

## Reducing Health Disparities

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### Overview:

In America the burden of disease and premature, preventable deaths is borne disproportionately by politically disfranchised and economically disadvantaged communities. In all leading public health mortality and morbidity indices, there is a persistent gap between the privileged and the deprived that is euphemistically referred to as “health disparities.” Health disparities are “differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States.”<sup>1</sup> Even when access-related factors are controlled, such as insurance status and income, minorities still receive a lesser quality of healthcare.<sup>2</sup> For African American women, the lifetime and generational exposure to institutional and interpersonal racism have been shown to affect pregnancy outcomes such as birth weight,<sup>3</sup> as well as other health conditions.<sup>4</sup>

There are several areas of health disparities that are of particular concern to midwives<sup>5</sup>, specifically, infant mortality, preterm birth, low birth weight, sudden infant death syndrome (SIDS), maternal mortality, breast and cervical cancer, HIV/AIDS infection and heart disease among women.

- The disparities in **infant mortality** (deaths per 1,000 live births), are great: African Americans (13.9), American Indians (8.6), Non-Hispanic Whites (5.8), Hispanics (5.6) and Asian/Pacific Islanders (4.8).
- **Preterm birth** (less than 37 weeks gestation) is the leading cause of death and disability among African American infants. In 2003, the rate for African American infants was 17.8% compared to 10.5 % for Asian and Pacific Islander women and 11.5% for white women.<sup>6</sup>
- **Low birth weight** (less than 5 pounds 8 ounces at birth)<sup>7</sup> also displays a disparity gap between races and ethnicities: African Americans (13.4%), Asian/Pacific Islanders (7.8), American Indians (7.3%), Hispanics (6.6%), and Non-Hispanic Whites (6.9%).

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<sup>1</sup> <http://crchd.cancer.gov/definitions/defined.html>

<sup>2</sup> Institute of Medicine of the National Academies: Shaping the Future, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*. The National Academies Press, Washington, D.C., 2003.

<sup>3</sup> Collins JW, David RJ, Symons R, Handler A, Wall S and Andes S. *African-American Mothers' Perception of their Residential Environment, Stressful Life Events, and Very Low Birthweight*. *Epidemiology*, 9 (3): 286-289, 1998.

<sup>4</sup> Williams DR. *Race, Socioeconomic Status and Health: The Added Effects of Racism and Discrimination*. *Annals of the New York Academy of Sciences*; 896:173-188 (1999)

<sup>5</sup> Midwives and midwifery as used throughout this document refer to the health care professionals and practice of certified nurse-midwives (CNMs) and certified midwives (CMs) who have been certified by the American College of Nurse-Midwives (ACNM) or the American Midwifery Certification Board, Inc. (AMCB), formerly the American College of Nurse-Midwives Certification Council, Inc. (ACC).

<sup>6</sup> Institute of Medicine, *Preterm Birth: Causes, Consequences and Prevention*. The National Academies Press, Washington, D.C., July 2006.

<sup>7</sup> March of Dimes [www.marchofdimes.com](http://www.marchofdimes.com)

- **SIDS** statistics (deaths per 100,000 live births) are disproportionate between populations: American Indians (123.3), African Americans (110.9), non-Hispanic Whites (55.2), Hispanics (29.7) and Asian/Pacific Islanders (24.3).
- **Maternal mortality** (maternal deaths per 100,000 live births) exhibits significant health disparities. The overall maternal mortality rate for 2003 was 12.1 deaths per 100,000 live births. The maternal mortality rate for black women was 30.5, 3.5 times the rate for white women, which was 8.7.<sup>8</sup>
- **Cancer** is the second leading cause of death for most racial and ethnic minorities in the United States. In 2001, African American women were 20% less likely to have been diagnosed with breast cancer, but were 30% more likely to die from breast cancer, compared to non-Hispanic white women. Hispanic women were 2.2 times more likely as non-Hispanic white women to be diagnosed with cervical cancer. American Indian women were 1.9 times more likely to die from cervical cancer as compared to white women.<sup>9</sup>
- The majority (almost 70 percent) of newly diagnosed cases of **HIV and AIDS** in 2004 were among racial and ethnic minorities. 89% of babies born with HIV/AIDS belonged to minority groups. AIDS is the leading cause of death in African American women aged 25-34. African American females had more than 25 times the AIDS rate of non-Hispanic white females, and were more than 22 times as likely to die from HIV/AIDS as non-Hispanic white females. American Indian/Alaska Native women had 3 times the AIDS rate as non-Hispanic white women. Hispanic females had more than 5 times the AIDS rate as non-Hispanic white females. HIV/AIDS was the 7th leading cause of death for Asian/Pacific Islander women ages 25 to 34.<sup>10</sup>
- African American women are twice as likely to have **heart disease** as white women and yet are less likely to be given certain standard drugs to treat cardiac disease.<sup>11</sup>

The source of these disparities is complex and multi-rooted and therefore requires a comprehensive examination and improvement at all levels, from health care providers, facilities, and insurance companies to the social, political and cultural context in which these women live.

### **The Competence and Desire to Reduce Disparities in Reproductive Health:**

The American College of Nurse-Midwives (ACNM) acknowledges that eliminating health disparities is an important issue that we must continue to address. American midwives have a legacy of compassionate, competent care “that respects human dignity, individuality and diversity among groups.”<sup>12</sup>

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<sup>8</sup> National Vital Statistics Report, Vol.54, No. 13, April 19, 2006, p. 12.

<sup>9</sup> Cancer Data/Statistics, <http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=20>

<sup>10</sup> HIV/AIDS Data/Statistics; <http://www.omhrc.gov/templates/browse.aspx?lvl=1&lvlID=4>

<sup>11</sup> Ashish K. Jha, Paul D. Varosy, Alka M. Kanaya, Donald B. Hunninghake, Mark A. Hlatky, David D. Waters, Curt D. Furberg, and Michael G. Shlipak. Differences in Medical Care and Disease Outcomes Among Black and White Women With Heart Disease. *Circulation*, Sep 2003; 108: 1089 - 1094

<sup>12</sup> Philosophy of the American College of Nurse-Midwives <http://www.midwife.org/display.cfm?id=480>

It is an unassailable fact that midwives care disproportionately for women at highest risk for poor pregnancy outcomes—women of color (African-, Mexican-, and Native-American), women who are adolescent and/or unwed and/or relatively uneducated and/or multiparous and/or receiving late or no prenatal care, and immigrant women.<sup>13</sup> Yet it is a curious fact that midwives realize lower infant (including neonatal) mortality rates than do their medical colleagues.<sup>14</sup>

There are numerous examples of midwifery care working locally to reduce disparities among disadvantaged groups throughout our history:

- During the first 30 years of care by nurse-midwives of the Frontier Nursing Service (FNS) in eastern Kentucky, low birth weight and maternal mortality rates dropped dramatically from levels that were among the highest in the country to those among the lowest.<sup>15</sup> From 1925-1958, the maternal mortality rate was 9.1 per 10,000 for FNS, while the national rate was 34 per 10,000; the low birth weight rate was 3.8% for FNS, while the national rate was 7.6%.<sup>16</sup>
- In the 1960's in Madera County, California, at the county hospital with a higher percentage of Mexican-American, African American and teen mothers than elsewhere in the county, neonatal deaths dropped from 23.9 to 10.3 per 1,000 live births during the 3 years that nurse-midwifery care was piloted at that site, and preterm births dropped from 11% to 6.4%.<sup>17</sup>
- Today in the District of Columbia, nurse-midwives at the Family Health and Birth Center (FHBC) provide care for African-American women and their children who are otherwise politically disfranchised and economically impoverished. After only five years of such care the percentage of preterm births was 9% for women at the FHBC compared to 14.2% for the District generally. Similarly, the percentage of low birth weight infants was halved at the Center compared to the wider District community (7% vs. 14.6% respectively).<sup>18</sup>

### **Midwifery Education, Practice, and Political Activism:**

In addition to providing competent and compassionate care to childbearing women, midwives are striving to increase now underrepresented racial and ethnic groups among the ranks of our profession. In particular, ACNM has established the Midwives of Color Committee to define and address the diverse cultural, social, and economic assets and needs of women contemplating

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<sup>13</sup> Scupholme A, DeJoseph J, Strobino DM, Paine LL. *Nurse-midwifery care to vulnerable populations, phase I: Demographic characteristics of the national CNM sample.* J Nurse-Midwifery 1992; 37:341-348.

<sup>14</sup> MacDorman, Marian F., Gopal K. Singh. *Midwifery care, social and medical risk factors, and birth outcomes in the USA.* Journal of Epidemiology & Community Health. May 1998, Vol. 52, No 5, p 310-317.

<sup>15</sup> Frontier Nursing Service. *Summary of the first 10,000 confinement records of the Frontier Nursing Service.* Q Bull Frontier Nurs Service 1958:33:45-55.

<sup>16</sup> Browne H, Isaacs G. *The Frontier Nursing Service: the primary care nurse in the community hospital.* Am J Obstet Gynecol 1976;124 (1):14-17.

<sup>17</sup> Levy BS, Wilkinson FS, Marine WM. *Reducing neonatal rates with nurse-midwives.* Am J Obstet Gynecol 1971; 109:50-58.

<sup>18</sup> Family Health and Birth Center. *Briefing Statement to the Committee on Health of the Council of the District of Columbia.* 2/22/07.

a vocation in midwifery. The Committee has established a fund to underwrite scholarships for student midwives of color. For example, the Four Corners Chapter of ACNM (located at the nexus of Arizona, Utah, Colorado, and New Mexico) has a scholarship program to aid Native-American midwifery students purchase computers and books. In addition, ACNM is actively working to facilitate the practice of midwives trained abroad and for whom English is not their native language.<sup>19</sup>

Each of the foregoing efforts are informed by our awareness that midwifery is an honorable and rewarding vocation, that diversity enhances the creativity of midwifery practice, and that the representation of diverse groups in its ranks strengthens opportunities for providing midwifery care to otherwise underserved communities.

### **Summary**

Certified nurse-midwives have a long legacy of compassionate, competent, effective care improving the health of women and their families. The midwifery model of care “affirms the power and strength of women and the importance of their health in the well-being of families, communities and nations.”<sup>20</sup> This model engenders the empowerment of women and is essential to promoting health.<sup>21</sup> The American College of Nurse-Midwives whole-heartedly endorses efforts to improve the health of women and most especially of those women at greatest risk for poor health outcomes. Toward that end we commit to the following:

- 1) Continue to promote the midwifery model of care as the standard of care for women.
- 2) Facilitate research on the efficacy of midwifery care in improving the health of women and narrowing (if not eliminating) the disparate outcomes between the poor and the privileged.
- 3) Increase the cultural humility of every midwife and student midwife.<sup>22</sup>
- 4) Increase the diversity of racial and ethnic representation in the ranks of midwives in clinical, academic and administrative spheres.
- 5) Continue to facilitate the ability of foreign educated midwives to become certified to practice midwifery in the U.S.
- 6) Work in coalition with other groups and organizations such as the U.S. Department of Health and Human Services Office of Minority Health’s *Closing the Health Gap Campaign* to improve the reproductive health of women, particularly those most burdened by disease and premature death.

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<sup>19</sup> ACNM, Foreign Educated Midwives: Moving beyond the AEO pilot – Resource packet for education program directors. 2<sup>nd</sup> Edition, 2003. [http://www.midwife.org/siteFiles/education/Moving\\_Beyond\\_AEO\\_Pilot.pdf](http://www.midwife.org/siteFiles/education/Moving_Beyond_AEO_Pilot.pdf)

<sup>20</sup> Philosophy of the American College of Nurse Midwives, <http://www.midwife.org/display.cfm?id=480>.

<sup>21</sup> World Health Organization, Health Evidence Network. *What is the evidence on effectiveness of empowerment to improve health?* February 2006.

<sup>22</sup>Tervalon M, Murray-Garcia J. *Cultural humility versus cultural competence: a clinical distinction in defining physician training outcomes in multi-cultural education.* J Health Care Poor Underserved. 1998 May; 9(2):117-25.