

# Uncovering the Role of Racism in DC Reproductive Health Inequities

The DC City Council provided funding for the District of Columbia Department of Health (DC Health) to support a research study to better understand the role that racism may be playing in Black women’s decisions about when and where to access prenatal care—particularly those who live in Wards 5, 7 and 8. Timing for entry into prenatal care has been linked to poor perinatal health outcomes, such as low birth weight, preterm delivery and can also contribute to maternal and infant deaths. This literature review was completed by researchers at the Georgetown University Center for Child and Human Development to inform the development of a qualitative data collection protocol. Once approved by the Institutional Review Board of DC Health, this study will collect data through interviews and focus groups with community stakeholders and women from areas of the city that have been disproportionately impacted by these perinatal health outcomes. The data gathered from this study during 2020 will help inform DC Health’s efforts to close the racial and income gaps that persist in the city.

## Statement of the Problem: Persistent Racial Reproductive Health Disparities

Infant mortality rates (IMR) (the number of infant deaths per 1,000 live births) and maternal mortality rates (MMR) (number of pregnancy-related deaths for every 100,000 live births) convey critical information about a jurisdiction’s capacity to promote the health and well-being of citizens—including its youngest and most vulnerable populations<sup>4, 24, 25, 26, 33, 32</sup>. The District of Columbia (DC) has one of the highest infant mortality rates, (7.59)<sup>8</sup>, and maternal mortality rates in the U.S. (36/100,000)<sup>8, 24, 26</sup> despite the fact that most DC residents are insured<sup>10, 38</sup>. The IMR and MMR in DC are even higher for non-Hispanic Black families<sup>8, 9, 24, 33, 38, 42</sup> especially for those living in Wards 5, 6, 7 and 8. Furthermore, comparing 2013 data from the *District of Columbia Community Health Needs Assessment*<sup>31</sup> with the *Perinatal Health and Infant Mortality Report* (2018) showed infant mortality rates had the greatest increase in Ward 8 from 10.9 to 14.57.\*

\* Because the DC resident population of women is relatively small (i.e., there is never anything close to the 100,000 denominator for MMR), there are often large variations year to year in this statistic.

Not only do Black families in DC living in Wards 5, 7 and 8 have high rates of IMR and MMR<sup>8,9,38</sup>, they also have higher rates of preterm and low birthweight deliveries<sup>8</sup>, which when differentiated by race, are the leading cause of infant mortality for non-Hispanic African Americans in the U.S.<sup>13,47</sup>. In 2016, Ward 5 (10.9), Ward 7 (13.9), and Ward 8 (14) had the highest rates of low birthweight rates in DC<sup>8</sup>. Furthermore, the highest preterm birth rates were also found in the same three Wards: Ward 5 (11.8), Ward 7 (13.4), and Ward 8 (13.8)<sup>8</sup>.

**TABLE 1 Perinatal Reproductive Health Disparities by Ward, DC** [Infant Mortality Rate Years: 2012-2016; Preterm Birth and Low Birthweight Years: 2015-2016]

Ward	Infant Mortality Rate	Preterm Birth Percentage	Low Birthweight Percentage
1	5.65	7.87	7.30
2	2.22	7.12	6.96
3	2.27	8.59	7.68
4	5.15	9.84	8.08
5	9.19	11.53	10.64
6	5.71	8.61	8.21
7	9.34	13.10	13.64
8	14.57	13.61	14.41

\*Data taken from *Perinatal Health and Infant Mortality Report*, 2018

Pregnant women who do not access prenatal health care services are at greater risk for giving birth to preterm and low birth weight babies; preterm birth and low birth weight, in turn, are associated with higher rates of infant mortality<sup>8, 23</sup>. In DC, non-Hispanic Black women had the lowest rates of accessing prenatal care either late (9.75% access care in the third trimester compared to Hispanic 5.06% and White 1.87%) or not at all (4.26% compared to Hispanic 1.24% and White 0.23%) compared to their racial and ethnic counterparts<sup>8</sup>.

**TABLE 2 Pregnancy characteristics of women who had live births, overall and by maternal race and ethnicity, District of Columbia 2015-2016**

		Maternal Race/Ethnicity <sup>a</sup>									
		DC Overall		Non-Hispanic, White		Non-Hispanic, Black		Hispanic		Non-Hispanic, Asian/Pacific Islander	
		N	Percent	N	Percent	N	Percent	N	Percent	N	Percent
<b>Total Births</b>		19,425	100.00	6,050	100.00	9,650	100.00	2,670	100.00	903	100.00
<b>Trimester prenatal care initiated</b>	First Trimester	12,759	65.68	5,213	86.17	5,027	52.09	1,718	64.34	705	78.07
	Second Trimester	4,343	22.36	619	10.23	2,857	29.61	694	25.99	152	16.83
	Third Trimester	1,232	6.34	113	1.87	941	9.75	135	5.06	30	3.32
	No Prenatal Care	464	2.39	14	0.23	411	4.26	33	1.24	2	.22

District of Columbia Department of Health (May 2018). *Perinatal Health and Infant Mortality Report*. Washington, DC: Government of the District of Columbia.

Furthermore, from 2009 to 2012 prenatal care access in the 1st trimester decreased in DC (74.7% to 65.3%), while late access to care in the 3rd trimester and no prenatal care rates increased (5.8% to 8.2%)<sup>9</sup>. In terms of Ward level data from 1999 to 2007, Ward 4, 5, 7, and 8 has the lowest frequency of prenatal care use compared to Wards 3, 2, and 6<sup>5</sup>.

One of the factors that may be contributing to late entry into prenatal care is the high rates of unintended pregnancy in DC. In fact, recently DC had the highest percentage of unintended pregnancies across the nation (62% compared to the national percentage of 45% in 2010)<sup>17</sup>. Furthermore, even though teen pregnancy rates have been decreasing in DC, teenage pregnancies in DC are still higher than the rest of the nation<sup>8, 17</sup>. On a national level, approximately 15% of adolescent girls did not intend to become pregnant—underscoring the importance of family planning and peri-conceptual care in any reproductive health justice agenda<sup>17</sup>.

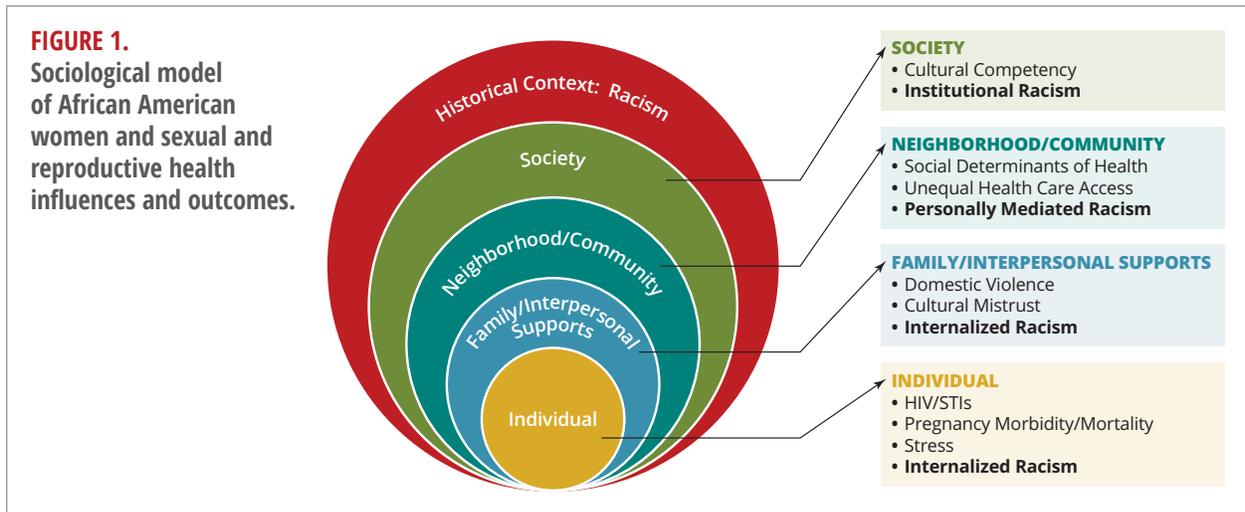
Overall, these data highlight the persistent racial and geographic reproductive health disparities and the risk of adverse health outcomes for Black families living in the nation's capital. These figures and trends underscore the urgent need to better understand the root causes of poor reproductive health outcomes for Black women in Wards 5, 7 and 8 and to develop effective public health interventions to reduce these racial health inequities.

## Frameworks for Understanding Racial Reproductive Health Inequities

As researchers have sought to understand and document the root causes of persistent racial health disparities in maternal and child health in the US and across the globe, social determinants of health (SDOH) are highlighted as a major factor in predicting poor outcomes<sup>36</sup>. When these SDOH are examined through a racial equity lens, the role of racism often rises to the surface as a proposed causal variable. Prather et al. (2016) proposed a socioecological model to help articulate the ways in which racism operates on multiple levels, leading to poorer health outcomes for African American women in the US (see **Figure 1**).

On a broader societal level, culturally incompetent care and institutional racism affects health outcomes for Black Americans<sup>36</sup>. Lack of cultural competence in the health care system is when systems fail to use a person-centered approach to treat diverse populations, which often leads to poor provider-patient interactions, negative experiences, and less use of health services by minority communities<sup>36</sup>. Furthermore, institutional racism at the societal level also plays a role in health outcomes. Institutional racism includes attitudes and policies that do a disservice for minority groups and communities of color and favor White individuals<sup>36</sup>. Limited access to healthcare, education, and employment are all examples of SDOH that are influenced by societal level institutional racism<sup>36</sup>.

In addition, at the neighborhood/community level, communities of color are subjected to limited access to healthcare and employment, higher poverty rates, as well as providers' discriminatory beliefs and lower quality of care<sup>36</sup>. On the interpersonal level, stressors such



Prather, C., Fuller, T. R., Marshall, K. J., & Jeffries, W. L. (2016). The impact of racism on the sexual and reproductive health of African American women. *Journal of Women's Health, 25*(7), 664-671. doi:10.1089/jwh.2015.5637

as domestic violence and the internalization of racism also negatively affect health outcomes for Black Americans<sup>36</sup>. These compounded effects of racism on SDOH at multiple levels impact the individual both indirectly and directly. In addition, the internalization of racism may negatively affect Black Americans' psychological, physical, and reproductive health<sup>36</sup>.

One study investigating the impacts of both personal and group racism on African American women's use of prenatal care found differences in denial of personal and group racism and prenatal care use<sup>41</sup>. It was more common for Black women to indicate that others, rather than themselves, have been affected by racism<sup>41</sup>. Further, the denial of experiencing group racism was found to negatively impact women's use of prenatal care services such that women either entered care late or not at all<sup>41</sup>.

To further unpack Black families experiences in seeking health care, the provider-patient relationship has been explored. A systematic review found that health care providers tend to hold a negative racial bias towards patients of color (Black, Hispanic/Latino/Latina)<sup>18</sup>. These negative racial biases were found to negatively impact care and health outcomes in several ways<sup>18</sup>. Black patients experienced poor relationships with their providers and providers tended to use different approaches to care for their Black and White patients<sup>18</sup>. For example, providers did not use client-centered care strategies with their Black clients, perceived Black patients to be less engaged in care, and used poorer treatment methods<sup>18</sup>. In addition, the review found links between negative racial bias and poorer health outcomes for Black individuals<sup>18</sup>.

More than a decade ago, Geronimus et al (2006) proposed a theory about the mechanisms through which racism might impact reproductive health outcomes in poor

Black women. The “weathering hypothesis”—as it was called—identified chronic social stressors, grounded in institutional racism and other forms of discrimination, as causing adverse health impacts by eroding internal physical capacities and resources<sup>2, 16, 48</sup>. Over time, the damaging effects of racism, discrimination, minority stress, lower socioeconomic status, and other stressors can accumulate—depleting internal resources and creating chronic wear and tear on the body<sup>2, 16, 48</sup>. Researchers have suggested that this “weathering” effect has implications for long-term, intergenerational effects on families’ health, childbirth outcomes, and infant mortality rates<sup>2, 16, 48</sup>.

In related literature, a few years earlier, Bruce McEwen (1998) put forward the construct of allostatic load as a way to quantify the accumulation of stressors in the body as it seeks to maintain homeostasis. Studies have shown that Black Americans, especially Black women, have higher allostatic load stress compared to their White counterparts across socioeconomic status<sup>16</sup>. According to the literature, these allostatic scores, which approximated the presence of risk factors for poor health, continue to rise over one’s lifetime, with lasting implications for health and mortality<sup>16</sup>. Together these theories may begin to explain the biological basis for how racism is related to adverse health outcomes for Black women in DC.

## Defining a Reproductive Health Equity Approach

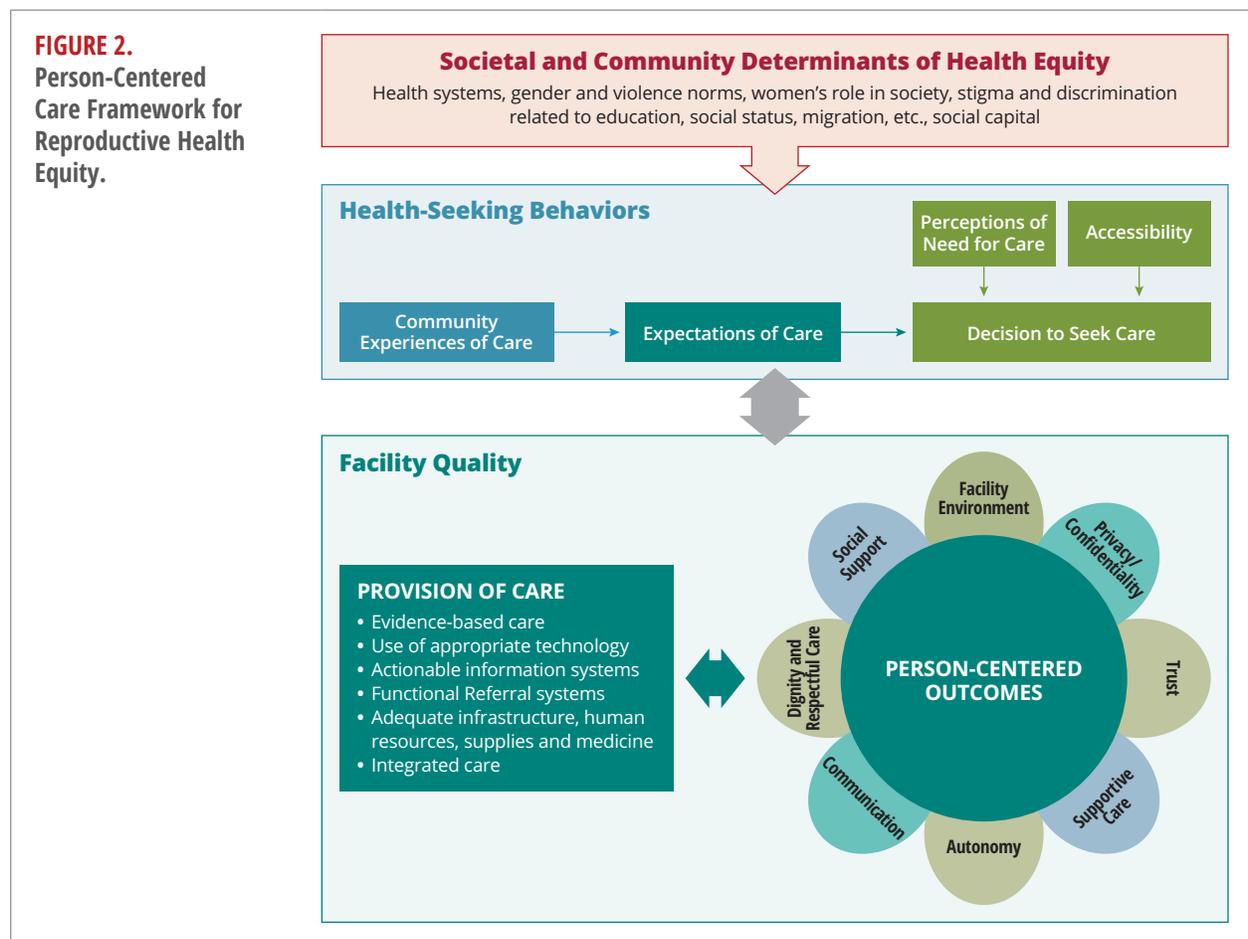
There is an abundance of literature highlighting the role of racism in health and reproductive health inequities<sup>7, 35, 36, 41</sup>. As cited earlier, racism has been linked to stress, birth outcomes, as well as prenatal care use, and discrimination experienced in health care settings<sup>19, 29, 30, 35, 36, 40, 41</sup>.

As researchers have developed frameworks to understand barriers and facilitators of care-seeking and receipt of care during the perinatal period, they have built upon concepts of patient-centered care<sup>27</sup>. This model identified four constructs that are important for researchers and policy makers to consider: (1) prerequisites which focus on provider attributes; (2) care environment which includes effective patient-staff relationships and organizational structures and systems; (3) person-centered processes which include shared decision-making, integration of patients’ beliefs, attitudes and values; and (4) person-centered outcomes which focuses on the patient’s involvement with their care as well as their satisfaction.

From this broader approach, Sudhinareset, et al (2017) proposed a Patient-Centered Reproductive Health Care Framework (see **Figure 2**), which seeks to promote new standards of relationship-based and respectful maternity care. These authors emphasized the central role that patient-provider relationships play in engaging mothers in maternity care. While these models have mostly focused on labor and delivery, the constructs are

clearly relevant across the perinatal health continuum of care—from pre-conceptual health care visits through the postpartum visit with the mothers’ maternity care provider. Therefore, the 8 domains the authors identified in this framework are central for reproductive health equity: dignity; autonomy; privacy/confidentiality; communication; social support; supportive care; trust and the health facility.

Others have identified important determinants of care-seeking for women during the perinatal period. Thaddeus and Maine (1994) had identified three critical delays that contribute to maternal mortality; and Gabrysch and Campbell (2009) extended this to situations where women were seeking care for uncomplicated pregnancies. In their paper focused on understanding disparities in women’s use of skilled birth attendants, Gabrysch and Campbell identified three important determinants: (1) *perceived need for care*; (2) *perceived accessibility*; and (3) *perceived quality of care*. The important thing to note here is how determinative the women’s perceptions are in their treatment-seeking behaviors.



Sudhinaraset, M., Afulani, P., Diamond-Smith, N., Bhattacharyya, S., Donnay, F., & Montagu, D. (2017). (2017). Advancing a conceptual model to improve maternal health quality: The person-centered framework for reproductive health equity [version 1; peer review: 2 approved, 2 approved with reservations]. *Gates Open Research*, 1, 1. <https://doi.org/10.12688/gatesopenres.12756.1>

Finally, cultural health capital theory helps to explain how patients' past experiences with health care as well as their perceptions of health care institutions can lead to a set of learned behaviors that influence decisions about when and where to seek care<sup>11</sup>. At the core of this theory is the sociological construct of habitus—which is essentially a product of an individual's temperament, personality and approach to being in the world that largely affects (but does not predetermine) how they react to situations they experience in their life. In this theory, one's habitus is influenced by their lived experiences, including their upbringing, culture and socialization<sup>11</sup>. As a patient, an individual's past experiences with health care providers will shape their care-seeking behavior as well as their own beliefs about and understanding of wellness and illness<sup>11</sup>. Similarly, a health care provider's habitus will be shaped by their own upbringing, clinical training and experiences, as well as the organizational cultural in which they have and are currently practicing medicine<sup>11</sup>. These personal experiences then intersect when an individual patient and provider interact during a health care encounter, which places the construct of habitus in a central role in the delivery and receipt of respectful maternity care<sup>11</sup>.

## State of the Evidence for Perinatal Health Equity

These theories help empirical researchers to focus their research so that the validity and relevance of these constructs and their relationship to outcomes can be tested in real world settings. Qualitative researchers have explored the experiences of low-income pregnant and postpartum women in health care settings across various geographical regions in the US and Canada<sup>1, 12, 21, 22</sup>. Literature was mixed about whether women did or did not see the importance of prenatal care<sup>1, 15</sup>, but it seems that women did perceive value in postpartum care and obtaining birth control<sup>22</sup>.

Researchers have also examined the relationship between Black pregnant mothers' experiences with racism/discrimination and utilization of prenatal care services, birth outcomes, and infant mortality rates<sup>6, 26, 34, 37, 39</sup>. Findings suggest that numerous factors, such as the quality of the provider-patient relationship, providers' racial and socioeconomic discrimination towards their patients, and patients' trust in their providers, influenced patients' attitudes towards prenatal care services<sup>6, 34, 37</sup>. Furthermore, Black Americans, who comprise the majority of those with government health insurance, describe an overlay of discrimination associated with non-private health insurance status, such as Medicaid<sup>2, 3, 8, 37, 39, 49</sup>. Providers expressed hesitancy in providing care for Medicaid patients and viewed individuals' with this type of insurance as challenging to serve<sup>1, 37, 39</sup>. Providers' negative biases toward Medicaid patients are also evident in patients' experiences in care settings. Medicaid patients described being discriminated against by providers and health care staff based on their race, insurance, and socioeconomic status, which impacted the quality of care they received<sup>37, 39</sup>. These negative and discriminatory experiences serve as an additional deterrent for Black Medicaid patients' engagement in care<sup>1, 37, 39</sup>. Since

research has shown that the Affordable Care Act has been successful in improving access to Medicaid in DC, with 93% of all adult and 91% of Black residents having access to insurance<sup>10,38</sup> (for mothers who gave birth between 2013-2016: 38.81% had Medicaid, 45.78% had private insurance<sup>8</sup>), these discriminatory experiences which impact quality of care compounds the withstanding challenges/barriers to attending/utilizing care visits such as logistics around scheduling, commuting, etc.<sup>10,38</sup>. Altogether, these findings further emphasize how racism and discrimination can impact Black patients' experiences and how those experiences can in turn influence their use of prenatal care services and the subsequent health outcomes for Black families.

Providers are not necessarily cognizant of their racial biases. While providers accurately recognized several challenges to prenatal and postpartum care for patients (e.g., transportation, childcare, Medicaid insurance, poor provider-patient relationship, providers brief time with patients, patients need for additional support services, drug use and mental health considerations, and family system struggles), they seemed unaware of their own biases and how these biases may impact their practice/ quality of care, as well as the role that institutional racism plays in pre- and post-partum disparities<sup>1, 12, 21, 22</sup>. Furthermore, adverse birth outcomes for Black mothers are prevalent regardless of educational attainment and socioeconomic status<sup>20, 23, 45</sup>. Providers' racial biases and their lack of awareness of its influence on their care for Black clients, coupled with the fact that Black patients may deny experiencing racism, underscores the complex role of racism in persistent health inequities.

Efforts to promote health equity need to be understood within both a historical context and socioecological framework of racism in our country. In regards to provider-patient relationships, a critical race framework that recognizes the detrimental role of racism on Black families health and well-being should be applied to all health care settings<sup>19</sup>. Under this framework, providers acknowledge that racism puts Black families at risk and holds the experiences of Black patients and the provider-client relationship at the forefront of care in an effort to improve health equity<sup>19</sup>. However, targeting the impacts of racism on health inequities needs to go further than the interpersonal provider-patient dynamic. Therefore, in addition to further exploring the internalized and interpersonal experiences of racism for Black families in DC, more research is needed to understand how to address structural and institutional racism to create effective systematic change.

## **Building a Racial Equity Agenda for Reproductive Health in DC**

As this review of the literature has underscored, each community must address the specific racial, economic and geographic disparities that manifest in their own populations if these gaps are to be narrowed. The DC Primary Care Association (DCPCA) recently

published a compelling report on reproductive and maternal health inequities for low income and communities of color in Washington, DC<sup>38</sup>. They spoke to 16 providers and experts in various roles (directors and senior staff of community organizations, schools, health insurance companies, nurse practitioner, OBGYNs, school-based provider, etc.) and 13 Black and Hispanic mothers living in Wards 1, 4, 5, 7, and 8 with Medicaid insurance<sup>38</sup>. Interviews aimed to identify barriers to accessing care and ideas to improve the current system<sup>38</sup>. Their findings were organized into the different stages of the reproductive health cycle: pre-pregnancy, prenatal, labor and delivery, postpartum, and findings that were relevant for each of the stages<sup>38</sup>.

During the pre-pregnancy stage, themes around inadequate sexual education and limited awareness of resources, misunderstandings, mistrust, and fears about side effects to contraceptives, and unplanned pregnancies arose from the interviews<sup>38</sup>. In the prenatal stage, women noted late entry into care and limited awareness of resources<sup>38</sup>. In addition, women who used group prenatal care programs such as Centering Pregnancy spoke highly of it<sup>38</sup>. During labor and delivery, a provider's reputation in the community dictated many women's delivery decisions<sup>38</sup>. However, many of these women were not informed of various birthing options<sup>38</sup>. In the postpartum period, women for the most part did not engage in these services and mentioned they would engage in care for their child but not themselves even though many stated struggles with postpartum depression and difficulty receiving contraceptives<sup>38</sup>. Those that had home visiting during this period spoke highly of this service as well<sup>38</sup>. Finally, across all these stages and periods, some major takeaways included the valuable role of peer and community recommendations, the need to improve quality and cultural competency in care, as well as the need to address issues with transportation, housing, insurance, and child care<sup>38</sup>. While the DCPCA report provided an in-depth picture of the reproductive needs of low income women of color living in DC and suggestions for improvement in health systems, more research is needed to better understand the role of racism in DC's reproductive health inequities<sup>38</sup>.

Qualitative research provides a platform for minority populations to be heard and may better comprehensively inform future policy action<sup>46</sup>. Research exploring the impact of racism on all levels, structurally, institutionally, interpersonally, and internalized, is needed to fully expose where change and reform in DC's perinatal health care system are needed. Through interviews and focus groups, the research team at the Georgetown University Center for Child and Human Development will partner with and learn from individuals at multiple socioecological levels across the health care system. Documenting how racism may be influencing the decisions women are making to seek care throughout the reproductive cycle (sexual education, contraceptive care, prenatal, labor/delivery, and postpartum care) may highlight areas for future collaborative work led by DC Health.

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