Black Maternal Health: Getting at the Root Cause of Inequity

Invited Testimony, MN House Health Finance and Policy Committee 02.10.21

Rachel R. Hardeman PhD, MPH
Associate Professor & Blue Cross Endowed Professor of Health and Racial Equity
UMN McKnight Fellow 2020-22

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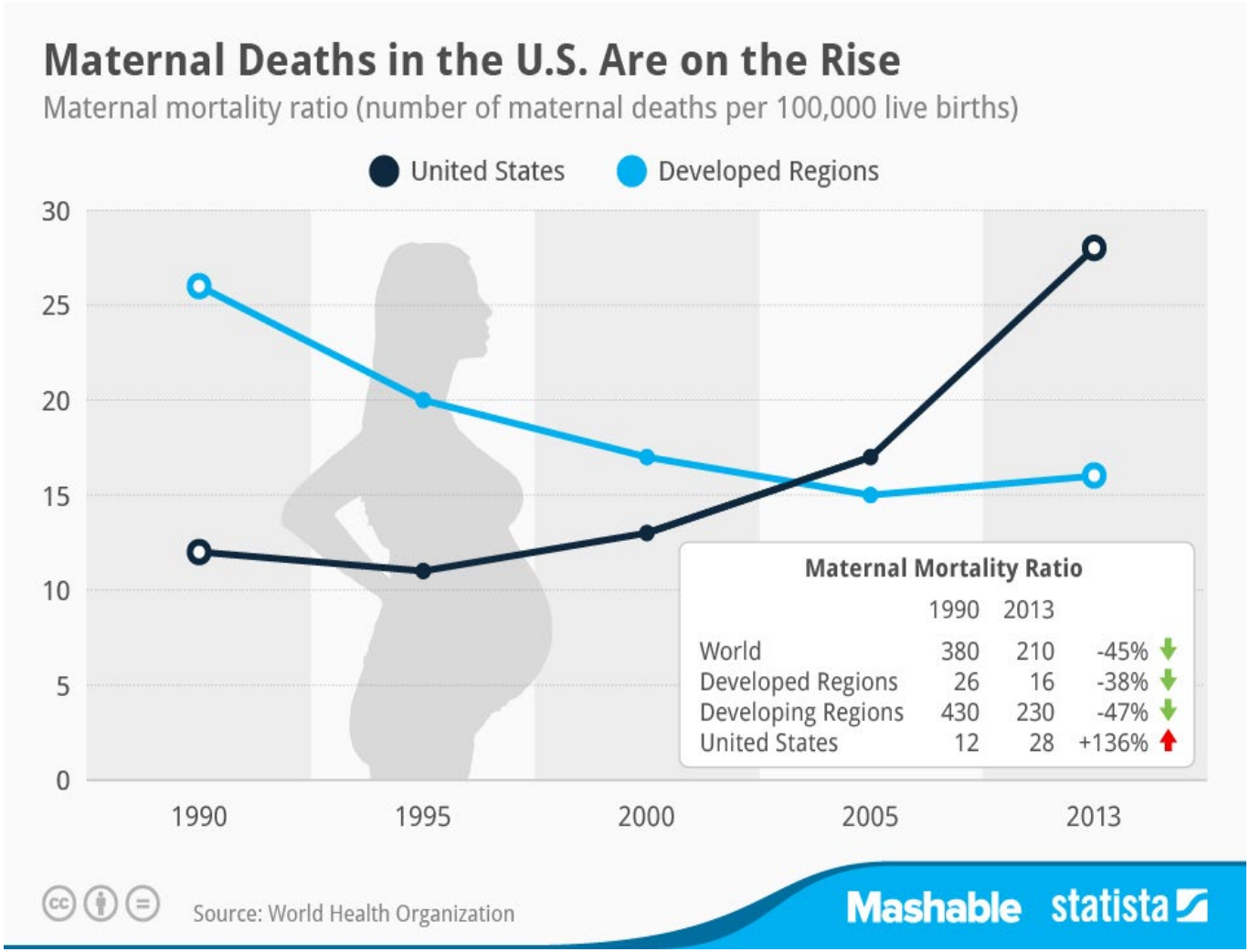
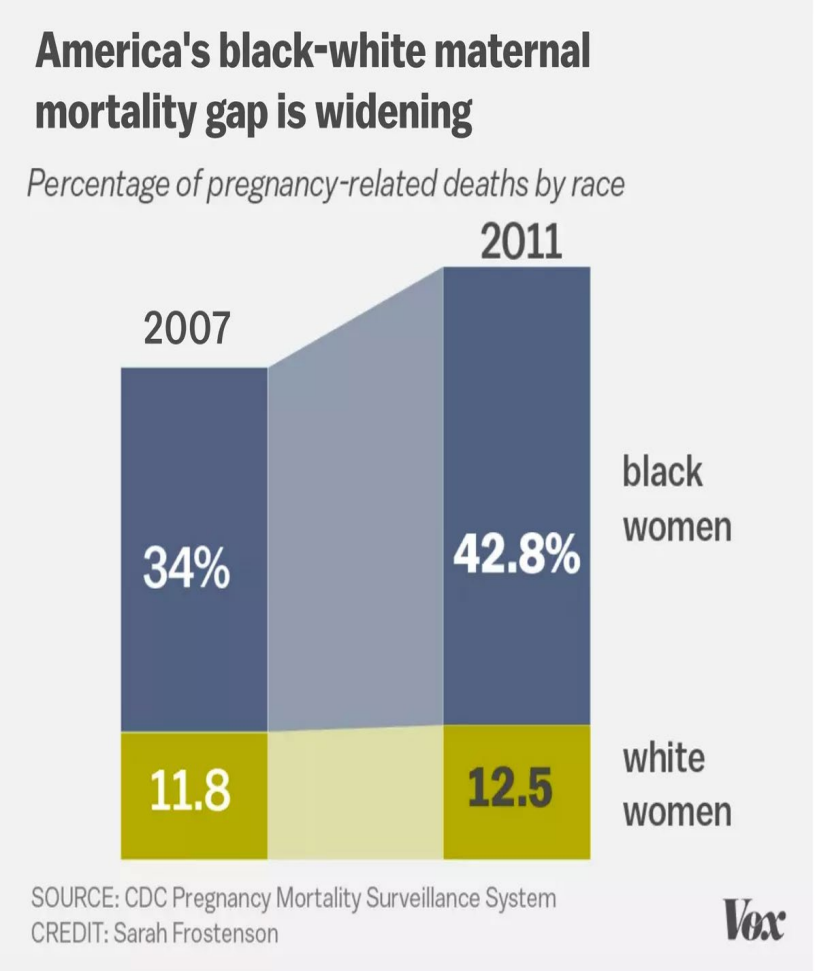
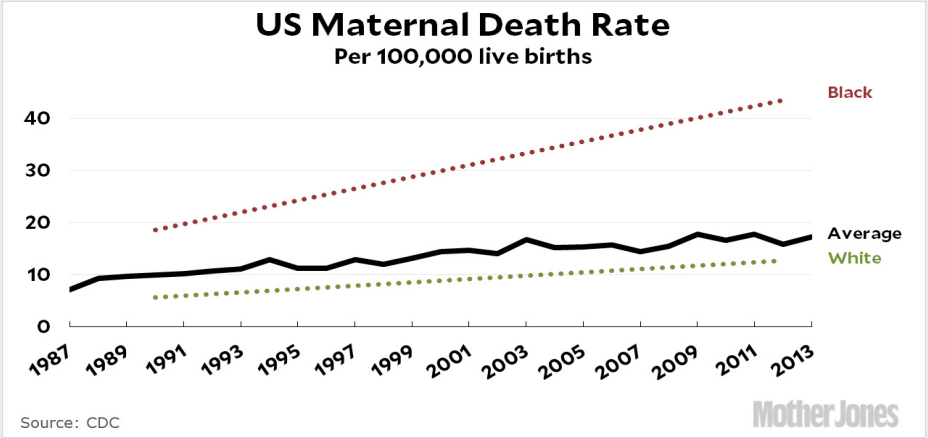
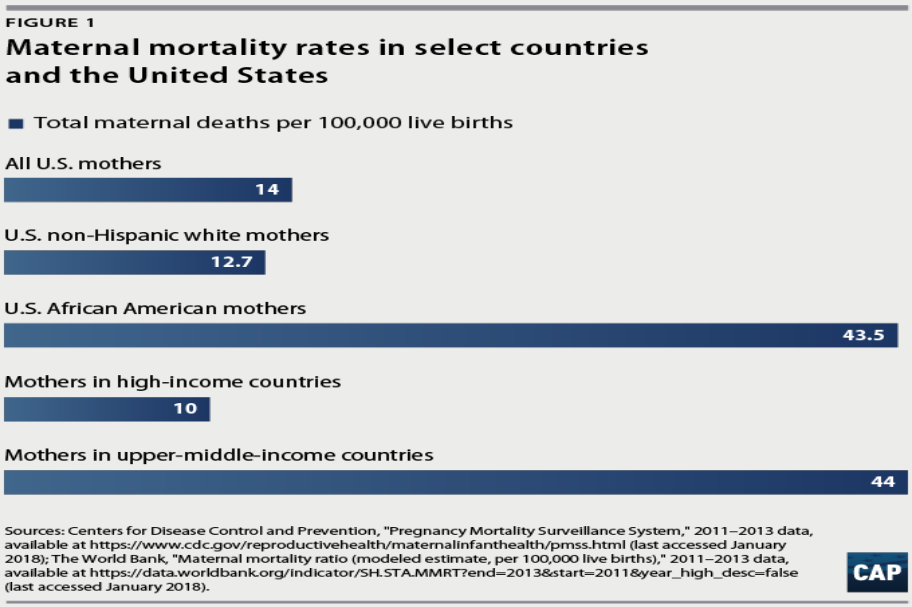
Rising rates of maternal mortality in the US



Racial inequities in maternal health



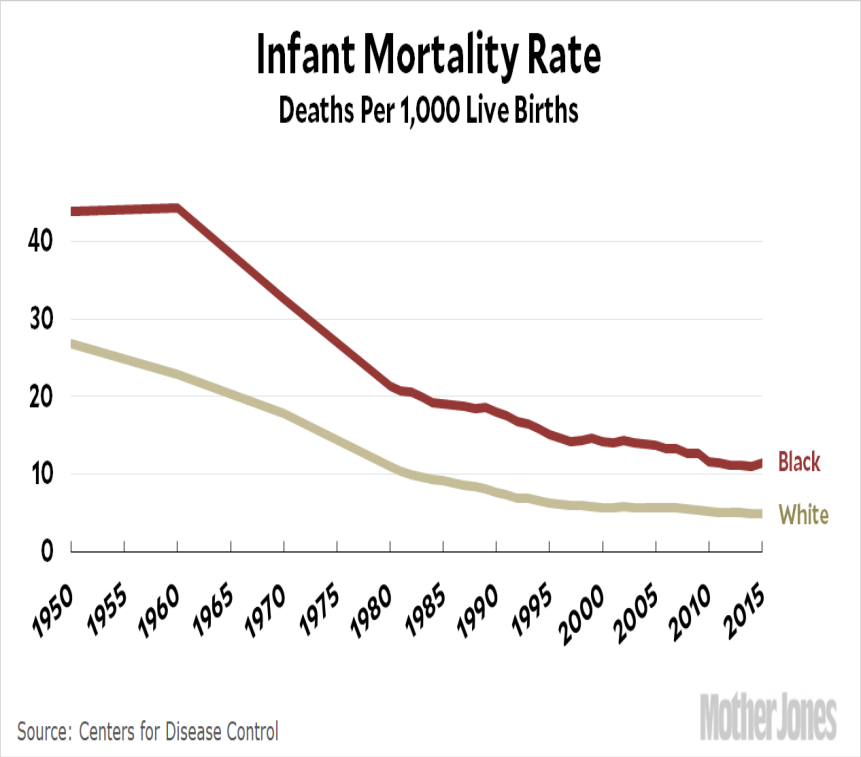


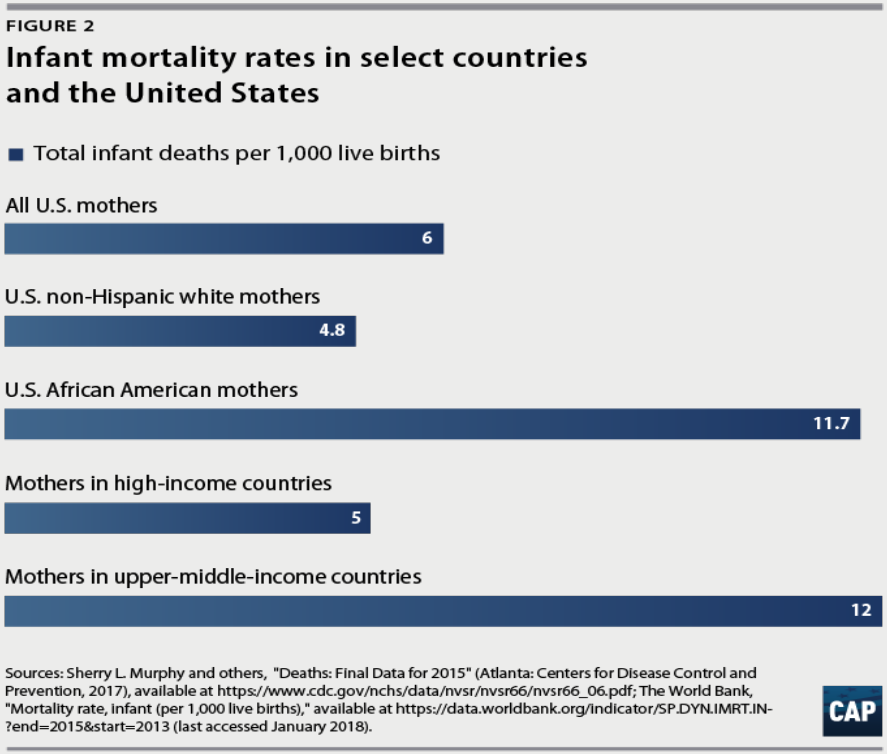


Maternal Mortality in Minnesota

- Based on preliminary data from 2011-2017, the maternal mortality rate for non-Hispanic Black women is 2.3 times higher when compared to white mothers.
- The American Indian maternal mortality rate is approximately 4 times higher than that for white mothers.
- These data suggest that almost half (47%) of maternal deaths occur in greater Minnesota.

Infant Mortality



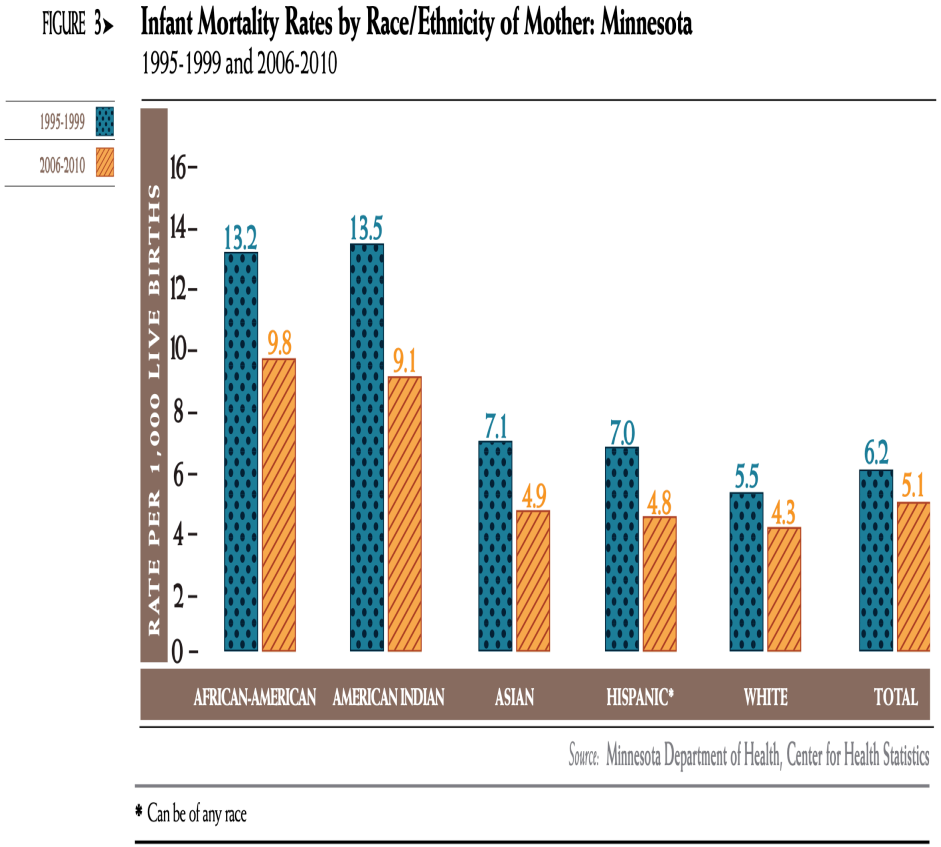


Infant Mortality in Minnesota

- MN infant mortality rate is one of the lowest in the US

But…

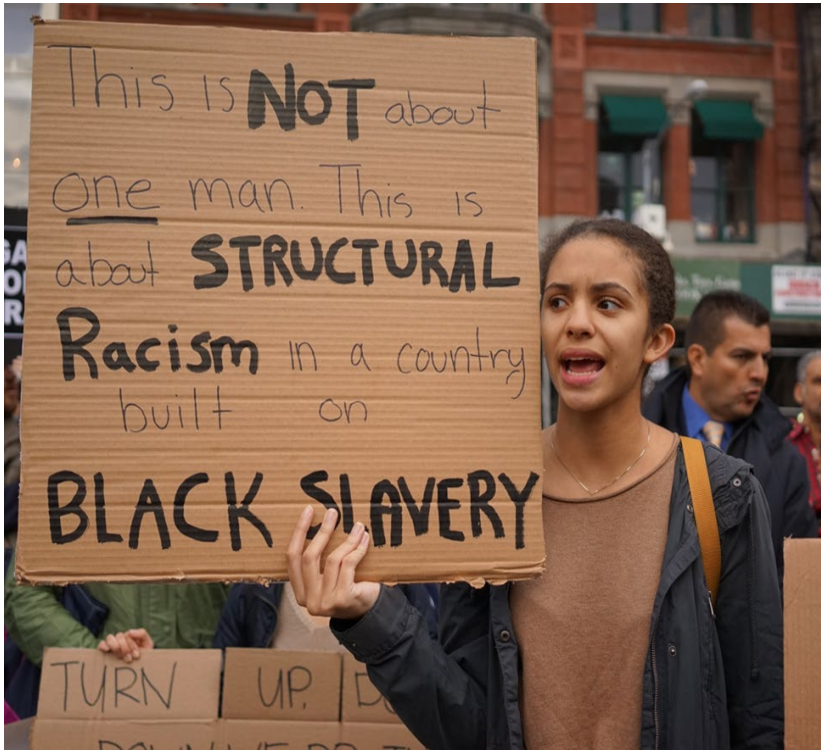
- Our overall IMR disguises substantial variation by race
- The burden of infant mortality is not shared equally

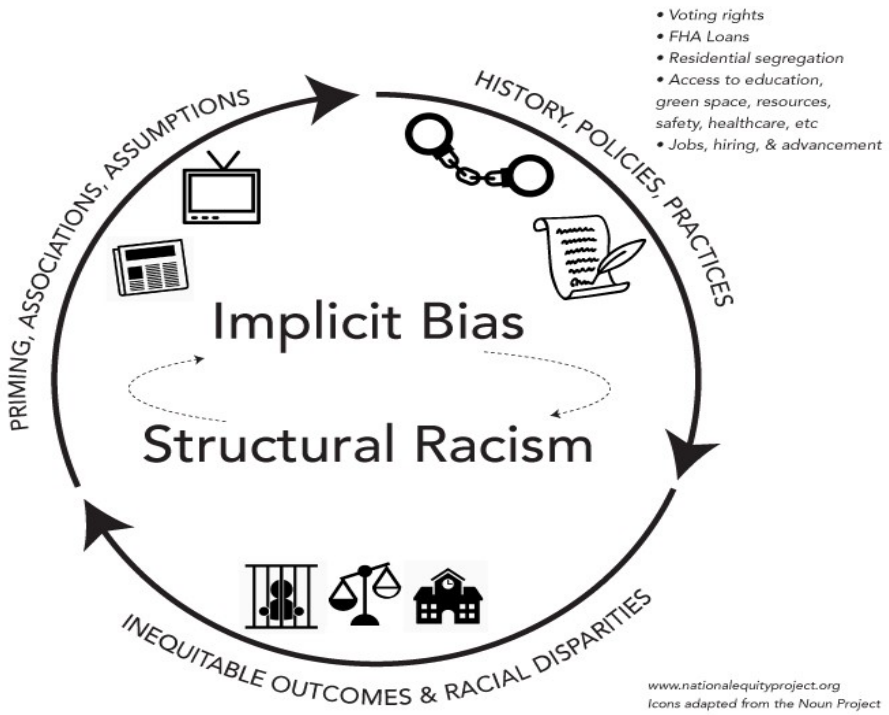


Root Cause?

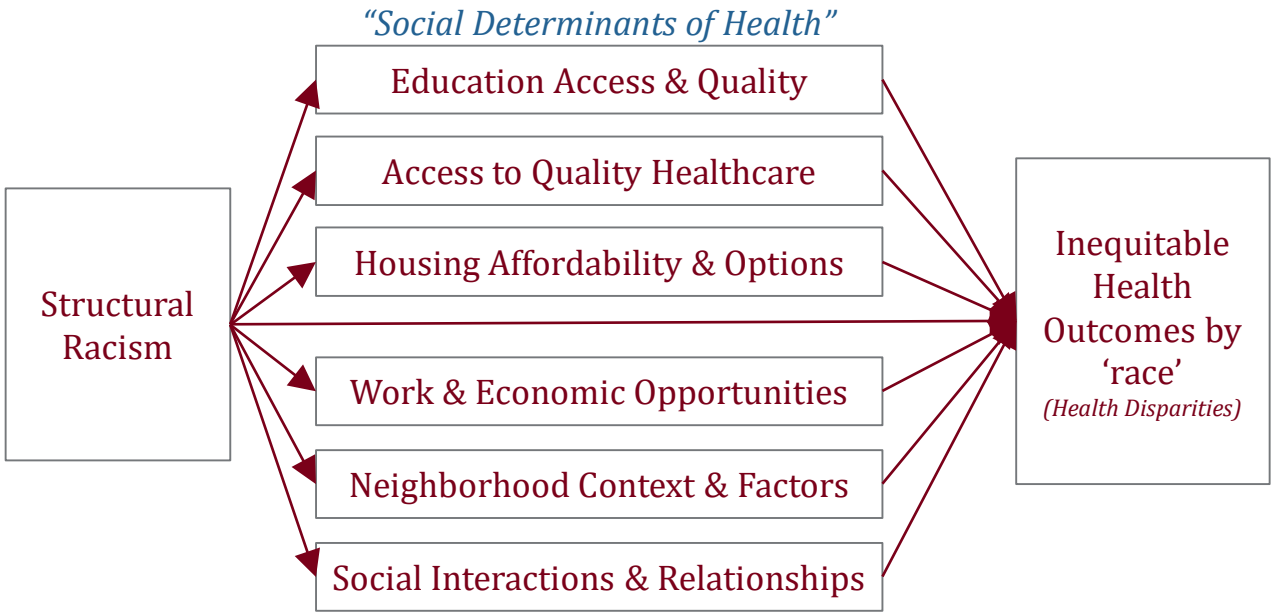
Racism not Race is a Risk Factor in Reproductive Health Inequities

-Dr. Joia Crear-Perry Founder, National Birth Equity Collaborative


This is NOT about
one man. This is
about STRUCTURAL
Racism in a country
built on
BLACK SLAVERY
TURN
UP


• Voting rights
• FHA Loans
• Residential segregation
• Access to education, green space, resources, safety, healthcare, etc
• Jobs, hiring, & advancement
HISTORY, POLICIES, PRACTICES
PRIMING, ASSOCIATIONS, ASSUMPTIONS
Implicit Bias
Structural Racism
INEQUITABLE OUTCOMES & RACIAL DISPARITIES
www.nationalequityproject.org
Icons adapted from the Noun Project

Structural Racism and Health Inequity



The Evidence:
How does the confluence of implicit bias and structural racism show up in health & health care delivery for Black moms and babies?

Structural Racism and Maternal Mortality

- ***Are there associations between county-level indicators of structural racism and Maternal Mortality among non-Hispanic Black and white populations in the US?***
  - *County level structural racism indicators* included the white to black ratio in:
    - Educational attainment;
    - Employment;
    - Median household income;
    - Prison rates;
    - Jail incarceration rates
- *Overall structural racism* :
  - a dichotomized variable of high & low structural racism
  - the Index of Concentration at the Extremes (ICE) where higher scores indicate a larger concentration of high-income residents.

Yes!

- Structural racism in:
  - **median household income** and **educational attainment** were associated with a 12% and 16% increase in overall Maternal mortality
  - **median household income** and **county-level prison incarceration** were associated with a 27% and 28% increase in Black maternal mortality
- Counties with **higher ICE scores** (larger concentration of high-income residents) had 21% lower overall Maternal mortality
- **Overall structural racism** in the county was associated with a 37% increase in Black Maternal mortality

Police contact as a determinant of structural racism

RACE

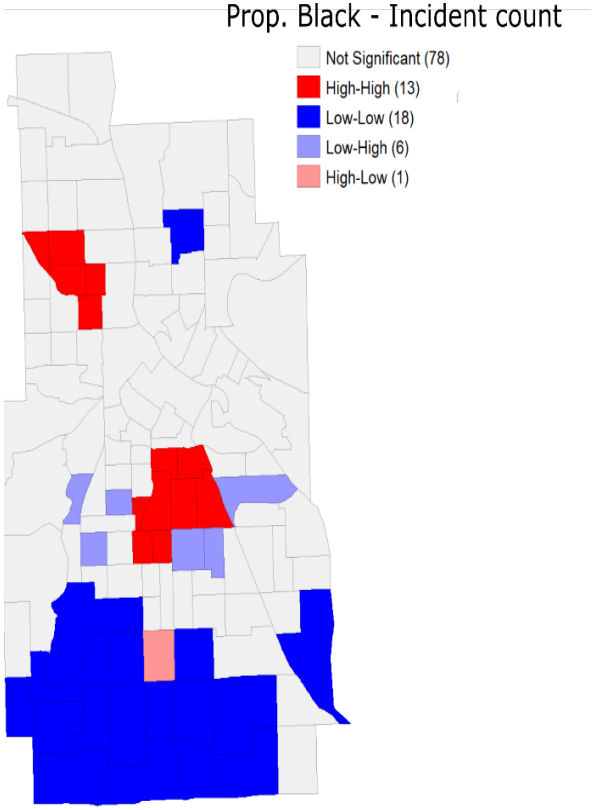
< How Police Violence Could Impact The Health Of Black Infants

November 13, 2020 · 5:01 AM ET

7-Minute Listen + PLAYLIST

Transcript

DAVID GREENE, HOST:



Learn more here: NPR Story

Vedam et al. Reproductive Health (2019) 16:77
https://doi.org/10.1186/s12978-019-0729-2

Reproductive Health

RESEARCH Open Access

The Giving Voice to Mothers study: inequity and mistreatment during pregnancy and childbirth in the United States

Saraswathi Vedam[1*], Kathrin Stoll[1], Tanya Khemet Taiwo[2,3], Nicholas Rubashkin[4], Melissa Cheyney[5], Nan Strauss[6], Monica McLemore[7], Micaela Cadena[8], Elizabeth Nethery[9], Eleanor Rushton[1], Laura Schummers[10], Eugene Declercq[11] and the GVtM-US Steering Council

Abstract

Background: Recently WHO researchers described seven dimensions of mistreatment in maternity care that have adverse impacts on quality and safety. Applying the WHO framework for quality care, service users partnered with NGOs, clinicians, and researchers, to design and conduct the Giving Voice to Mothers (GVtM)–US study.

Methods: Our multi-stakeholder team distributed an online cross-sectional survey to capture lived experiences of maternity care in diverse populations. Patient-designed items included indicators of verbal and physical abuse, autonomy, discrimination, failure to meet professional standards of care, poor rapport with providers, and poor conditions in the health system. We quantified the prevalence of mistreatment by race, socio-demographics, mode of birth, place of birth, and context of care, and describe the intersectional relationships between these variables.

Results: Of eligible participants ($n = 2700$), 2138 completed all sections of the survey. One in six women (17.3%) reported experiencing one or more types of mistreatment such as loss of autonomy; being shouted at, scolded, or threatened; and being ignored, refused, or receiving no response to requests for help. Context of care (e.g. mode of birth; transfer; difference of opinion) correlated with increased reports of mistreatment. Experiences of mistreatment differed significantly by place of birth: 5.1% of women who gave birth at home versus 28.1% of women who gave birth at the hospital. Factors associated with a lower likelihood of mistreatment included having a vaginal birth, a community birth, a midwife, and being white, multiparous, and older than 30 years.
Rates of mistreatment for women of colour were consistently higher even when examining interactions between race and other maternal characteristics. For example, 27.2% of women of colour with low SES reported any mistreatment versus 18.7% of white women with low SES. Regardless of maternal race, having a partner who was Black also increased reported mistreatment.

Conclusion: This is the first study to use indicators developed by service users to describe mistreatment in childbirth in the US. Our findings suggest that mistreatment is experienced more frequently by women of colour, when birth occurs in hospitals, and among those with social, economic or health challenges. Mistreatment is exacerbated by unexpected obstetric interventions, and by patient-provider disagreements.

Keywords: Respectful maternity care, Mistreatment, Pregnancy, Childbirth, Race, Disrespect, Abuse, Participatory research, Hospital birth, Home birth, Health equity, Midwifery, Quality measure

* Correspondence: saraswathi.vedam@ubc.ca
[1]Birth Place Lab, Division of Midwifery, Faculty of Medicine, University of British Columbia, Vancouver (Canada), 5410 Shaughnessy (Mailbox 80), 4500 Oak Street, Vancouver, BC V6H 3N1, Canada
Full list of author information is available at the end of the article

Social Science & Medicine 201 (2018) 127–135

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Health care experiences of pregnant, birthing and postnatal women of color at risk for preterm birth

Monica R. McLemore[a,*], Molly R. Altman[b], Norlissa Cooper[c], Shanell Williams[b], Larry Rand[d], Linda Franck[d]

[a] Family Health Care Nursing Department, University of California, 2 Koret Way, N631H, San Francisco, CA, 94143, United States
[b] UCSF Preterm Birth Initiative, 3333 California Street, Suite 285, San Francisco, CA, 94118, United States
[c] Department of Social and Behavioral Sciences, Health Policy, University of California, 3333 California Street, San Francisco, CA, 94118, United States
[d] Mary and Lynne Benioff Endowed Chair in Maternal Fetal Medicine, Director of Perinatal Services, Fetal Treatment Center, University of California, Dept. of Ob/Gyn and Surgery, Division of Perinatology and Pediatric Surgery, 550 16th Street, Box 94132, San Francisco, CA, 94143-0132, United States
[e] Department of Family Health Care Nursing, Jack and Elaine Koshes Endowed Chair in Pediatric Nursing, University of California, 2 Koret Way, N631H, Box 0606, San Francisco, CA, 94143, United States

ARTICLE INFO

Keywords:
Preterm birth
Health inequities
Health disparities
Stress
Women of color

ABSTRACT

Background: Chronic stress is a known risk factor for preterm birth, yet little is known about how healthcare experiences add to or mitigate perceived stress. In this study, we described the pregnancy-related healthcare experiences of 34 women of color from Fresno, Oakland, and San Francisco, California, with social and/or medical risk factors for preterm birth.

Methods: This study was a secondary analysis of focus group data generated as part of a larger project focused on patient and community involvement to preterm birth research. English and Spanish-speaking women, age 18 or greater with social and/or medical risk factors for preterm birth participated in two focus groups, six weeks apart. Data from the first focus groups are included in this analysis.

Results: Five themes emerged from thematic analysis of the transcripts. Participants described disrespect during healthcare encounters, including experiences of racism and discrimination; *stressful interactions* with all levels of staff; *unmet information needs*; and *inconsistent social support*. Despite these adverse experiences, women felt *confidence in parenting and newborn care*. Participant recommendations for healthcare systems improvement included: greater attention to birth plans, better communication among multiple healthcare providers, more careful listening to patients during clinical encounters, increased support for social programs such as California's Black Infant Health, and less reliance on past carceral history and/or child protective services involvement.

Discussion: The women in this study perceived their prenatal healthcare as a largely disrespectful and stressful experience. Our findings add to the growing literature that women of color experience discrimination, racism and disrespect in healthcare encounters and that they believe this affects their health and that of their infants.

1. Introduction

Preterm Birth (PTB) is defined as birth occurring prior to 37 weeks of gestation (Behrman and Butler, 2007). It is estimated that 1 in 9 infants in the US are born too early and these infants are at risk of mortality and neonatal morbidity, with the risk inversely related to gestational age (Muraca et al., 2016). The causes of PTB remain poorly understood (Behrman and Butler, 2007). Epidemiologic evidence suggests preventable socio-behavioral risk factors for PTB, including: substance use (i.e., alcohol, illegal drugs, tobacco) (Bryant et al., 2010), stress and pregnancy-related anxiety (Hogue and Bremner, 2005; Rich-Edwards and Grizzard, 2005), poor nutrition (Hennessey et al., 2009), late entry to prenatal care (Bryant et al., 2010; Genuneo et al., 2008), and unintended pregnancy (Behrman and Butler, 2007). Non-Hispanic Black women in the US are 50% more likely to experience PTB than white women (Martin et al., 2014). Additionally, in 2014 the PTB rate for Black women was estimated to be 13.23% and 9.03% in Hispanic women (Martin et al., 2014). Despite attempts to elucidate the causes of this health-related disparity, PTB remains a complex medical-social condition where little progress has been made over recent decades to reduce rates or improve outcomes. Research that more fully engages the people most affected by PTB may lead to breakthroughs in addressing

* Corresponding author.
E-mail addresses: monica.mclemore@ucsf.edu (M.R. McLemore), molly.altman@ucsf.edu (M.R. Altman), norlissa.cooper@ucsf.edu (N. Cooper), shanell.williams@ucsf.edu (S. Williams), larry.rand@ucsf.edu (L. Rand), linda.franck@ucsf.edu (L. Franck).

https://doi.org/10.1016/j.socscimed.2018.02.013
Received 23 September 2017; Received in revised form 25 January 2018; Accepted 15 February 2018
Available online 16 February 2018

Social Science & Medicine 232 (2019) 270–277

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Declined care and discrimination during the childbirth hospitalization

Laura B. Attanasio[a,*], Rachel R. Hardeman[b]

[a] Department of Health Promotion and Policy, University of Massachusetts Amherst School of Public Health and Health Sciences, Amherst, MA, USA
[b] Division of Health Policy and Management, University of Minnesota School of Public Health, Minneapolis, MN, USA

ARTICLE INFO

Keywords:
U.S.
Childbirth
Discrimination
Women of color
Patient-provider interaction

ABSTRACT

Many studies have documented poorer patient-provider interactions among people of color compared to Whites, including lower-quality patient-provider communication, less involvement in decision making, and higher chances of perceived discrimination or healthcare encounters. In maternity care, where overuse of medical interventions such as cesarean delivery is a concern, women may try to exert agency by declining procedures. However, declining procedures may brand these women as uncooperative or non-compliant patients. The potential consequences of this are likely worse for women of color, who already expend more effort to manage their image during healthcare encounters in order to avoid stereotypes (e.g. the "angry Black woman"). Using a national sample of women who gave birth in U.S. hospitals in 2011–2012, we examined the relationship between declining procedures and discrimination during the childbirth hospitalization. We found that women who reported having declined care for themselves or their infant during the childbirth hospitalization were more likely to report "poor treatment" based on race and ethnicity, insurance status or having a difference of opinion with a healthcare provider. Moreover, the increase in odds of perceived discrimination due to a difference of opinion with a healthcare provider was significantly larger in magnitude for Black women compared to White women. These results suggest that in the context of childbirth care, women pay a penalty for exhibiting behavior that may be perceived as uncooperative, and this penalty may be greater for Black women.

1. Introduction

Many studies have documented poorer patient-provider interactions among people of color compared to Whites (Attanasio et al., 2018; Bertakis and Azari, 2011; Ghods et al., 2008; Hausmann et al., 2008; Martin et al., 2013; Ratanawongsa et al., 2010; Street et al., 2007; Weech-Maldonado et al., 2012; White-Means and Osmani, 2017). In maternity care, where overuse of medical interventions such as cesarean delivery is a concern (American College of Obstetricians and Gynecologists, 2014; Committee on Obstetric Practice, 2017; MacDorman et al., 2008; Molina et al., 2015; Queenan, 2011; Ye et al., 2014), women may try to exert agency by declining procedures. (We acknowledge that not all birthing people identify as women. Throughout the manuscript we use the terminology of "women" and "mothers" for consistency with the survey data source used is the analysis and the literature cited.) However, declining procedures may result in these women being viewed as uncooperative or non-compliant patients (Kozhimannil et al., 2016; Morton et al., 2016). The potential consequences of this are likely worse for women of color, who already expend more effort to manage their image during healthcare encounters in order to avoid stereotypes (e.g. the "angry Black woman") (Malat et al., 2006; McLemore et al., 2018). Using a national sample of women who gave birth in United States (U.S.) hospitals in 2011–2012, we sought to examine the relationship between declining procedures and discrimination during the childbirth hospitalization.

1.1. The patient-provider relationship

Over the last two decades, patient-centered care has been held up as the ideal model of patient-provider interaction in all types of healthcare; the implementation of patient-centered care is now recognized as an integral component of care quality (Committee on Quality of Health Care in America, 2001; Epstein et al., 2010). In an approach consistent with patient-centered care, clinicians respect and take into account individual patients' preferences and values, and involve patients in decision-making (Berwick, 2009; Committee on Quality of Health Care in America, 2001; Ruhnet et al., 2013). Along with this shift toward patient-centered care, patients are increasingly viewed as consumers (Boyer and Lutfey, 2010; Lupton, 1997; Potter and McKinley, 2005). In this model, healthcare providers are charged with providing adequate information to patients to enable them to make decisions that best fit their preferences, while patients are charged with active involvement in

* Corresponding author. University of Massachusetts Amherst, 318 Arnold House, 715 North Pleasant St. Amherst, MA, 01003, USA.
E-mail address: lattanasio@umass.edu (L.B. Attanasio).

https://doi.org/10.1016/j.socscimed.2019.05.008
Received 17 July 2018; Received in revised form 6 May 2019; Accepted 9 May 2019
Available online 10 May 2019

Numerous studies document Black women's experiences of racism in the healthcare system

Vedam, Saraswathi, et al. *Reproductive Health* 16.1 (2019): 1-18.
McLemore, Monica R., et al. *Social Science & Medicine* 201 (2018): 127-135.
Attanasio, Laura B., and Rachel R. Hardeman. *Social Science & Medicine* 232 (2019): 270-277.

Health

Mortality rate for Black babies is cut dramatically when Black doctors care for them after birth, researchers say

Rachel Hardeman has dedicated her career to fighting racism and the harm it has inflicted on the health of Black Americans. As a reproductive health equity researcher, she has been especially disturbed by the disproportionately high mortality rates for Black babies.

In an effort to find some of the reasons behind the high death rates, Hardeman, an associate professor at the University of Minnesota School of Public Health, and three other researchers combed through the records of 1.8 million Florida hospital births between 1992 and 2015 looking for clues.

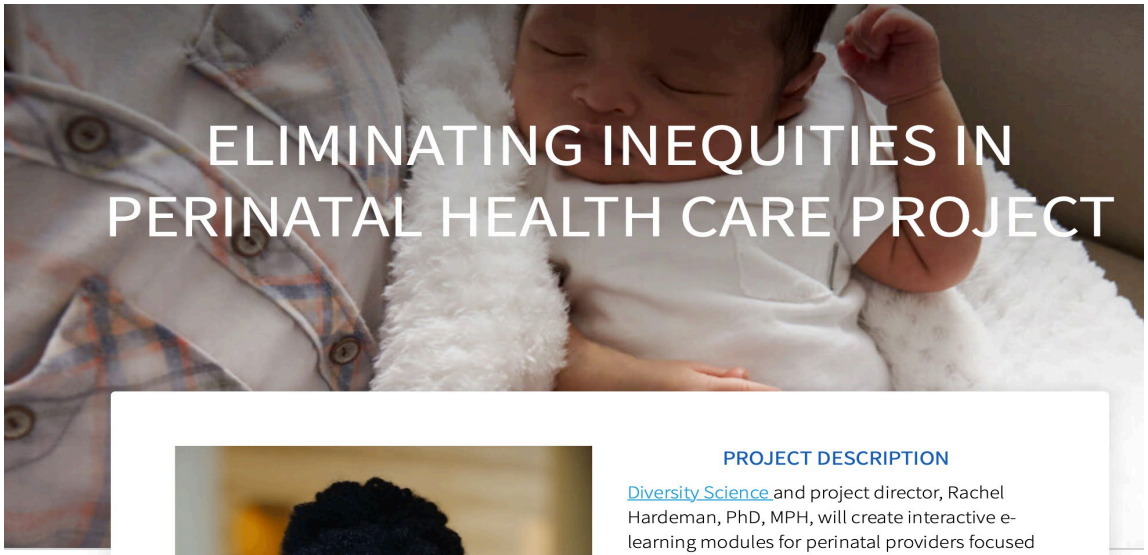
They found a tantalizing statistic in the Florida births. Although Black newborns are three times as likely to die as White newborns, when Black babies were cared for by Black doctors after birth — primarily pediatricians, neonatologists and family practitioners — their mortality rate was cut in half. They found an association, not a cause and effect, and the researchers said more studies are needed to understand what effect, if any, a doctor's race might have on infant mortality.

(Dóra Kisteleki for The Washington Post)

Potential Policy Solutions

- Invest in the Social Determinants of Health
- Fund community based, Black led organizations
- Grow and diversify the perinatal & healthcare workforce
- Improve and mandate data collection and quality measures
  - Support MMRC and FIMR
- Support innovative care models & payment models
- Medicaid coverage up to 1 year postpartum
- Mandate training

Implicit bias & Anti-racism training



Project Director, Rachel Hardeman, PhD, MPH

PROJECT DESCRIPTION

Diversity Science and project director, Rachel Hardeman, PhD, MPH, will create interactive e-learning modules for perinatal providers focused on implicit bias and reproductive justice.

These resources are developed in accordance with the training requirements outlined in the California Dignity in Pregnancy and Childbirth Act (Senate Bill 464) which went into effect in January 2020.

All of the e-learning modules and resources developed for this project will be available free of charge. This project was funded by the California Health Care Foundation in response to strong evidence of racial inequalities in perinatal care

https://www.diversityscience.org/training/equal-perinatal-care/

Thank You!

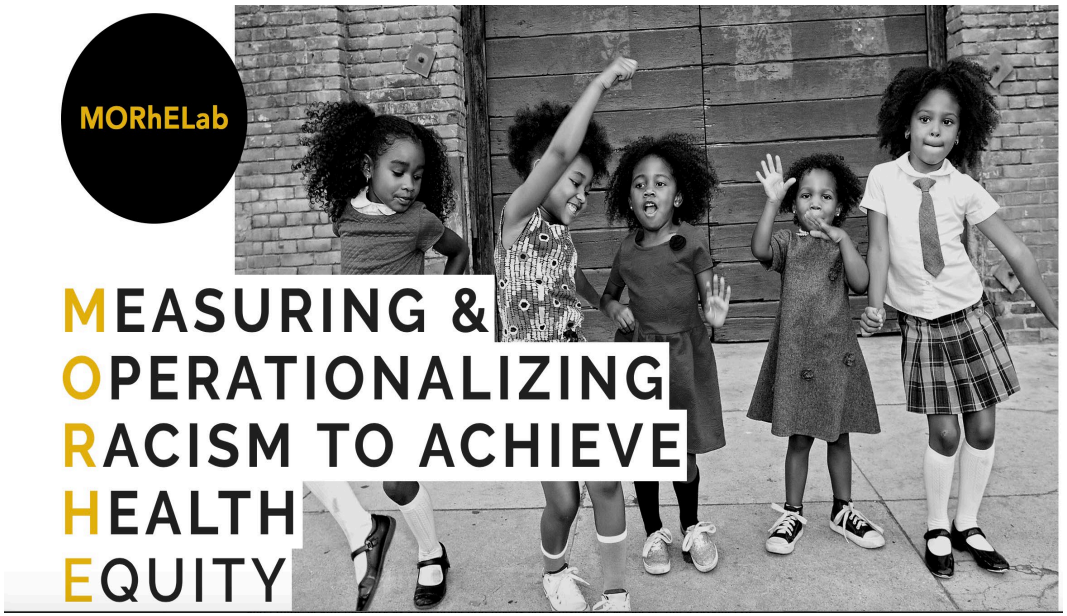
Acknowledgements: Alyssa Fritz MPH

Rachel R. Hardeman PhD, MPH

hard0222@umn.edu

RachelHardeman.com

MORHELab.com



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