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Preterm Birth and Infant Mortality among African American and Caucasian Women: A Critique of the Systematic Devaluing of African American Women and Infants

CATHERINE COOPER

Introduction

The prevalence of health disparities in the United States between racial groups is a well-documented fact that has largely gone unattended in a culture that continues to lay individual blame at the feet of the disenfranchised. There appears to be a reluctance to address these concerns at a policy or institutional level, while interventions at the practice level do very little to bring about meaningful, widespread results in the outcomes. One possible reason for this is the notion that well-intentioned professionals are intervening at a level that continues to put responsibility for societal problems on the individual by attempting to force behavior change, rather than examining the conditions that existed before a patient sought healthcare (Culhane

& Goldenberg, 2011).

This work examines the multiple layers of institutional and structural racism that contribute to the perpetuation of negative outcomes for African American women and their newborns, while also delineating cultural and socioeconomic factors affecting this health disparity. The intersection of socioeconomic status and race is explored, and possible explanations for the limited research of this intersection as it pertains to the incidence of pre-term birth and infant mortality among African Americans are suggested. The ethical requirements of social workers in taking on this injustice is a final point of discussion.

Statistical Significance

A review of the literature demonstrates that there is a persistent disparity in preterm births between African American and Caucasian women in the United States. According to the Centers for Disease Control and Prevention (CDC), one-third of infants are born preterm in the United States each year, and though there was a reduction across all races in preterm births between 2006 and 2010, significant disparities persist between African American and Caucasian populations (2017). The 8% decrease in the preterm birth rate for children born to African American women between 2006 and 2010 is undercut by the fact that in 2010, this group's preterm birth rate remained 60% higher than that for White women; 17.1% versus 10.8% (CDC, 2017). While the CDC has prioritized reduction of the preterm birth rate across all races and ethnicities, the continued variance cannot be definitively accounted

for; therefore, the health disparity continues to be inadequately addressed. This is evidenced by the fact that African American women give birth to preterm infants twice as often as Caucasian women (Hauck, Tanabe, & Moon, 2011). Normal, healthy gestation during pregnancy is 40 weeks, and birth prior to 37 weeks' gestation is categorized as a preterm birth. Within the latter categorization, there is further specificity based on the number of weeks before complete gestation that a baby is born. Very early preterm births are babies born at less than 32 weeks' gestation, and late preterm births are those born 34 to 36 weeks' gestation (MacDorman, 2011). Preterm birth is one of the largest indicators for infant mortality as well as a host of physical, neurological, emotional, and social problems if the infant survives (Lu & Halfon, 2003).

There is a demonstrated association between preterm birth and infant mortality, the latter of which has also been linked to health disparities characterized by race. Non-Hispanic Black babies are 2.5 times more likely to die than non-Hispanic White babies (Hauck et al., 2011). Currently, statistics indicate that 54% of the racial differences in infant mortality can be ascribed to the increased incidence of preterm births among African American women (Hauck et al., 2011).

Competing Explanations on Outcome Variances

As with other well-established health disparities, there are a multitude of explanations in the literature for why the incidence of pre-term birth and infant mortality is higher among the African American population. In the following section, an exploration of

the role personal behavior and the environment plays in determining outcomes is discussed. Additionally, the convergence of class and race are examined, and the influence of socioeconomic status is highlighted as it pertains to the health disparity under discussion.

Behavior Versus Environment

There have been numerous suggestions for why these disparities exist, but there is a debate in the literature whether these differences should be attributed to individual health behaviors, socioeconomic status, prenatal care, or infections as the primary reason for the different experiences of African American and Caucasian expectant mothers in the United States. These four categories have been identified by multiple researchers as the leading possible explanations for the preterm birth rate disparity between African American and Caucasian women (Braverman et al., 2010; Culhane & Goldenberg, 2011; MacDorman, 2011). To focus on individual behaviors such as smoking, drug and alcohol use, educational attainment, diet, or delayed prenatal care as cause for this phenomenon may seem an obvious answer. However, it is notable that controlling for these factors in multiple studies has revealed that behavior alone does not explain increased preterm births among African American women (Culhane & Goldenberg, 2011; Osypuk & Acevedo-Garcia, 2008). For example, women with higher levels of education generally have lower rates of preterm births, but African American women with 13 or more years of education still have considerably higher rates of premature births than Caucasian women with less than 12 years of education (Culhane & Goldenberg, 2011). Similar findings

are noted with tobacco use, which is strongly associated with preterm births. Culhane and Goldenberg found that non-Hispanic Black women have much lower rates of tobacco use than non-Hispanic White women (2011). The conclusion, taken alone, behavior does not fully explain the higher incidence of preterm births in Black women, and a wider lens is necessary. Focusing exclusively on behaviors reinforces the cultural tendency for victim blaming. Historically, this tactic has resulted in a continuation of disparate outcomes for African American and Caucasian women in rates of preterm births and infant mortality and provides an excuse to divert resources into research deemed to have a more deserving cohort.

Putting aside individual behavior, researchers have identified infection and congenital defects as causes of preterm births. These physical conditions would most likely be categorized as beyond the control of both the patient and medical professionals as well as exempt from racial significance. However, the Vaginal Infections in Pregnancy study identified six urogenital infections that are strongly associated with preterm births. All of these infections occur at higher rates in African American women than Caucasian women (Culhane & Goldenberg, 2011). Additionally, Culhane and Goldenberg (2011) documented that urogenital infections have been found to account for as much as 50% of the preterm birth rate disparity between African American and Caucasian populations. What is most interesting about this is the absence of interventions designed to counter this physical occurrence. One of the six infections identified by the Vaginal Infections in Pregnan-

cy Study, bacterial vaginosis, occurs two to four times more often in African American women than Caucasian women, and its diagnosis has been associated with higher levels of stress in the patient and incidence of preterm births (Nansel et al., 2006). This link supports the need to examine the influences of social and racial inequity on differential rates of preterm births between African American and Caucasian women.

The Intersection of Socioeconomic Factors and Race

To fully understand and appreciate the implications of increased likelihood of preterm births and infant mortality among African Americans, the intersection of race and socioeconomic status must be examined. Research into the incidence of preterm births and infant mortality frequently focuses on race as the singular point of disparity; however, Braverman, Cubbin, Egerter, Williams, and Pamuk (2010) surveyed the data from five nationally representative studies, encompassing 11 health indicators and determined that the addition of social disadvantage had a significant impact on patterns of poor health. The research showed that incorporating class into the examination of both child and adult health indicators resulted in distinct advantages for Caucasians over African Americans, who had consistently better health outcomes in all areas (Braverman et al., 2010). What makes this critical to understanding differences among these two groups when it comes to infant mortality and preterm births is the association of negative outcomes with education and income combined with race. Again, research underscores why this health disparity must be scrutinized from multiple angles if change is to occur.

In an effort to delve into this point of intersection, Osypuk and Acevedo-Garcia (2008) examined the influence that living in racially segregated areas within larger cities had on rates of preterm births among African American women. Negligible attempts to desegregate in the past three decades have resulted in continued elevated concentrations of African Americans living in urban centers, and 40% of childbearing African American women live in hyper-segregated areas (Osypuk & Acevedo-Garcia, 2008). In 2008, researchers found that hyper-segregation (segregation across multiple dimensions) was associated with preterm births in African American women, especially older African American women (Osypuk & Acevedo-Garcia). The suggestion from this study is that characteristics of residentially segregated areas including poverty, elevated crime rates, and the high levels of stress may contribute to the high incidence of preterm births among African American women.

The Importance of Early Intervention

As with many health conditions, early access to care is critical to both the mother's and unborn child's health during pregnancy. By entering care as soon as pregnancy becomes known, women can benefit from early detection and treatment of risk factors or health conditions as well as receive information about making healthy lifestyle choices throughout pregnancy. Apart from a potentially unwanted pregnancy, it's reasonable to assume that accessing quality care as soon as possible would be a priority for women. However, the statistics do not bear this out. In 2011, researchers determined that 78.8% of non-Hispanic White women entered pre-

natal care in their first trimester as compared to 63.4% of non-Hispanic Black women (U.S. Department of Health and Human Services). A further analysis of prenatal care among pregnant women using Medicaid to access healthcare illustrates some possible explanations for the lower rate of medical care early in pregnancy. Gavin et al. (2004) discovered that there was a higher rate of screening for diseases often associated with high-risk behaviors, such as drug testing and HIV testing, among African American women as compared to Caucasian women. If racial profiling is a perceived reason for the administration of these tests in communities where minority populations reside, word of mouth may influence women's willingness to seek prenatal care early in pregnancy. This same study revealed racial discrepancies in the services offered, and tests typically administered to pregnant women. Non-Hispanic White women were more likely to be given an ultrasound or amniocentesis and be prescribed prenatal vitamins during prenatal care than non-Hispanic Black women (Gavin, et al., 2004). While direct causation cannot yet be linked between these findings and increased rates of preterm births and infant mortality, they are outstanding factors that require serious consideration in how these health disparities are addressed.

Minority Women Interact with the Health Care System

One of the foundational qualities necessary for women to access and continue with quality prenatal care is trust between them and the care providers (Sheppard, Zambrana, & O'Malley, 2004). Using qualitative methods, researchers evaluated low income, minority wom-

en's perception of trust in their physicians, nurses, and lay healthcare workers, such as those utilized through home visiting programs. There were remarkable differences between trust in trained medical providers versus lay healthcare workers. Minority women reported distrust in health care settings, where the medical practitioner changed throughout the course of care, while expressing complete confidence in lay health workers, especially when that worker had been a mother herself (Sheppard et al., 2004). Some of this difference may be attributed to the importance of how minority women perceived their doctors' care about their individual circumstances and challenges. Impact of this perception is critical and can have serious consequences as evidenced by one study participant's statement, "They just acted like you are too young to be having all these kids anyway. So after that, I never went back to (name of institution) or their clinic or nothing" (Sheppard et al., 2004, p. 487). Patient perception should not be minimized, particularly given the role implicit bias plays in provider-patient interaction. Tucker et al. (2014) documented significant findings in the continuity of care based on African American patients' perceptions of being treated as fairly as other patients. What these studies reveal is the complexity of racial bias in how African American women access care, participate in the healthcare process, and experience divergent health outcomes in a multitude of areas including preterm birth and infant mortality.

The Role of Personal Health Values

Health beliefs play a vital role in how all people access and utilize medical care, but the established bias

toward non-Hispanic White women while accessing prenatal care enhances the probability of providers failing to identify and consider how Black women perceive and experience their pregnancies. There are several beliefs about pregnancy that may impact how early African American women enter prenatal care. One perception, particularly by low-income women, is that being pregnant is considered an indication of wellness, and, therefore, medical oversight is unnecessary. A second belief is that acceptance of a pregnancy is tied to one's economic station in life (Lowdermilk, Perry, Cashion, & Alden, 2012). The latter belief can be applied to both self-perception and fear of how the pregnancy may be perceived by a provider, both of whom could potentially sway the decision of when to seek prenatal care. On the contrary, Caucasian women generally perceive pregnancy as a condition that necessitates medical oversight to ensure the best health for mother and baby and value the earliest possible prenatal care (Lowdermilk et al., 2012). If a provider does not understand these differences between African American and Caucasian women, the chances of an African American woman being judged for entering prenatal care later are increased; a judgement that could result in termination of care. Caucasian women value and emphasize technology in an institutional setting as the dominate means to manage labor and delivery, while African American women are more likely to arrive at a hospital further along in the labor process (Lowdermilk et al., 2012). The crucial aspect, again, in these difference lies in how the medical setting and care providers respond to the manifestations of the differences. As previously established by Sheppard et al. (2004) and Tucker et al. (2014), patient per-

ception plays a vital role in the establishment of trust with providers and the level of adherence to medical advice by non-Hispanic Black women. Providers have the unique opportunity to change the experience of minority women in prenatal care by providing meaningful education and training to office staff. Research has illustrated that commonly used diversity or cultural competence trainings have little effect on the individual's capacity to arrest implicit bias responses during initial patient interactions (Stone & Moscovitz, 2011). However, Stone and Moscovitz (2011) propose a workshop model anchored in social psychology that employs strategies designed to interrupt the activation of implicit bias and teaches medical providers to disrupt the process of acting upon non-conscious stereotyping and prejudices. This conscious disruption has the potential to positively influence health outcomes for minorities.

Even though African American women experience infant loss twice as often as Caucasian women, there is a scarcity of literature exploring how they manage in the aftermath of such a tragedy. There is even less available research on how the family/caregiver system is impacted by such a loss. In 2001, Van conducted the first study comprised entirely of African American women who had experienced pregnancy or infant loss. Although a small sample size, the qualitative interviews revealed four primary ways members of this community managed their grief, all of which had a characteristic in common – they fell into the self-help category, which was prompted by the lack of external resources (Van, 2001). Van points out that spirituality and/or religion was identified as the primary coping

mechanism, capturing 40% of the sample, and extended to the belief that the lost infant was being cared for by predeceased ancestors. In the context of limited research, these findings are thought-provoking because they appear to be commensurate with perceptions of African American women as more religious than Caucasian women. This study begs the question, if African American women look inward to cope with their loss, how are spouses, partners, and other family members processing the loss? This remains an area warranting research.

Complexities of Structural Racism

Lack of effectual methods to counter the higher rates of preterm births and infant mortality among African American women is perhaps the most significant indicator of how the healthcare system in the United States views this problem. This long-since acknowledged health disparity continues to exist despite national agendas by large health organizations to reduce it, and non-Hispanic Black women are not a cohort that receives equal funding when it comes to research and intervention design. This general lack of attention indicates low priority in our society given that our culture generally assigns social capital based on how much financial capital has been allocated to a group. Sadly, that belief is being reinforced by current events and the proposed slashing of Medicaid that will primarily affect the poor, disabled, elderly, and minorities.

Perhaps one of the reasons there has been no meaningful interventions to address this health disparity is because of the pervasive unwillingness by those

in positions of power and privilege to examine multiple socioeconomic factors and incorporate all areas into an intervention that truly addresses structural disadvantage. Researchers, practitioners, and medical providers have an interconnected relationship in driving the development of effective interventions given that they operate with a degree of educational, racial, authoritative, or socioeconomic privilege beyond that of the minority women under consideration. Members of these groups take cues from each another about what is considered a valuable enough cohort into which they should invest human and financial capital. Therefore, establishing shared goals and an action-specific roadmap for achieving justice for African American women in the areas of preterm births and infant mortality is a critical place to start.

It is a daunting task that many may feel ill-equipped to take on, but continued resistance to acknowledging the role class and economic disadvantage plays in health disparities in the United States only ensures the continuation of them. If there is any hope of bringing equity to African American women in the areas of preterm births and infant mortality, the medical and research professions must care equally about women of all races, ethnicities, and socioeconomic status. Additionally, front-line medical professionals must commit to actively combating their implicit bias when treating women of color during pregnancy. Establishing a personal connection with a patient through discussion of a shared interest has been shown to stimulate social group identification in an area disconnected from race and inhibit the activation of thoughts stem-

ing from stereotypes associated with a racial group (Stone & Moscovitz, 2011). Additionally, utilizing lay health care workers has demonstrated success among low-income, racial minority women and is especially effective in their retention while utilizing prenatal care (Sheppard et al., 2004).

The Social Work Mandate

Social workers adhere to an imperative that demands social justice for all. Addressing the health disparities between African American and Caucasian women regarding preterm births and infant mortality falls into this category, and several methods that fall within the social-determinants approach show promise for making meaningful change. As demonstrated in the literature, a one-pronged approach has not worked. The social-determinants framework integrates “social and economic factors, social support networks, physical and social environments, access to health services, and social and health policies” (Koh et al., 2010, p. 73). This approach demands that the social worker view the patient and their situation through varied lenses, increasing the likelihood that all aspects of patient care are met. Advocating for this methodology within organizations or health care settings gives social workers the chance to make change on an institutional level. Under this umbrella, social workers can encourage community-based, participatory research that encourages an egalitarian relationship between researchers/academics and community members, while providing the opportunity to test interventions in a real-world setting (Koh et al., 2010). One of the greatest potential benefits to this is more quickly establishing the difference between

clinical trials and real-world effectiveness, potentially speeding the resolution of a life-threatening problem. On a larger policy scale, social workers can engage in and advocate for establishing time-limited goals in lieu of pilot programs with the intention to push for wider access to treatment and support for adherence programs (Koh et al., 2010).

Finally, on a continuing basis, social workers must actively challenge their own biases and increase awareness of cultural sensitivity when working with people from marginalized populations. Acting in this manner promotes equality and dignity for African American women and other minorities and puts social workers in the position of being change agents within their organizations.

Conclusion

Health disparities, while pervasive, have been shown to have lethal consequences for African American women and their newborns. Rates of preterm births and infant mortality among this group remain significantly higher than Caucasian counterparts, and the absence of attention to the problem reveals a disturbing hierarchy of care in the medical system. Attention to the intersection of race, culture, socioeconomic class, personal health beliefs, and behaviors influencing how African American women access and receive health-care must be attended to by individual providers and overarching government entities alike for there to be meaningful and lasting change.

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About the Author

Catherine is pursuing her Master of Social Work after working in social services for many years. Initial research for this project was completed under the supervision of Dr. Barbara Bond in the summer of 2017, and revisions were completed under the mentorship of Dr. Jeffrey Steen in the fall of 2017. Catherine will be graduating in May 2019 and plans to pursue her clinical license while working in the field.