THE REALITY FOR PREGNANT BLACK MOTHERS:

THE U.S. HEALTH CARE SYSTEM AND INFANT MORTALITY RATES

JAHNIA CHERENFANT
AMERICAN SOCIAL POLICY (PLSC 312) | PROFESSOR KANG

Introduction:

Black women are three to four times more likely to die from pregnancy-related causes than white women according to the centers for disease control and prevention. This has contributed to the number of U.S. pregnancy-related deaths rising over the last two decades making the maternal mortality rate in the U.S. the worst in any industrialized country. Black women who were pregnant have more adverse contributing factors to LBW (low birth weight babies) compared to white women which may explain racial disparities between black and white women. As a developed nation, the U.S. is top-ranked medically yet falls short when it comes to mortality rates which gives us an insight to identify the correlation with adverse pregnancy outcomes and racial disparities within the U.S. health care system. Institutionalized racism is the main focal point that focuses on inequalities in social factors, income, employment status, education, and access to health care.

Research:

The study from Loggins Clay, S., Griffin, M., & Averhart, W. (2018). Black/White disparities in pregnant women in the United States: An examination of risk factors associated with Black/White racial identity. Health & Social Care in the Community, 26(5), 654–663. https://doi.org/10.1111/hsc.12565 uses a cross-sectional approach to explore Black and White disparities using data from the 2012 National Survey on Drug Use and Health (NSDUH), which collects interviews data from approximately 70,000 randomly selected participants. The guiding research questions are: (1) What is the relationship between institutional racism and pregnancy risk factors that contribute to adverse pregnancy outcomes? (2) Are there racial disparities between Black and White women in the areas of health behaviors, access to care, and social context stressors? The selection of the participants was defined by seven categories including (1) Non-Hispanic White, (2) Non-Hispanic Black/African American, (3) Non-Hispanic Native American/Alaskan Native, (4) NonHispanic Native Hawaiian/Other Pacific Island, (5) Non-Hispanic Asian, (6) Non-Hispanic more than one race and (7) Hispanic. The factors that were considered in the research were pregnancy status, educational attainment, marital status, income level, employment status, Access to health care, age, depression, father in the household, and health-eroding behaviors (smoking, alcohol, and illicit drugs). The statistical analysis compared the differences between White and Black pregnant women across individual and social stressors (e.g. measures of institutionalized racism, individual health behaviors, access to quality care, and social context factors) were assessed using chi-square analyses. Multivariate analyses were performed to predict the likelihood of experiencing each risk factor if a woman was either White or Black. Estimates from the multivariate analyses are presented by odds ratios (OR), 95% confidence intervals (CI), and p values.

Summaries of percentages for table 1, the variables are listed and compare the percentages of pregnant black and white women characteristics in the study. 33.5 percent of white women (WW) were married compared to 15 percent of black women (BW) who were married. Education level: 21.4 percent of WM graduated high school, 23.0 percent of WW attended some college, 20.1 percent of WW graduated college. 26.1 percent of BW graduated high school, 22.5 percent of BW attended some college, 10.2 percent of BW graduated college. Income (total family) 31.5 percent of WW earn 75k or more, 12.8 percent of BW earned 75k or more. Most BW earned between 10k-20k with 21.8 percent while most WW earned 75k or more with 31.5 percent. Employment: 85.2 percent of WW were employed, 76.0 percent of BW were employed. Age: ages 12-17 were 32.8 of pregnant WW, ages 18-25 were 38.1 percent of WW. Ages 12-17 were 33.9 of pregnant BW, ages 18-25 were 40.4 percent of BW. Health eroding behaviors: 70.9 percent of WW did not smoke, 80.0 of BW did not smoke. 35.4 percent of WW did not use alcohol, 47.2 percent of BW did not use alcohol. 79.3 percent of WW did not use illicit drugs, 77.7 percent of BW did not use illicit drugs. Household-level stress (access to healthcare): 89.7 percent of WW had access to any healthcare coverage, 85.8 percent of BW had access to any healthcare coverage. 15.8 of WW had Medicaid/CHIP, 42.9 of BW had Medicaid/CHIP. 33.4 percent of WW had government assistant program healthcare coverage, 25.8 percent of BW had government assistant program healthcare coverage. Other SES contextual variables: 16.6 percent of WW Attend religious services 25-52 times per year, 22.9 percent of black women attend religious services 6-24 times per year. 15.6 percent of WW were depressed, 12.0 of BW were depressed. 48.3 percent of WW had a father in the household, 42.9 percent of BW had a father in the household.

The takeaway from the Statistical Analysis: Most women were unmarried (69.9%), had varying levels of education, made more than $75,000 per year (28.0%), were employed (86.8%), and were between the ages of 18 and 25 years old (38.5%). Most women did not smoke (72.6%), and did not use illicit drugs (79.0%); however, the majority of women used alcohol (62.5%). Furthermore, most women had some type of healthcare coverage (89.0%), did not attend religious services (37.6%), were not depressed (80.9%), and had a father in the household (72.2%). **In our sampled population, the demographic characteristics of the two groups were similar for some measures of risk.** (Loggins Clay, Griffin, & Averhart)
The results from the logistic regression analyses were directly aligned with the results from the chi-square statistics. The exploration revealed prominent racial differences in White and Black women who were pregnant. Black women were less likely to be married (OR = 0.014), less likely to have higher family income levels (OR = 0.31), and less likely to be employed (OR = 0.52). However, Black pregnant women were more likely to be younger (OR = 1.82). Black pregnant women were less likely to smoke (OR = 0.53) and use alcohol (OR = 0.52). Furthermore, Black women were more likely to be covered by Medicaid/CHIP (OR = 3.21), more likely to have health coverage through government assistant programs (OR = 3.80), and less likely to have private health insurance (OR = 0.38) (Table 2)

Conclusion:

The study concluded that stress factors directly related to perceived or actual discrimination persist and contribute to black pregnant women's experience which causes additional stress. So basically Black women are more likely to have factors of stress due to institutionalized racism which leads them to making less money, less access to health care etc. and on top of that having to deal with racism is another added stresser that can affect LBW and the outcome of their pregnancies. the study found that white women had higher levels of health-eroding behaviors such as smoking during pregnancies and the use of alcohol. Supriinsgly white women were more likely to partake in 'self-infliced' and damaging health-eording behaviros and still have better maternal outcomes compared to black women. Most black women did not have control over most of the risk factors that are traditionally associated with LBW, the opposite is said for white women. Most of the risk facots associated with LBW for white mothers were controlled. If white women were to resist engaging in "self-infliced" health-eroding behaviors that are associated with LBW the racial gap between LBW outcomes of black women compared to white women an possibly increase. In contrast, black pregnant women cannot control certain risk factors associated with LBW (e.g. insitutialtionaized racism/racism-inequities). So we can conclude that statistically, black pregnant mothers have slightly higher risk factors yet additional risk factors due to race-inequities that are present within our health care systems.