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A Call For Change: Racial Disparities in Infant Mortality Rates

Since before the Revolutionary War, race has played a part in almost every aspect of American society. The slave trade sat the core of the new nation's economic success so that by the time Thomas Jefferson and his contemporaries drafted the Consitution, the ideals on which they hoped to establish the United States (e.g. free speech and equality for all men) did not incorporate the Black man because, they argued, it would cause too much strife inside the new found nation. As French political philosopher Alexis Tocqueville noted at the time, the United States was able to operate beyond the restraints of a class system because of, the slave trade. It was a given that Black men and women were at the bottom of the class system. Unfortunately, this mentality did not die out with the abolishment of slavery or even, the Civil Rights movement, especially in respect to health care. Researchers, in the past ten years, are finding that the differences in mortality, particularity with infants, are actually a reflection of racial health care disparities as opposed to differences in genetics. Many Black women's inability to access proper health care during their pregnancies, coupled with a decreased amount of education and information directed toward women of color, especially in low-income areas, increases the rate of mortality among Black infants. Studies show that these disparities are not found in other minority groups, which seems to attest that women of color receive a more severe form of discrimination from the health care field. Furthermore, many of the studies highlight the need for a feminist perspective for health care providers when seeking to tackle the issue, so that the burden does not fall on Black women, but rather on health care professionals.

By definition, infant mortality rate (IMR) is the rate at which babies die before their first birthday. The data regarding infant birth weight and mortality between races is conclusive: children born to Black women have a statistically higher mortality rates and lower birth weights. Nationally, Black infants are more than twice as likely as White infants to die before the age of

one (Howell, 2008). Some studies place the rate as high as two and half (Fiscella 2002). The disparities in mortality spread throughout infancy with neonatal mortality (those that occur in the first 27 days of birth) being 2.3 times higher in Black infants as opposed to White infants (Chima 2001). On average, Blacks account for only about 17 percent of live births but 33 percent of infant deaths in the United States (Chima 2001). In addition, studies show that the disparities in infant mortality are specific to the black community with Hispanic infants having a mortality rate closer to that of White infants. The Black community is unique in its mortality rate for reasons that will be discussed throughout this paper. The literature on the issue varies. Some papers seek to simply point out the disparities while others want to find the root of the cause. Very few, however, try to solve the problem.

The only other minority groups that face an IMR remotely close to Blacks are Native Americans and the Hawaiian natives. The average IMR is 7.0 (7 deaths in every 1000) in the United States; the rate for Blacks is 13.9, 9.6 for Hawaiians and 8.6 for American Indians (Anachebe 2006). Many researchers previously understood the findings to be a biological defect within the Black community, but further research has proven this to be incorrect. Howell discuss a study by David and Collins, which looks at the birth weights between African, Black American, and White American babies (2008). The researchers hoped to prove that if low birth weights in Black Americans was biological then birth weights in African babies would have a lower birth weight than White babies as well. However, the researchers found that the overall, birth weight distribution for infants of US-born White women and African born women were almost the same (Howell 2008). It was the US-born Black babies that showed a weight disparity by hundreds of grams. The evidence did not support the scientists' initial assumptions, a pattern that has plagued the Black women for decades. Their results actually point to socioeconomic

factors, not biological factors as the cause for the decreased birth weight in US-born Black babies. In fact, even as early as second-generation Black babies were shown to have a decreased birth weight (Howell 2008). The scientists surprise points to the flaw in the much of the research in the area in the past—doctors assumed that that disparity was caused by biology; therefore, their studies were focused on a finding a biological reason instead of a socioeconomic reason. By not embracing the feminist perspective, researchers have inhibited the wellness of Black women and their children. By focusing on biological reasons for the disparities, researchers wasted valuable time, disadvantaging Black women and their children.

Research has only recently moved beyond the assumption that genetics plays a part in the disparities among the races. Scholars now embrace the idea that racism plays a key role in the differences in health care. Institutionalized racism, defined by Jones as "differential access to the goods, services, and opportunities of society by race. Institutionalized racism is normative, sometimes legalized and often manifests as inherited disadvantage" (Jones, 2000, p. 1212) has shown to correlate directly to the value of health care that Blacks receive. According to Chima, institutionalized racism most directly affects Black men, which, he argues, can have long-term and more damaging affects on the Black male's ability to maintain employment and succeed in education (2001). By extension, the effect of institutionalized racism on Black males decreases the marriages rates among Blacks, which contributes to an increased number of single family-headed households (Chima 2001). As Chima notes, "Marital status and single parenthood have been identified as factors having substantial net association with Black infant mortality" (2001, p. 5). Due to the racism inflicted upon members of the Black community, many women are left to support a family on a single-parent income, decreasing the funds available to spend on healthcare. Gender and race relations play a complex role in IMR. Patriarchy places Black

women in submission to the men in their lives while race inhibits the modes to success for these men. To pinpoint one cause of IMR is impossible, but the fact remains that its roots are tied into both race and gender.

In addition to the racial barriers that women face, Chima points out that women are also held back by their gender. Black women face what many White women do in the workplace: lower salaries. This, coupled with a higher prevalence of single-parent households, puts greater financial stresses on women of color. In addition to the economic constraints that Black women face, they also lack proper health care education. Much of the literature on gender roles and identity is geared toward and written from a white, middle class perspective, which limits the amount of information available to Black women, especially concerning health care options (Chima 2001). For instance, studies have shown that education on the causes of sudden infant death syndrome (SIDS) (i.e. the risk of SIDS is reduced when infants are placed on their backs while sleeping) drastically reduces the syndrome's occurrence, yet SIDS occurs more frequently in the Black community as opposed to the White community (Howell 2008). The study highlights the disparities that women of color face in accessing education as well as the consequences of ineffective literature. The study also shows that many of the statistics that attribute to IMR are skewed due to the racial disparities. Feminists must recognize the pitfalls of their perspective and seek to solve the problem for all women. The Black community suffers from discrimination in every field including the literature on infant mortality rates. IMR is inherently tied into racism and poverty, problems that health care professionals are unwilling to tackle. Most of the articles simply point out the statistics (Black infants die more frequently) without attempting to solve the problem.

The black woman's inability to access health care as early as her first sexual experience also affects the IMRs in the community. Statistics show there are higher rates of sexually transmitted diseases (STDs) among Black woman than other racial groups as well as a decrease in overall reproductive health (Armstrong and Maddox, 2007). Studies have shown that sexual education is a key factor in reducing the occurrence of STDs as is access to contraceptives such as condoms. Women of color are not receiving enough education on prevention of STDs most likely because they are already disadvantaged because of their race. Low income as well as lack of a two income household forces children to attend weakly funded schools, which, perhaps, is unable to fund adequate sex education classes.

Both Anachebe and Fiscella refer to the risk factors associated with the Black births. Theses factors include premature birth and low birth weight; in addition, Black women have a four times higher risk of dying from complications of pregnancy and childbirth than White women (Anachebe, 2006). According to Anachebe, "two thirds of the disparity in IMR is due to higher rates of preterm delivery and low birth weight among Black women and their newborns" (2006, p. S3-72). Still, the reasons for why Black women and infants face such disparities are complicated. Much of the research certainly points to disparities in the value of health care that black women receive. There is a direct correlation between consistent and early pre-natal visits and IMR and the percentages of women who receive late or no prenatal care are higher among minorities (Armstrong, 2007). Many of the studies point to the distinctive stresses that black women face. As noted earlier, black women face steeper financial disadvantages and responsibility than their white counterparts. In particular, Fiscella points to the disparities embedded in the social context of Black women's lives. He notes that they face exposure to life long stress, high rates of poverty and discrimination, unstable partner relationships, and

inadequate prenatal care (Fiscella, 2004). He does note, however, that, "the specific pathophysiologic pathways through which these factors are mediated are not well understood" (Fiscella 2004, p.45). Taking into consideration the effects of institutionalized racism mentioned above, it appears that the root cause of low birth rate and ultimately IMR the disadvantages that Black women face, which certainly ties back to race. The life long stress could certainly be in reference to financial struggles they face throughout life, as well as the unstable partner relationships. Black women face unique struggles in life, which ultimately influence both their own physical state as well as the state of their child.

There are researchers and hospitals that have implemented plans in order to tackle the IMR disparity in Black communities, however. Byrd, Katcher, Peppard, Durkin & Remington (2007) looked at the infant mortality rates in Wisconsin while Howell, Hebert, Catterjee, Kleinnman & Chassin (2007) analyzed the very low birth weight and neonatal mortality rates in New York City Hospitals. Byrd et al. found that within racial groups, increasing access to health care and prenatal care will improve infant mortality rate but they will not reduce the disparity between Black and Whites (2007). However, the most startling statistic that the paper revealed was that "College educated [B]lack women who receive adequate [prenatal care], had a 3-fold greater risk of an infant death compared to [W]hite women with the same level of education and adequate prenatal care" (Byrd et al., 2007, p. 325). Furthermore, Byrd et al. pointed out that several studies found that college-educated Black women have higher infant mortality rates when compared to White women. Previous studies have already proven that the epidemic is not genetic; therefore, Byrd et al. is actually implying that the health care community is the cause of IMR imbalances. The study points to disparities in the *value*, not the amount, of health care that women are receiving before and after birth as the main cause for IMR.

In comparison, Howell et al. (2007) analyzed birth weights among IMR in 45 New York hospitals between 1996 and 2001. The researchers' findings were predictable; they found that overall, Black infants have a higher IMR. Since Black women are more likely to have high-risk babies, the researchers "sought to determine whether differences in hospitals at which black and white infants are born contribute to black/white disparities in very low birth weight neonatal morality rates in New York City" (Howell et al., 2008, p. e407). Their results were conclusive: the lower the birth rate, the higher chance they have of being born in a hospitals with a higher rate of IMR. The found fault with the hospital. The researchers proposed that had the Black babies been born in hospitals with lower IMR (where most White babies were born) then the overall IMR would decrease for Blacks (Howell et al., 2007). Howell et al. writes, "differences in quality of [health] care may exist" (2007, p. e414).

Howell et al. and Byrd et al.'s results fault hospitals. Aizer, Lleras-Muney & Stabile, too, cite access to quality care as a core cause of higher IMR within the Black community. The study, however, also pinpointed a key problem within the Black community: Black women are less likely to seek higher quality care when given the opportunity compared to other racial groups (Aizer et al., 2004). The researchers found that mothers who were privately insured and had their children in private hospitals had significantly lower IMR than mothers insured by Medicaid (Aizer et al., 2004). The study followed a plan implemented in California where in the early 1990s the state increased Medicaid payments to hospital leading to sharp change in where women on Medicaid delivered (Aizer et al., 2004). The study sought to find which poor women responded to the increase in provider access. They found that, "black mothers responded *least* to the increase in provider choice afforded by the policy change" (Aizer et al., 2004, p. 4). Since Howell et al.'s study showed which hospital a child is born in influences the child's mortality,

the question becomes, why didn't Black mothers take advantage of new law that might save the life of their child? Of course, the women did not have access to the statistics that I present in this paper to know the effect that hospital choice has on the health of their child, but other minorities profited from the change in policy without the information. Once again, the results highlight the distinctive position that Black women are in. They face challenges that do not exist in other racial groups. It does not necessary matter what these obstacles are but health care professionals must be aware that an added effort is required when dealing with Black women. Professionals should embrace the feminist perspective when dealing with Black women, if only to make them aware or the pitfalls that they are potentially causing.

As the arguments above support, the feminist perspective is required in helping to solve the disparity in infant mortality rates between Black women and White women. From the Howell et al.'s statistical look at IMR in New York City to Chassin theoretical discussion concerning IMR, the consensus is that race plays a key role in its cause. However, as all the studies point out, the matter traces back to a variety of roots, some of which are not easily located. Since these causes are often difficult for Black mothers to pinpoint, much less control, it must become the responsibility of the health care community to both embrace and implement practices that will ensure a lower IMR. These may include but are not limited to increased education geared toward Black women, state support of higher quality of care for high-risk pregnancies and overall effort to decrease racist tendencies in the health care field.

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