



# NCEMCH Policy Brief

No. 3 / November 1998

## *Racial and Ethnic Disparities in Maternal and Child Health*

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*"...the U.S. health care system fails to effectively serve many of the nation's communities."*

**D**emographic experts predict that, by the end of the 21st century, no one racial or ethnic group will constitute a majority in the United States. In fact, as early as the year 2000, one of every three Americans will be African American, Asian/Pacific Islander, Middle Eastern, or Hispanic. People of color will be the majority in 53 of America's largest cities.<sup>1</sup> This trend indicates that there will be increasing numbers of minority children and families whose health care needs deserve special attention.

Understanding the health care needs of racial and ethnic minority groups will empower maternal and child health (MCH) professionals and policymakers to develop effective strategies and programs for the future. Failure to address

the needs of this growing segment of the population will have far-reaching economic, political, and social ramifications for the country.

Despite increasing health care expenditures and extraordinary medical breakthroughs, the U.S. health care system fails to effectively serve many of the nation's communities. Much evidence indicates that minority race and ethnicity are associated with disparate health outcomes; minority children are at greater risk for poor health for reasons that can include lack of health insurance, poverty, and difficulty accessing culturally competent health care. Although health outcomes can be affected by genetic makeup and lifestyle choices, many external factors are at work to derail good health and appropriate access to health care. An

agenda for promoting personal responsibility for one's health should be implemented with strategies designed to address the systemic barriers to good health care.

To achieve new insight and direction for meeting the health care needs of growing minority groups, the MCH community can strive to collect more complete and accurate data. The MCH community can also work to institutionalize guidelines for creating culturally competent, community-based systems of care that respect patients' cultures and customs while designing the best course of action for health.

In February 1998, President Clinton unveiled the Initiative to Eliminate Racial and Ethnic Disparities in Health, which aims to eliminate such disparities by 2010. This initiative parallels goals and objectives that will be established by *Healthy People 2010*, and focuses on six priority areas: infant mortality; immunization; HIV/AIDS; diabetes; cardiovascular disease; and cancer screening and treatment.

## Infant Mortality Rates

Infant mortality is an important indicator of the well-being of infants, children, and pregnant women because it is associated with a variety of factors, such as maternal health, quality of and access to medical care, socioeconomic conditions, and public health practices.<sup>2</sup> While the overall infant mortality rate in the United States has declined to a record low of 7.2 deaths per 1,000 live births (1996 data), the United States still ranks 24th in infant mortality among industrialized nations. Furthermore, when U.S. infant mortality rates are broken down by vari-

ous subpopulations, it becomes very clear that there is substantial variation in mortality rate by race and ethnicity.<sup>3</sup>

Recent data continue to reveal infant death rates among African Americans, American Indians/Alaska Natives, and Hispanics that are higher than the national average. The greatest disparity exists for African Americans, whose infant death rate (14.2 deaths per 1,000 live births in 1996) is over twice that of white infants (6.0 deaths per 1,000 live births in 1996). The overall rates for American Indian populations (9.0 deaths per 1,000 live births in 1995) and Hispanic populations (7.6 deaths per 1,000 live births in 1995) are also higher than the national average. Moreover, some American Indian communities have infant mortality rates that approach twice the national average, and some subgroups in the Hispanic community have higher infant mortality than their overall group rate would indicate.<sup>4</sup>

Although Asian/Pacific Islander populations have a higher-than-average perinatal risk profile, they appear to have the nation's lowest infant mortality rates. However, this does not imply that Asian/Pacific Islander communities are free from maternal and infant health problems. Although rates of low birthweight differ among ethnic groups within Asian/Pacific Islander populations, overall they are higher than among white Americans. Asians also have the highest proportional infant mortality from birth defects.<sup>5</sup>

The greatest racial and ethnic disparities are seen in the following causes of death in infants: disorders relating to preterm birth (PTB) and unspecified low birthweight; respiratory distress syndrome; infections specific to the perinatal

## Did You Know?

- In 1996, the teen birth rate (number of live births per 1,000 females ages 15–17) was 69 for Hispanics, 65 for African Americans, 47 for American Indian/Alaska Natives, 22 for whites, and 16 for Asian/Pacific Islanders.<sup>6</sup>
- Hispanic children are at greatest risk for lack of health insurance coverage. In 1996, 27.7% of Hispanic children were uninsured, compared with 17.6% of African-American children and 12.3% of white children.<sup>7</sup>
- A 1991 Indian Health Service survey noted that 75% of American Indian/Alaska Native children experienced dental decay in their primary teeth.<sup>8</sup>
- Between 1985 and 1995, the death rate for African-American adolescent males ages 15–19 rose from 125.5 to 202.4 per 100,000 adolescents.<sup>9</sup>
- Data from 1991 through 1994 show that 11.2% of African-American children ages 1–5 had elevated blood lead levels.<sup>10</sup>
- Approximately 19,000 women infected with the hepatitis B virus give birth each year; 46% of these women are members of Asian/Pacific Islander groups.<sup>11</sup>
- The rate of fetal alcohol syndrome among American Indian/Alaska Native infants is 33 times higher than among white populations.<sup>12</sup>



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period; maternal complications of pregnancy; and sudden infant death syndrome (SIDS). In some American Indian/Alaska Native populations, for example, the incidence of SIDS is three to four times that of the white population.<sup>13</sup>

In addition, studies have shown that minority women receive less prenatal care than their white counterparts, contributing to negative outcomes for newborns in minority populations. This may be caused by a confluence of factors: financial constraints and lack of insurance coverage; nonfinancial barriers related to physician supply (especially the availability of culturally competent providers); the belief that an individual cannot control health outcomes;<sup>14</sup> transportation barriers; and difficulties in obtaining adequate child care. Other studies highlight the consequences of maternal risk factors, such as poor nutrition, tobacco use, alcohol use, drug abuse, and the incidence of sexually transmitted diseases.

Overall, very little is known about the causes of the persistent ethnic-group

differences in low birthweight and infant mortality. The educational level of the mother does not appear to explain these disparities. Instead, differences in preterm births and SIDS may reflect variations in the prevalence of risk factors, including socioeconomic and demographic factors, certain medical conditions (such as the high incidence of hypertension and urogenital infections in African-American women), quality of and access to health care, and differences in child-rearing practices.<sup>15</sup> It is interesting to note that foreign-born status is associated with lower risks of low birthweight and infant mortality. Further study is needed to identify which factors of life in the United States negatively influence birth outcomes in minority populations.<sup>16</sup>

## Immunization

Over the past century, the development and widespread use of safe and effective vaccines have led to a tremendous reduction in the incidence of human disease—including the eradication of smallpox. Childhood immunization rates are at an all-time high, with coverage rates of over 90 percent for the most critical vaccines.<sup>17</sup>

Although U.S. immunization rates historically have been lower in minority populations than in white populations, the differential has narrowed in recent years. Nevertheless, pockets of underimmunization still exist among our nation's children, especially in urban areas where many underserved minority populations reside. Efforts must be sustained to both maintain current levels of immunization and encourage full coverage rates to prevent outbreaks of vaccine-preventable disease.

Studies have shown that, even when other factors (such as insurance coverage and income) are controlled for, minority youth are less likely to seek care, including immunizations. This fact should stimulate new directions for outreach programs that consider each subgroup's motivations as well as hesitations in seeking care, so that effective immunization programs can be designed for maximum participation.

## HIV/AIDS

In December 1997, the Centers for Disease Control and Prevention announced a decrease in the number of deaths due to AIDS, citing increased use

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of protease inhibitors that fight HIV and effective therapies to prevent AIDS-opportunistic infections.<sup>18</sup> For the first time since the epidemic began, the impact of HIV/AIDS on the nation was reported to be improving. However,



despite these recent advances in treatment, the AIDS crisis continues to have an increasingly disproportionate effect on racial and ethnic minority communi-

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ties. Although minorities constituted an estimated 27 percent of the U.S. population in 1996, they accounted for 52 percent of AIDS-related deaths in 1995 and 1996.<sup>19</sup> African Americans and Hispanic Americans accounted for 43 percent and 20 percent, respectively, of all new AIDS cases reported from July 1996 through June 1997.<sup>20</sup> This disheartening trend increasingly affects the maternal and child health population.

The incidence of HIV/AIDS in women is growing faster than in any other segment of the population, a fact that is only beginning to receive public attention. Through the end of 1997, 77 percent of AIDS cases and 75 percent of HIV infections reported in young and adult women were among racial and ethnic minorities.<sup>21</sup> The majority of HIV-

positive women are of childbearing age, and their infection obviously poses additional risks to their health during pregnancy and to the health of their children.

Perinatal transmission, the cause of the majority of AIDS cases in children through age 13, has decreased considerably with the promotion of voluntary HIV counseling and screening for pregnant women, and the prenatal use of zidovudine (ZDV). However, these essential benefits often are not available for pregnant women in minority populations, because of a lack of health insurance coverage, high costs, and a health care system that is often physically inaccessible and culturally unfamiliar. The incidence of pediatric AIDS is more than three times greater in African-American children, and two-and-one-half times greater in Hispanic children, than in white children.<sup>22</sup> The continued transmission of perinatal AIDS in minority populations underscores the need for additional strategies to ensure that minority women receive culturally competent, high-quality prenatal care that includes HIV counseling, opportunities for testing, access to services and new drug therapies, and breastfeeding education.

AIDS also has a disproportionate impact on minority adolescents. As of 1996, 46 percent of reported AIDS cases in adolescents were among African Americans, 34 percent among whites, and 19 percent among Hispanics.<sup>23</sup> Educating adolescents about HIV prevention is complicated because the primary method of transmission differs for each community. More than half of the infections in white adolescents are due to the receipt of infected blood transfusions or clotting factor for hemophilia; 18 per-

cent of white patients were exposed through male-to-male sexual contact; and 10 percent through heterosexual contact. Among African-American adolescents, 33 percent acquired AIDS through heterosexual contact; male homosexual contact accounted for 26 percent of cases.<sup>24</sup>

Although the number of AIDS cases among Asian/Pacific Islander and American Indian/Alaska Native youth is small in the context of the entire U.S. population, the incidence of HIV infection continues to increase, and must be studied more fully.<sup>25</sup> Little is known about the risk factors for these two populations, thus critically hampering efforts to prevent infection and provide necessary care to those living with HIV/AIDS. For example, American Indian/Alaska Native adolescents account for only .6 percent of the adolescent AIDS caseload, yet this population continues to be at increased risk for HIV infection due to socioeconomic and behavioral factors that include high rates of poverty, sexually transmitted diseases, and drug use.<sup>26</sup> The development of effective prevention strategies for American Indian/Alaska Native youth is continually hampered by the scarcity of data on incidence and risk factors within each of the culturally diverse tribes.

### Cardiovascular Disease, Cancer, and Diabetes

Cardiovascular disease, cancer, and diabetes are the first, second, and seventh leading causes of death, respectively, in the United States, accounting for millions of fatalities each year.<sup>27</sup> A disproportionate burden of these illnesses is borne by racial and ethnic minorities, causing



increased mortality rates and impairing quality of life with higher incidences of disability. These chronic conditions not only have devastating physical and emotional consequences for minority families, but also result in striking economic repercussions for our health care system.

Recognizing that minority communities are more likely to have certain risk factors for these diseases is an important element in efforts to eliminate disparities in the incidence of these diseases. Racial and ethnic minorities experience higher rates of hypertension, high cholesterol levels, obesity, sedentary lifestyle, and cigarette smoking.<sup>28</sup> These same populations may lack health insurance coverage and access to culturally competent health

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care providers; the combination of high risk and difficulties in gaining access to quality care has had a profound impact on minority health.

Prevention is key to addressing the problem. To effectively prevent chronic

disease in minorities, it is necessary to determine the contributions of both genetic and environmental factors early in a child's life. Studies that shed light on the causes and effects associated with disease in minority populations can be useful in establishing early preventive measures. The Bogalusa Heart Study noted that African-American boys had higher blood pressure throughout childhood and adolescence, even though their white counterparts had a higher body mass index.<sup>29</sup> More adolescents are developing type 2 (non-insulin-dependent) diabetes during adolescence, a particular concern for American Indian/Alaska Native youth, who have a prevalence rate more than twice that of the total population.<sup>30</sup> Adolescent tobacco use, a risk factor for lung cancer, coronary heart disease, and stroke, is climbing among Hispanic and African-American adolescents, after years of substantial decline for all four minority groups.<sup>31</sup> Poor diet, lack of physical activity, and a variety of sociocultural factors continue to lead to an increased incidence of obesity in minority children; frequently, the obesity persists as these children enter adolescence and adulthood.

Childhood and adolescence offer an important window of opportunity to lay the foundation for healthy behaviors that reduce the likelihood of disease. Culturally appropriate interventions that provide preventive health care services, promote healthy and active lifestyles, and screen for prevalent risk factors will improve the health status of minority children. Good health practices early in life will hopefully carry through to adulthood. ■

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