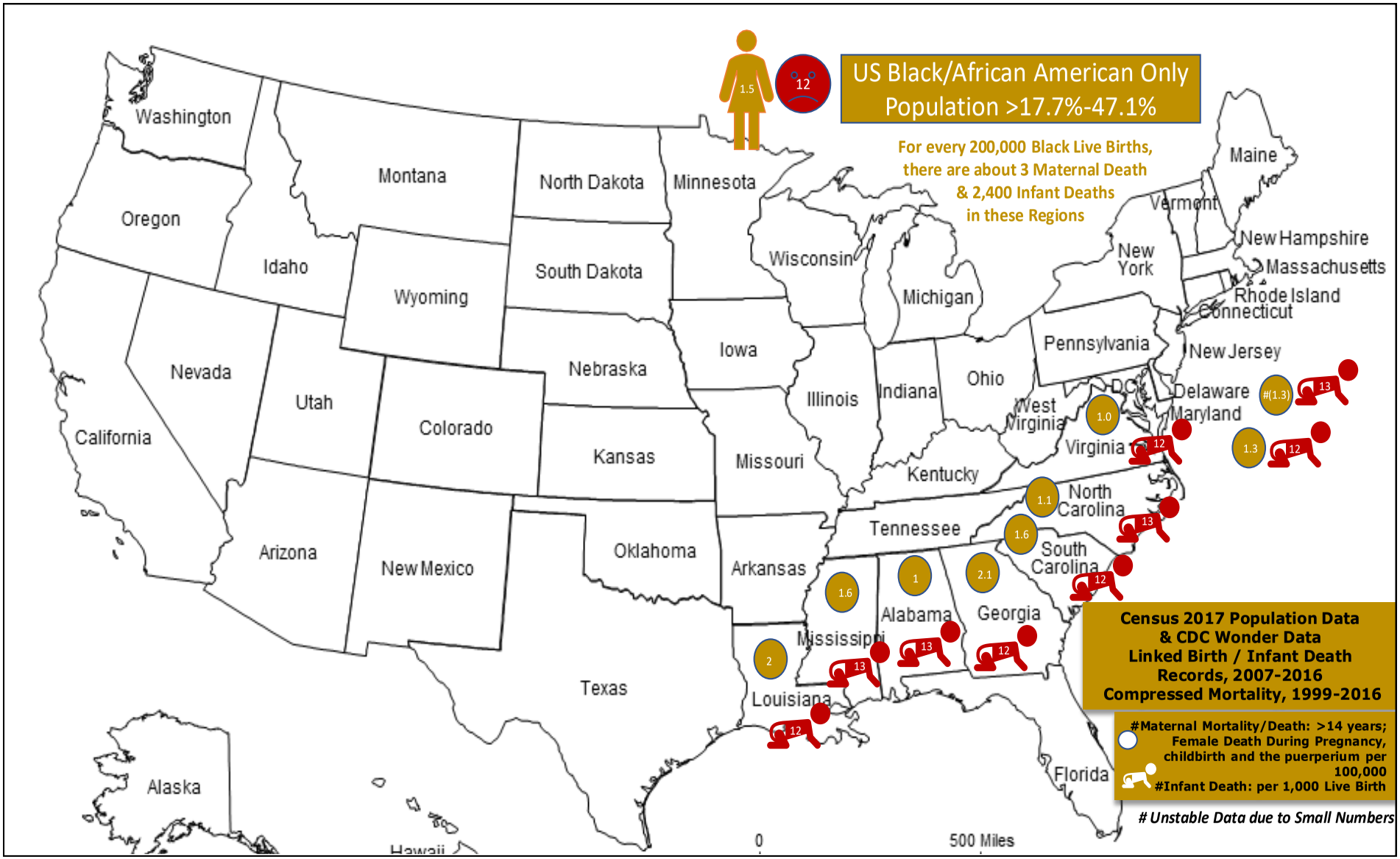

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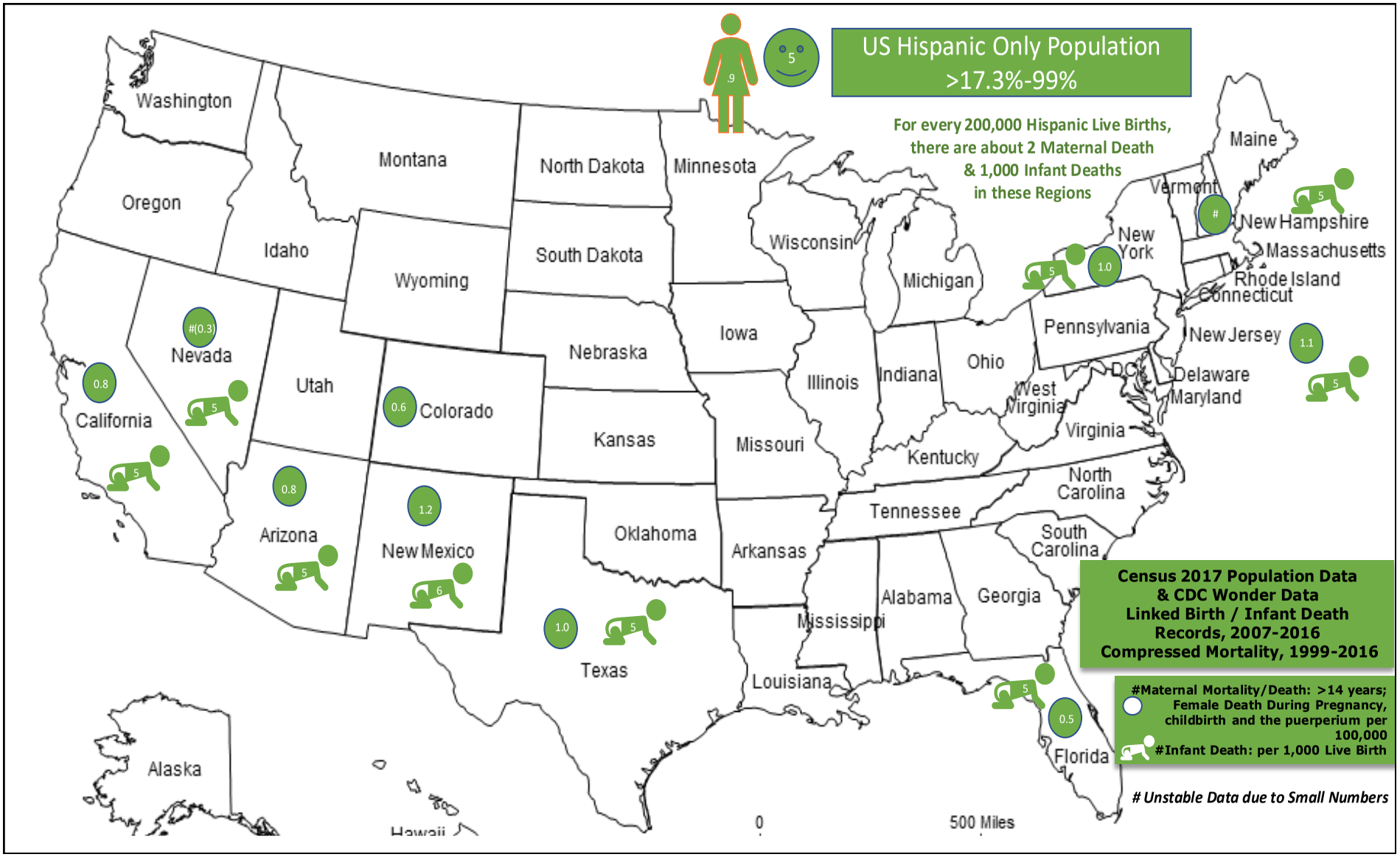

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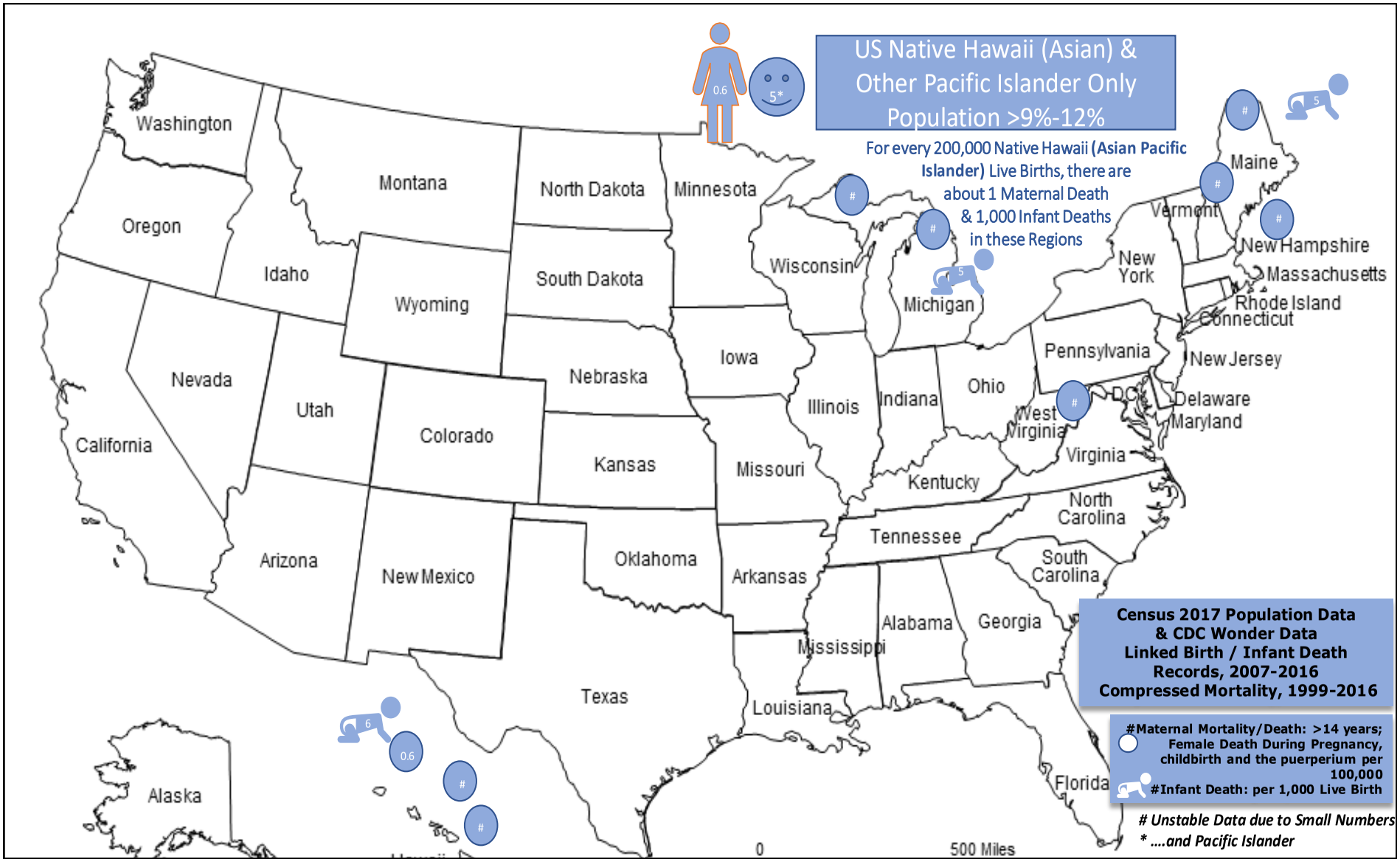

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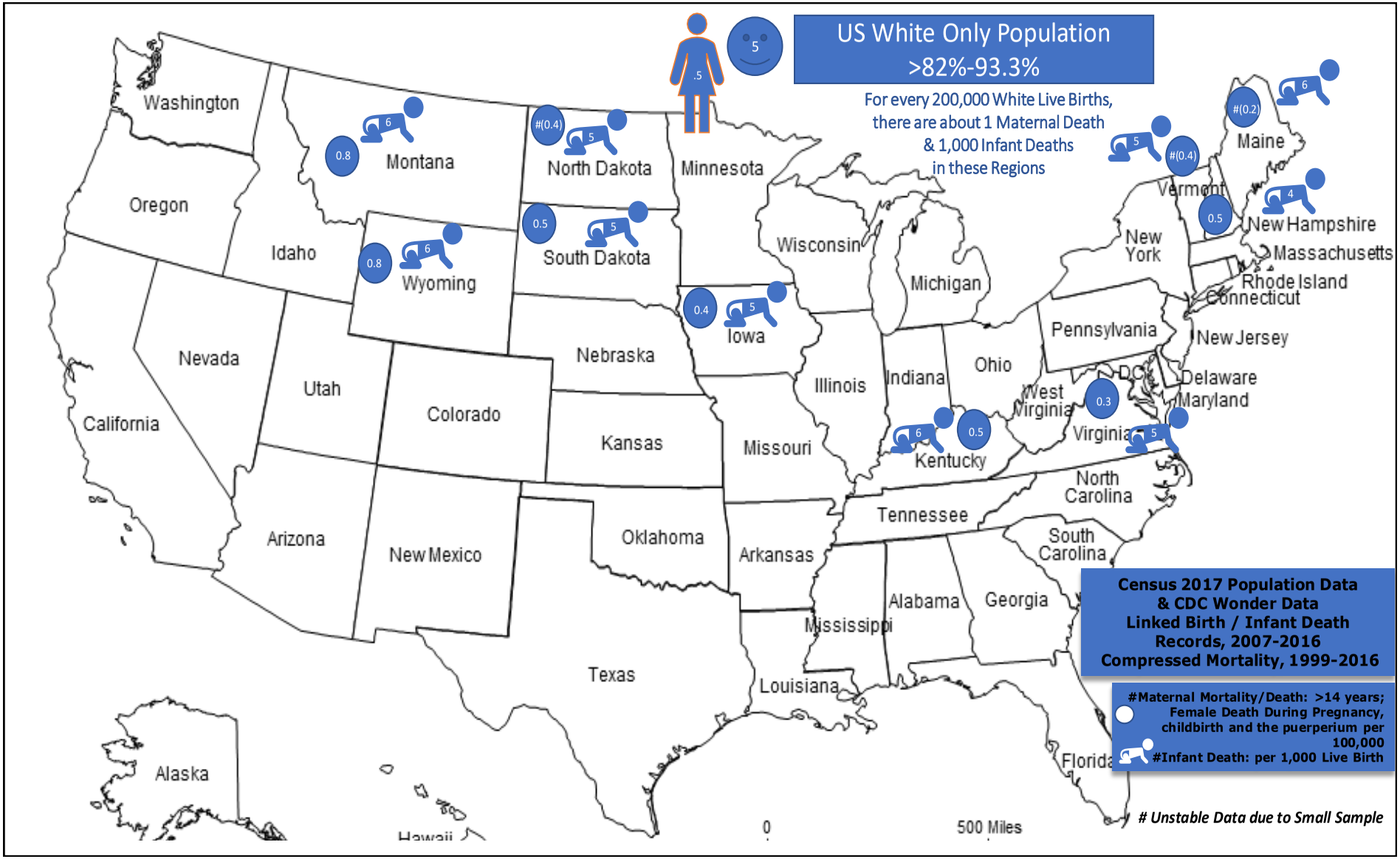

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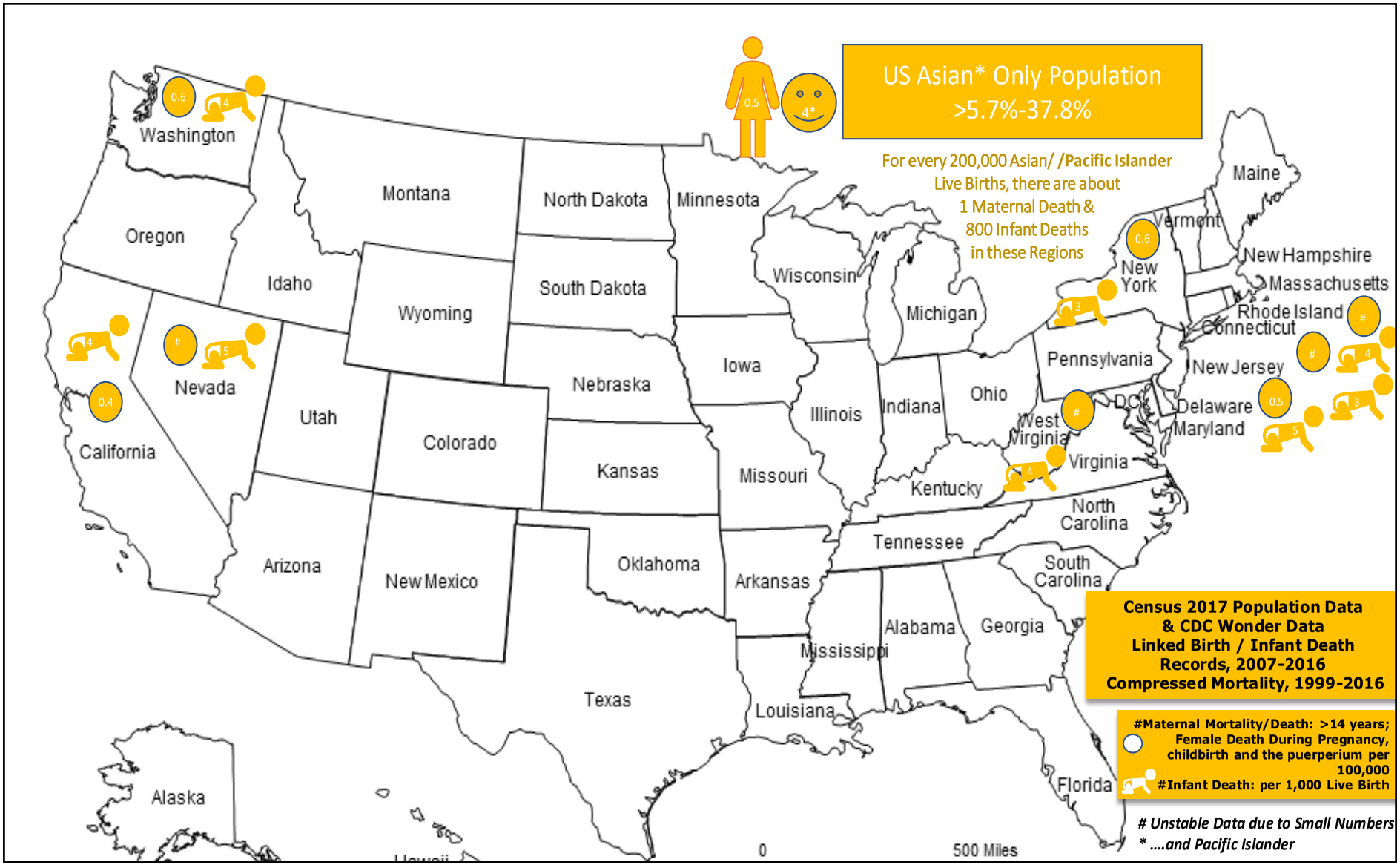


Maternal and Child Health Care Funding & Health Outcome Disparities

ethnicity; and with time, the nutrition needs do change. So one Nutrition design, may not work for different races/ethnicities over a very extended period of time.

The disparities seen in the lack of correlation between the funding allocations and the health outcomes of the maternal and child health population in US is due partly to the misconception of the business world, thinking health care can be canned and packaged into each individual race/ethnicity in the same systematic mechanistic way, as a manufacturing company conveyor belt (see page 6).

Health care of the people has to be canned and packaged in the light of health outcome goals for each individual race/ethnicity. It is time to treat people as humans and not cans of tinned tomatoes. Treating patients in the health care systems as individuals helps one give room for genes, different behaviors to different environmental stimuli and ultimately accommodate for any shortcomings that may occur in the health outcome measures as anticipated, and not as surprises. In order to be able to confidently anticipate and adjust for shortcomings in health care outcome measures for each race/ethnicity, one needs knowledge and has to be well informed. Having researched and tested various combinations of nutrition at the tables and their

US is still found wanting in light of **"EQUALITY & EQUITY of OFFERINGS"** with varying genes, & varying dietary needs.

In US, Tomato (White) means to one ʻōhiʻa ma ka nahele (Hawaii), Fan Quie (Chines), Tomate (Spanish), Tomati (Yoruba), ...and Chil Linchxiʼi (Navajo) to others. Each having different species of favorable tomato.

effect on the race/ethnic genes, and the anticipated response to different stimulus in order to create the same good health outcome, should not be a surprise.

The same way the table is set for all to accommodate equality, and those who cannot make it to the table are helped along the way, to get to the table, accommodating equity; is how health outcomes works. In order to get the same level of good health outcomes, each race must be researched for the effect of the nutrition at the table on their genes in order for the maximum "out-show" - phenotype of good growth to be achieved and those who are found not to respond to the combination of nutrients served, should be given other options that have been researched. Some will still not reach the desired outcome despite accommodating and adjusting the nutrients at the table, so the environmental stimulus that is hindering the growth process has to be investigated. One has to research what environment the combination of nutrients is being offered and investigate which environmental stressors are causing the particular race "not to thrive" at the table. Controlling for the environmental stimulus that affects thriving at the table is the final key to the equity in health outcomes. Hence, the need for community interventions and strategies, while engaging these races/ethnicities and exploring which environment helps them thrive with the right

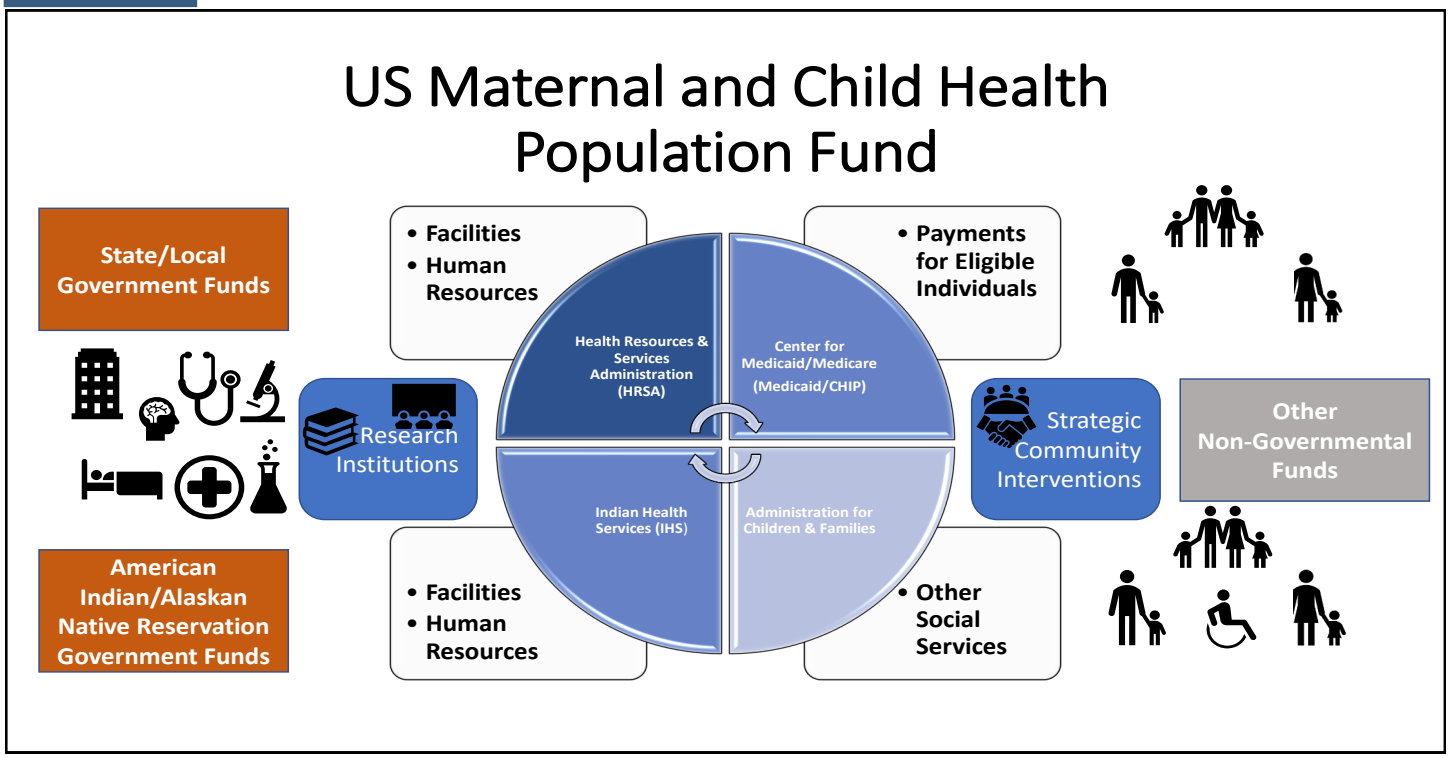
Maternal and Child Health Care Funding & Health Outcome Disparities

combination of nutrition at the table. These strategies will "effect equity in health outcomes" (see below).

For the purpose of these research and community interventions, I have selected the two poorer maternal and child health population outcomes among American Indian/ Alaskan Natives and African American population. I have tried to pull out the states with the highest quartile of population and also explored the hypothesis of the environmental stimulus of numbers. That is, the settlings of the same types of races for these two race/ ethnic groups. Settlings of togetherness as a race/ethnicity actually makes their health outcomes worse. These two races/ethnicities are the least researched in US and the least investigated for social norms and how these dynamics affect health outcomes. Most of the known norms and psychological understandings for other races/ ethnicities do not work in these two races/ethnicities settlings. The earlier these races/ethnicities are researched for genetic and environmental stimuli effecting good health outcomes, the better the understanding of how to go about improving the health of these populations.

Equality in Health Outcomes is achieved by researching the right combination of nutrition to serve for dinner, in order for each individual race/ ethnicity to achieve expected optimal growth.

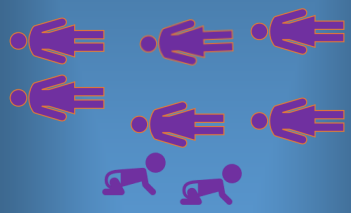
Taking Hypertension in pregnancy for instance, most hypertension medications were created and tested on the White Male 70kg Human. Not all the medications that work for a White Male 70kg Human work



Maternal and Child Health Care Funding & Health Outcome Disparities

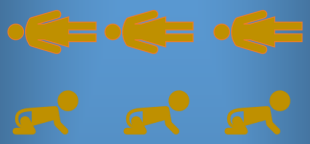
US American Indian/ Alaskan Native

For every 200,000 American Indian/ Alaska Native Live Births, there are about 6 Maternal Death & 2,000 Infant Deaths in these Regions



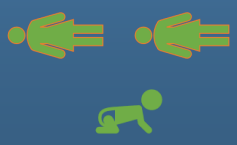
US African American

For every 200,000 Black Live Births, there are about 3 Maternal Death & 2,400 Infant Deaths in these Regions



US Hispanic

For every 200,000 Hispanic Live Births, there are about 2 Maternal Death & 1,000 Infant Deaths in these Regions



for all other races. It is important to research which medication or combination of medications work better for which race and tailor treatment towards findings, for maximum health outcome benefits. The genes of black women for instance gives them phenotypic vascular diseases that affect the birth outcome of the children, causing small for gestational babies or premature births. The environmental stimuli that makes the genes default to this degree of vascular disease is yet to be found, but the vascular disease shrinks the blood vesicles and makes the blood fight to reach vital organs for every day living and more importantly for the growth of the unborn child.

In white women, the vascular disease seen is actually clogs up in blood vessels and surround the heart, making it difficult for the heart to function properly. Both women will report with hypertension in pregnancy, one will have mild heart disease and the other will have end artery disease like kidney problems and less blood supply to the unborn child. The treatment for these hypertensions in pregnancy are different as different medication corrects the different types of hypertension and the urgency of the state of each woman is different. Environmental triggers are also different. One is triggered by food and the other just shows up due to genes and other stressor factors in the environment, yet to be fully explored. Food could aggravate both symptoms, as both vessels can be clogged up, the black women more quickly than the

US Native Hawaiian/ Asian Pacific Islander

For every 200,000 Native Hawaiian (Asian Pacific Islander) Live Births, there are about 1 Maternal Death & 1,000 Infant Deaths in these Regions

US White

For every 200,000 White Live Births, there are about 1 Maternal Death & 1,000 Infant Deaths in these Regions

US Asian/Other Pacific Islander

For every 200,000 Asian/ Other Pacific Islander Live Births, there are about 1 Maternal Death & 800 Infant Deaths in these Regions

Maternal and Child Health Care Funding & Health Outcome Disparities

Louisiana MCH Population/Number of Births	Births (%)	Total Infant Death	Dead Small Baby at Birth (<2500g)	Total Small Baby at Birth (<2500g)
Total Number All Races 2016	63,178 (100%)	504 (100%)	326 (100%)	6,740 (100%)
Total Number Black (Non-Hispanic) 2016	23,428 (37.10%)	291 (57.7%)	202 (62%)	3,620 (55.4%)
Louisiana MCH Population Served 2017	Direct and Enabling Only: Form 5a Count	Direct, Enabling, and Public Health Services and Systems: Form 5b %	Title V Federal-State Partnership	FY 2017 Expenditures
Pregnant Women	883	100	Federal Allocation	$11,934,034
Infants < 1 Year	1,373	99	State MCH Funds	$5,363,321
Children 1 through 21 Years^	48,651	42	Local MCH Funds	$0
CSHCN (Subset of all children)	11,409	42	Other Funds	$0
Others*	35,314	34	Program Income	$3,587,205
Louisiana Total Children Under 18 Years, 2017	Medicaid Child Enrolment	Medicaid CHIP Enrolment		
1,104,415	581,825	131994	Total Title V Funds	$20,884,560

Alabama MCH Population/Number of Births	Births (%)	Total Infant Death	Dead Small Baby at Birth (<2500g)	Total Small Baby at Birth (<2500g)
Total Number All Races 2016	59,151 (100%)	534 (100%)	360 (100%)	6,109 (100%)
Total Number Black (Non-Hispanic) 2016	17,989 (30.4%)	261 (48.8%)	200 (55.6%)	2,783 (45.55%)
Alabama MCH Population Served 2017	Direct and Enabling Only: Form 5a Count	Direct, Enabling, and Public Health Services and Systems: Form 5b %	Title V Federal-State Partnership	FY 2017 Expenditures
Pregnant Women	1,030	100	Federal Allocation	$11,264,929
Infants < 1 Year	57,484	100	State MCH Funds	$32,943,966
Children 1 through 21 Years^	30,782	4	Local MCH Funds	$0
CSHCN (Subset of all children)	10,287	12	Other Funds	$775,151
Others*	82,753	2	Program Income	$48,978,741
Alabama Total Children Under 18 Years, 2017	Medicaid Child Enrolment	Medicaid CHIP Enrolment		
1,099,771	462,051	169,078	Total Title V Funds	$93,962,787

Mississippi MCH Population/ Number of Births	Births (%)	Total Infant Death	Dead Small Baby at Birth (<2500g)	Total Small Baby at Birth (<2500g)
Total Number All Races 2016	37,928 (100%)	329 (100%)	220 (100%)	4,352 (100%)
Total Number Black (Non-Hispanic) 2016	15981 (42.1%)	179 (54.4%)	132 (60%)	2.527 (58.1%)
Mississippi MCH Population Served 2017	Direct and Enabling Only: Form 5a Count	Direct, Enabling, and Public Health Services and Systems: Form 5b %	Title V Federal-State Partnership	FY 2017 Expendi-tures
Pregnant Women	10,918	100	Federal Allocation	$7,596,577
Infants < 1 Year	10,485	100	State MCH Funds	$7,155,908
Children 1 through 21 Years^	9,263	100	Local MCH Funds	$0
CSHCN (Subset of all children)	1,414	100	Other Funds	$0
Others*	9,345	1	Program Income	$4,233,068
Mississippi Total Children Under 18 Years, 2017	Medicaid Child Enrolment	Medicaid CHIP Enrolment		
713,781	347,037	75,088	Total Title V Funds	$18,985,553

Georgia MCH Population/Number of Births	Births (%)	Total Infant Death	Dead Small Baby at Birth (<2500g)	Total Small Baby at Birth (<2500g)
Total Number All Races 2016	130,042 (100%)	972 (100%)	694 (100%)	12,747 (100%)
Total Number Black (Non-Hispanic) 2016	45,457 (35%)	515 (53%)	396 (57.1%)	6,436 (50.5%)
Georgia MCH Population Served 2017	Direct and Enabling Only: Form 5a Count	Direct, Enabling, and Public Health Services and Systems: Form 5b %	Title V Federal-State Partnership	FY 2017 Expendi-tures
Pregnant Women	14,353	13	Federal Allocation	$16,870,802
Infants < 1 Year	533,440	94	State MCH Funds	$110,765,452
Children 1 through 21 Years^	1,392,801	61	Local MCH Funds	$0
CSHCN (Subset of all children)	8,664	11	Other Funds	$149,036,298
Others*	21,943	0	Program Income	$6,662,232
Georgia Total Children Under 18 Years, 2017	Medicaid Child Enrolment	Medicaid CHIP Enrolment		
2,535,193	1,005,571	207,289	Total Title V Funds	$283,334,784

Maternal and Child Health Care Funding & Health Outcome Disparities

South Carolina MCH Population/ Number of Births	Births (%)	Total Infant Death	Dead Small Baby at Birth (<2500g)	Total Small Baby at Birth (<2500g)
Total Number All Races 2016	57,342 (100%)	402 (100%)	264 (100%)	5,495 (100%)
Total Number Black (Non-Hispanic) 2016	17,071 (29.8%)	185 (46%)	137 (52%)	2,489 (45.3%)
South Carolina MCH Population Served 2017	Direct and Enabling Only: Form 5a Count	Direct, Enabling, and Public Health Services and Systems: Form 5b %	Title V Federal-State Partnership	FY 2017 Expenditures
Pregnant Women	9,303	100	Federal Allocation	$11,060,713
Infants < 1 Year	839	100	State MCH Funds	$18,641,818
Children 1 through 21 Years^	27,615	64	Local MCH Funds	$4,374,968
CSHCN (Subset of all children)	4,912	64	Other Funds	$28,578,379
Others*	29,150	4	Program Income	$13,928,925
South Carolina Total Children Under 18 Years, 2017	Medicaid Child Enrol-ment	Medicaid CHIP Enrolment		
1,118,508	553,537	87,698	Total Title V Funds	$76,584,803

North Carolina MCH Population/ Number of Births	Births (%)	Total Infant Death	Dead Small Baby at Birth (<2500g)	Total Small Baby at Birth (<2500g)
Total Number All Races 2016	120,779 (100%)	874 (100%)	616 (100%)	11,166 (100%)
Total Number Black (Non-Hispanic) 2016	28,503 (23.6%)	367 (42%)	290 (47.1%)	4,025 (36%)
North Carolina MCH Population Served 2017	Direct and Enabling Only: Form 5a Count	Direct, Enabling, and Public Health Services and Systems: Form 5b %	Title V Federal-State Partnership	FY 2017 Expenditures
Pregnant Women	31,817	90	Federal Allocation	$17,452,364
Infants < 1 Year	12,229	99	State MCH Funds	$37,733,048
Children 1 through 21 Years^	105,968	14	Local MCH Funds	$0
CSHCN (Subset of all children)	61,351	17	Other Funds	$56,231,660
Others*	21,805	2	Program Income	$70,779,201
North Carolina Total Children Under 18 Years, 2017	Medicaid Child Enrol-ment	Medicaid CHIP Enrolment		
2,325,931	1,182,351	255,519	Total Title V Funds	$182,196,273

Virginia MCH Population/Number of Births	Births (%)	Total Infant Death	Dead Small Baby at Birth (<2500g)	Total Small Baby at Birth (<2500g)
Total Number All Races 2016	102,460 (100%)	599 (100%)	380 (100%)	8,290 (100%)
Total Number Black (Non-Hispanic) 2016	21,288 (20.8%)	215 (36%)	165 (43.4%)	2,826 (34.1%)
Virginia MCH Population Served 2017	Direct and Enabling Only: Form 5a Count	Direct, Enabling, and Public Health Services and Systems: Form 5b %	Title V Federal-State Partnership	FY 2017 Expenditures
Pregnant Women	13,878	100	Federal Allocation	$12,128,653
Infants < 1 Year	77,189	100	State MCH Funds	$9,097,551
Children 1 through 21 Years^	29,480	77	Local MCH Funds	$0
CSHCN (Subset of all children)	7,601	77	Other Funds	$1,146,726
Others*	50,792	25	Program Income	$1,295,711
Virginia Total Children Under 18 Years, 2017	Medicaid Child Enrolment	Medicaid CHIP Enrolment		
1,882,408	551,694	141,712	Total Title V Funds	$23,668,641

Maryland MCH Population/Number of Births	Births (%)	Total Infant Death	Dead Small Baby at Birth (<2500g)	Total Small Baby at Birth (<2500g)
Total Number All Races 2016	73,136 (100%)	478 (100%)	369 (100%)	6,279 (100%)
Total Number Black (Non-Hispanic) 2016	23,534 (32.2%)	245 (36%)	198 (53.7%)	2,859 (45.5%)
Maryland MCH Population Served 2017	Direct and Enabling Only: Form 5a Count	Direct, Enabling, and Public Health Services and Systems: Form 5b %	Title V Federal-State Partnership	FY 2017 Expenditures
Pregnant Women	4,999	100	Federal Allocation	$11,673,326
Infants < 1 Year	2,738	100	State MCH Funds	$8,754,995
Children 1 through 21 Years^	207,576	86	Local MCH Funds	$0
CSHCN (Subset of all children)	6,694	86	Other Funds	$0
Others*	12,061	2	Program Income	$0
Maryland Total Children Under 18 Years, 2017	Medicaid Child Enrolment	Medicaid CHIP Enrolment		
1,347,526	454,798	156,666	Total Title V Funds	$20,428,321

Maternal and Child Health Care Funding & Health Outcome Disparities

Delaware MCH Population/Number of Births	Births (%)	Total Infant Death	Dead Small Baby at Birth (<2500g)	Total Small Baby at Birth (<2500g)
Total Number All Races 2016	10,992 (100%)	86 (100%)	64 (100%)	989 (100%)
Total Number Black (Non-Hispanic) 2016	2,954 (27%)	37 (36%)	30 (46.9%)	398 (40.2%)
Delaware MCH Population Served 2017	Direct and Enabling Only: Form 5a Count	Direct, Enabling, and Public Health Services and Systems: Form 5b %	Title V Federal-State Partnership	FY 2017 Expenditures
Pregnant Women	3,345	6	Federal Allocation	$1,913,137
Infants < 1 Year	11,628	21	State MCH Funds	$10,461,629
Children 1 through 21 Years^	1,616	19	Local MCH Funds	$0
CSHCN (Subset of all children)	1,511	22	Other Funds	$0
Others*	7,819	32	Program Income	$3,294,852
Delaware Total Children Under 18 Years, 2017	Medicaid Child Enrolment	Medicaid CHIP Enrolment		
206,007	94,282	11,450	Total Title V Funds	$15,669,618

Maternal and Child Health Care Funding & Health Outcome Disparities

American Indian/Alaskan Native -AI/AN MCH Population/Number of Births	Washington	Oregon	Montana	Wyoming	Alaska
All Races 2016 Total Births (%)	90,505 (100%)	45535 (100%)	12282 (100%)	7386 (100%)	11,209 (100%)
AI/AN 2016 Total Births (%)	2,164 (2.9%)	#	1537 (12.5%)	#	2,503 (22.3%)
2016 All Races Total Infant Death	391 (100%)	214 (100%)	71 (100%)	37 (100%)	58 (100%)
AI/AN 2016 Total Infant Death	21 (0.05%)	#	19 (26.8%)	#	22 (38.0%)
2016 All Races Total Small Baby at Birth (<2500g)	5802 (100%)	2981 (100%)	967 (100%)	630 (100%)	663 (100%)
AI/AN 2016 Total Small Baby at Birth (<2500g)	155 (2.7%)	#	129 (13.3%)	#	154 (23.2%)
2016 All Races Dead Small Baby at Birth (<2500g)	239 (100%)	142 (100%)	41 (100%)	23 (100%)	28 (100%)
AI/AN 2016 Dead Small Baby at Birth (<2500g)	12 (5.0%)	#	10 (24.4%)	#	11 (39.3%)
American Indian/Alaskan Native -AI/AN MCH Population/Number of Births	**Arizona**	**New Mexico**	**North Dakota**	**South Dakota**	**Oklahoma**
All Races 2016 Total Births (%)	84520 (100%)	24692 (100%)	11383 (100%)	12275 (100%)	52592 (100%)
AI/AN 2016 Total Births (%)	5310 (6.3%)	3206 (13.0%)	1029 (9.0%)	2001 (16.3%)	6149 (11.7%)
2016 All Races Total Infant Death	450 (100%)	152 (100%)	73 (100%)	60 (100%)	393 (100%)
AI/AN 2016 Total Infant Death	48 (10.7%)	19 (12.5%)	16 (21.9%)	21 (35.0%)	61 (15.5%)
2016 All Races Total Small Baby at Birth (<2500g)	6197 (100%)	2,235 (100%)	759 (100%)	830 (100%)	4126 (100%)
AI/AN 2016 Total Small Baby at Birth (<2500g)	386 (6.2%)	283 (12.7%)	#	#	452 (11.0%)
2016 All Races Dead Small Baby at Birth (<2500g)	285 (100%)	98 (100%)	45 (100%)	30 (100%)	236 (100%)
AI/AN 2016 Dead Small Baby at Birth (<2500g)	22 (7.7%)	10 (10.2%)	#	#	33 (14.0%)

IHS-INDIAN HEALTH SERVICE FOR AMERICAN INDIANS AND ALASKAN NATIVES

Medicaid coverage within the IHS user population by federal fiscal year					
FY 2012	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
621,939	657,668	626,440	648,427	677,811	715,138

IHS Budget Appropriation by federal fiscal year					
FY 2015	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**
#	$4.8 Billion	$5.0 Billion	$5.5 Billion	#	#

IHS Third-Party Collections by federal fiscal year					
FY 2015	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**
$940 Million	$968 Million	$1.02 Billion		#	#

HIS/Tribal Facilities					
Facilities	**Hospitals**	**Health Centers**	**Alaska Village Clinics**	**Health Stations**	
IHS	26*	55	N/A	21	
Tribal	19	280	134	62	

HIS/Tribal Health Care Professionals					
Facilities	**Nurses**	**Physicians**	**Physicians Assistants**	**Pharmacists**	**Dentists**
HIS/Tribal	2,384	731	131	746	271

Maternal and Child Health Care Funding & Health Outcome Disparities

Maternal and Child Health Care Funding & Health Outcome Disparities

white women on the same medication. To varying degrees, the birth outcome for the black mother and child is more of an emergency and could easily lead to death or complications that lead to death shortly after the birth of the child. Taking longer to correct in the black woman after birth than in the white woman.

For the American India/Alaskan Natives, more research need to be implemented on the effect of environmental stimulus and food on the genes, leading to various endocrine diseases that lead to a higher number of still births and infant deaths. The environment of care and access to preventive care should also be explored in both cases.

Equity in Health Outcomes is achieved by investigating the right environment for dinner to be served, in order for each individual race/ethnicity to thrive eating, achieving expected optimal growth.

These are just examples of the probable causes of poorer outcomes for these two races/ethnicities and should not be taken literarily. Research and community strategies need to be implemented in order to effect the change that would help change the phenotypic "out-show" of the genes, and the right combination of prevention and treatment "diet" need to be tailored to the needs of these individual races/ethnicities.

Race/Ethnicity	United States of America
US American Indian/Alaskan Native (States/Communities with **>1.7%-15.3%** American Indian/Alaskan Native Population)	Alaska; Oregon; Montana; Wyoming; North Dakota, South Dakota; Oklahoma
US African American (States/Communities with **>17.7%-47.1%** African American Population)	Louisiana; Mississippi; Alabama; George; South Carolina; North Carolina; Virginia; Maryland Delaware
US Hispanic (States/Communities with **>17.3%-99%** Hispanic Population)	California; Nevada; Arizona; Utah; New Mexico; Colorado; Texas; Florida; New Jersey; New York; New Hampshire
US Native Hawaiian/Asian Pacific Islander (States/Communities with **>9%-12%** Hawaiian/Asian Pacific Islander Population)	Hawaii; West Virginia; New Hampshire; Vermont; Maine
US White (States/Communities with **>82%-93.3%** White Population)	Montana; Wyoming; North Dakota, South Dakota; Iowa; Kentucky; Virginia; New Hampshire; Vermont; Maine
US Asian/Other Pacific Islander (States/Communities with **>5.7%-37.8%** Asian/Other Pacific Islander Population)	California; Nevada; Washington; New York; West Virginia; New Jersey; Connecticut; Massachusetts

Maternal and Child Health Care Funding & Health Outcome Disparities

.....Where we should be.
Giving Power back to the People

Major Functions of the Health Care System	The People	The Government	Health Care Regulatory Agencies	Health Care Market	Government Administrative Agencies
Power	√	X	√	X	X
Policy	√	X	√	X	X
Funds	√	√	√	X	√
Market	√	X	X	X	X
Price	√	X	X	X	√
Cost Savings	X	X	X	X	√
Health Care Status	√	√	√	X	X
Customer Selection	√	X	X	X	X

Giving Power back to the People

Maternal and Child Health Care Funding & Health Outcome Disparities

In conclusion, I hope I have been able to arouse interest in maternal and child health –MCH funding accountability and ways of maximizing return on investment among this population. I also hope I have been able to explain what it takes to have equal and equitable offerings to this population. I have explored possible ways of rethinking MCH population funding and intervention and highlighted large gaps in disparities, suggesting ways to start closing the gap, first in knowledge and then in offerings in an equitable manner, in order to effect an equal positive health outcome.

Closing the MCH disparity gap in health outcomes is possible. Comparing nations of the world without funds to US, one is amazed by the level of accountability and innovation that go on in these nations to effect the right change to see gaps change. The solutions reside with the peoples within US communities. I leave you with this note, to encourage harnessing the innovations within the communities and not being too reserved spending more funds on prevention other than treatment. Changing environmental stimulus with policies to effect prevention and developing policies that will reduce disparities in treatment of individuals with dignity and respect, knowing fully well that US is indeed made up of Peoples from nations, cultures, ways and believes, other than ours, and that not every one reacts the same way we would to stimulus around them. Mutual respect and kindness would go a long way.

Disparity reduction is achieved in Health Outcomes when optimal growth is achieved by all races/ethnicities at the dinner table; right combinations of nutrients and creating right environment for each individual race/ethnicity to be served, and to thrive eating, achieving expected optimal growth.

One should not be afraid of knowledge, but embrace the knowing. You never know, you may be able to save a life!

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Indian Health Service	https://www.ihs.gov/newsroom/factsheets/ihsprofile/
Center for Disease Control & Prevention (CDC WONDER)	https://wonder.cdc.gov/
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The Best of Two Worlds: Bar Beach, on the Island, Lagos Nigeria

Published Letters to the Editor

Author: Folorunso Akintan MD MPH MBA

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Looking forward to hearing from you!

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