

REDUCE REPRODUCTIVE, SEXUAL, AND MATERNAL, HEALTH DISPARITIES





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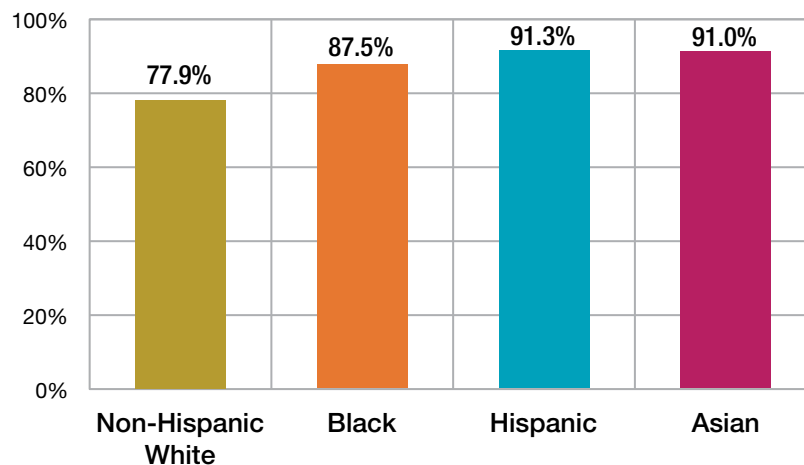
For many reproductive, sexual, and maternal health indicators, wide disparities exist based on socioeconomic status, race, and ethnicity. Although national rates have decreased for some of these indicators, racial, ethnic, and socioeconomic disparities continue to grow.¹ While these disparities are often attributed to personal behavior and individual decision-making, reproductive, sexual, and maternal health disparities highlight the failure of a broken health care system and underscore stark inequities in economic, environmental, and social conditions in the United States.¹ Many factors related to socioeconomic status, including income level and educational and employment opportunities, as well as the effects of racism, impact health choices and outcomes.² The social determinants of health, an emerging analysis used by public health leaders, elucidates the complex systems and social factors that perpetuate inequity and are impacting the health of urban communities. Acknowledging and addressing the social determinants of health are critical to closing persisting health disparities and achieving reproductive justice.

URBAN DEMOGRAPHICS

There are many reproductive, sexual, and maternal health disparities that must be eliminated, especially the increased rates of unintended pregnancy, abortion, teen pregnancy, infant mortality, and sexually transmitted infections (STIs) among poor women and women of color. Urban areas, which are more diverse and poor than other parts of the United States, are home to many women and families who are experiencing these health disparities. According to the U.S. Census Bureau, 87.5% of the U.S. Black population lives in a metropolitan area, with 51.5% living inside a central city;³ 91.3% of the Hispanic population lives in a metropolitan

area, with 45.6% living inside a central city;⁴ and more than 91% of Asian Americans live in metropolitan centers.⁵ In comparison, 77.9% of the non-Hispanic White population in the United States lives in a metropolitan area, with 21.1% living inside a central city.⁶ In 2007, the poverty rate in metropolitan areas reached 11.9%. Central city residents are almost twice as likely to be poor than those residing in the suburbs. Further, the poor in central cities are more likely to be foreign-born.⁷

PERCENT DISTRIBUTION OF U.S. RACIAL AND ETHNIC POPULATIONS LIVING IN METROPOLITAN AREAS



Source: U.S. Census Bureau

i Throughout the Agenda, we use the same racial and ethnic categorization as the data source.

EXAMINING THE CAUSES OF REPRODUCTIVE, SEXUAL, AND MATERNAL HEALTH DISPARITIES

Race is a social construct without a biological basis, as scientific consensus and research have determined.⁸ Therefore, the underlying factors for persistent health disparities based on race and ethnicity cannot be explained solely by genetic predispositions. Racial and ethnic reproductive, sexual, and maternal health disparities are the result of a complex interplay between the social determinants of health, structural racism, and individual behavior.

The World Health Organization has defined the social determinants of health as “the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices.”⁹ For low-income and poor people of color in the United States, the social determinants of health reflect a history of racist policies and practices that have led to the perpetuation of disparate health access and outcomes. In other words, health disparities are related to and caused by the overall impacts of racism. Racism is in turn connected to a wide range of interrelated factors that affect health disparities, such as disadvantaged socioeconomic status,¹⁰ lack of health insurance and other barriers to access, unhealthy living environments, residential segregation, and stress.¹¹

The frame of structural racism can further our understanding of how all of these economic, social, and environmental factors intersect to produce health disparities. The Aspen Institute states that structural racism “refers to a system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity.”¹²

Structural racism has created the conditions for people of color to be systemically disadvantaged socioeconomically. Socioeconomic determinants impact health by limiting the social and economic resources available to an individual and his or her community. Educational opportunities are connected to health, not only as a gauge for a person’s current and potential occupational and economic choices, but also because education helps to shape health behaviors.¹³ Occupational opportunities, which are related to education, can be linked to expected income earnings and the workplace’s effect on health, in both psychosocial and toxic exposures. Socioeconomic status also limits access to health

insurance and preventive care, which profoundly affect health outcomes.

However, socioeconomic status alone is insufficient in fully explaining racial and ethnic health disparities and outcomes. For example, recent analyses of birth outcome data, including low birthweight, preterm birth, and infant mortality, show racial disparities spanning socioeconomic status.¹⁴ African American infants are twice as likely to die before their first birthday as non-Hispanic White infants.¹⁵ These data correspond to an approximately twofold increase in low birthweight and preterm deliveries among African Americans in comparison to non-Hispanic Whites.¹⁶ Furthermore, even when controlling for socioeconomic status, African Americans continue to have higher infant mortality rates. This disparity is seen even when African American women of high socioeconomic status are compared with non-Hispanic White women with low socioeconomic status.¹⁷ If socioeconomic status cannot account for these disparities, then limited access to reproductive health care due to poverty cannot be the sole causal factor for disparate birth outcomes along racial lines.¹⁸ Here the life-course context becomes crucial in addressing maternal health development in relationship to race—there are factors adversely affecting the reproductive health of African American women that are not affecting the birth outcomes among non-Hispanic White women.¹⁹ These disparities must be interpreted inside the context of the accumulation of stressors related to the social determinants of health, including racism and discrimination.

Racism within the health care system specifically has direct impact on the reproductive, sexual, and maternal health of women of color. The Institute of Medicine report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* has stated that “(al)though myriad sources contribute to these disparities, some evidence suggests that bias, prejudice, and stereotyping on the part of health care providers may contribute to differences in care.”²⁰ A recent study of African American women found that 67% of the women who had received family planning and contraceptive services experienced race-based discrimination.²¹ The relatively small numbers of people of color in the health profession can reduce access for people of color and shape their health care experiences. As the United States has become more diverse, there has not been a proportional growth in the

diversity represented in jobs held by health professionals.²²

Provider bias, as well as lack of diversity among health care professionals, is a particular concern given the historical medical mistreatment of people of color in reproductive and sexual health care—a history that has sowed distrust of the health care system within many communities of color. One example of such mistreatment in reproductive and sexual health care is the Tuskegee Syphilis Study run by the U.S. Public Health Service from 1932 to 1972 during which the Service experimented on African American men by testing them for syphilis but withheld the diagnosis and treatment.²³ Another source of distrust is the historically coercive use of sterilization and long-term contraceptives in women of color, a practice that has been government-sponsored.²⁴

In sum, while much attention has been paid to individual behavior in regard to sexual health outcomes, recent studies show that individual behavior does not significantly correlate with many racial sexual health disparities.²⁵ For example, African American women who do not engage in high-risk behavior are still more likely to suffer high-risk outcomes than their White female counterparts. In a 2007 study in

which 37.6% of the African American participants fell into a low-risk category of sexual behavior and drug use, in contrast to only 12.7% of White participants, the African American participants were still 7.8 times more likely to contract human immunodeficiency virus (HIV).²⁶ Similarly, the 2002 National Vital Statistics Report from the Centers for Disease Control and Prevention (CDC) reported that African Americans who abstained from smoking during pregnancy were still more likely to experience infant mortality than non-Hispanic White women who smoked while pregnant.²⁷ Thus, on an epidemiological level, an individual can be considered only within the larger social network and community in which he or she lives—communities that are shaped by the social determinants of health.

In the following briefs, we lay out data on the most pressing reproductive, sexual, and maternal health issues facing urban areas today. For all of the issues highlighted in this Agenda, the social determinants of health must shape not only our understanding but also our plans for how to close disparities and increase equity.



RECOMMENDATIONS TO REDUCE REPRODUCTIVE, SEXUAL, AND MATERNAL HEALTH DISPARITIES

Continued inequality and lack of access to information and services perpetuate health disparities that harm communities. There are a variety of socioeconomic, social, and environmental inequities that affect reproductive, sexual, and maternal health disparities. To address reproductive, sexual, and maternal health disparities, urban areas should not only increase and ensure equitable access to health care but also work to dismantle the structures that perpetuate the inequities that adversely impact health.

WE CALL ON LOCAL LEADERS TO REDUCE REPRODUCTIVE, SEXUAL, AND MATERNAL HEALTH DISPARITIES BY:

Coordinating all local public agencies to implement efforts that will address disparities. Given the intersectionality of a myriad of determinants affecting health disparities, any efforts to redress these disparities must be across agencies and advocacy groups. Local government or administrative departments that may not often focus on reproductive, sexual, and maternal health care, such as public transportation, education, and housing, play an important role in reducing health disparities by facilitating access to services and supporting healthy neighborhoods.

- We urge local leaders to streamline and integrate service delivery of public assistance and health care to underserved communities.

Acknowledging and addressing the impact of structural racism in their communities through public commitment to reducing disparities. Learning about and understanding the frame of structural racism can help communities begin the work required to dismantle structures that benefit some groups at the expense of others.

- We urge local elected and public health officials to commit to reducing disparities through an exploration of the role that structural racism plays in their communities and health care systems.

Implementing data collection plans that will further support targeted education and health care interventions. Local policymakers are positioned to address health disparities. Collecting local data is essential to effectively prioritizing resources and developing programs aimed at eliminating disparities.

- We urge local leaders to create or support plans for local data collection on disparities in reproductive, sexual, and maternal health outcomes.

LOCAL EXAMPLES:

■ In 2007, the **Los Angeles County Department of Public Health** spearheaded collaborative local efforts to identify current gaps, trends, and future steps to improve the health status of women and to develop short-term priority policy recommendations that will reduce health disparities and improve health outcomes for Los Angeles County women, especially low-income women of color.

■ In order to further the analysis of health disparities, **The Boston Public Health Commission's Center for Health Equity and Social Justice** has standardized the collection and reporting of data related to health care access and utilization by race, ethnicity, education, and language.

■ In **Atlanta, Fulton County** has created a local health initiative, Common Ground, to transform local health services to better address the social determinants of health and eliminate health disparities.

ENDNOTES

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The Urban Initiative for Reproductive Health is a program of the National Institute for Reproductive Health (National Institute).

The National Institute is an innovation institute for state and local organizations working on reproductive health issues. We offer strategic guidance, hands-on support and funding to help state and local leaders remove barriers to health care, win public battles and change public policies. Together, we are helping women in communities across the country gain access to the full range of quality reproductive health care options, the freedom to exercise their reproductive rights and the opportunity to have healthy pregnancies.

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NATIONAL
INSTITUTE FOR
REPRODUCTIVE
HEALTH

470 Park Avenue South, 7th Floor South, New York NY 10016
P: 212-343-2031, F: 212-343-0119

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