



The American College of  
Obstetricians and Gynecologists  
WOMEN'S HEALTH CARE PHYSICIANS

# COMMITTEE OPINION

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## Committee on Health Care for Underserved Women

*This information should not be construed as dictating an exclusive course of treatment or procedure to be followed.*

## Racial and Ethnic Disparities in Obstetrics and Gynecology

**ABSTRACT:** Projections suggest that people of color will represent most of the U.S. population by 2050, and yet significant racial and ethnic disparities persist in women's health and health care. Although socioeconomic status accounts for some of these disparities, factors at the patient, practitioner, and health care system levels contribute to existing and evolving disparities in women's health outcomes. The American College of Obstetricians and Gynecologists is committed to the elimination of racial and ethnic disparities in the health and health care of women and encourages obstetrician–gynecologists and other health care providers to engage in activities to help achieve this goal.

### Recommendations

Reducing racial and ethnic disparities in health and health care should be a priority for all obstetrician–gynecologists and other women's health care providers. Obstetrician–gynecologists can help to meet this objective by

- raising awareness among colleagues, residents, staff, and hospital administrators about the prevalence of racial and ethnic disparities and the effect on health outcomes
- understanding the role that practitioner bias can play in health outcomes and health care
- strongly encouraging the adoption of federal standards for collection of race and ethnicity information in clinical and administrative data to better identify disparities
- promoting research that not only identifies structural and cultural barriers to care but also tests the effectiveness of interventions to address such barriers
- educating patients in a culturally sensitive manner about steps they can take to prevent disease conditions that are prevalent in their racial and ethnic groups
- supporting and assisting in the recruitment of obstetrician–gynecologists and other health care providers from racial and ethnic minorities into academic and community health care fields

### Background

Approximately 61 million females in the United States (38% of U.S. females) are members of a racial or ethnic minority group, or both (1). As of 2013, nearly one half of U.S. births were to women of color (2), and projections suggest that nonwhite individuals will represent most of the U.S. population by 2050 (3). With these changing demographics comes an awareness of previously unrecognized racial and ethnic disparities in women's health and an urgent need to identify and address factors that can explain or contribute to these disparities.

The National Institutes of Health defines a *health disparity population* as one in which there is a significant disparity in the overall rate of disease incidence, prevalence, morbidity, or mortality in the specified population as compared with the general population (4). Although significant health disparities occur for many groups, disparities in health and health care are most likely to occur among women who are members of racial and ethnic minority groups. Health conditions commonly encountered by obstetrician–gynecologists are no exception. It is important to distinguish between disparities in health conditions and outcomes (eg, presence of uterine fibroids or maternal mortality) and disparities in health care services (eg, receipt of early prenatal care or mammography). Both occur, but in many instances they require different solutions; thus, it is critical that obstetrician–gynecologists be aware of each category, have resources

to improve their understanding of the etiologies of such disparities, and engage in strategies to decrease them. In addition, clinical and administrative data collection should, at a minimum, follow federal standards for race and ethnicity to improve the quality of such data and their use in describing disparities (5).

### Examples of Racial and Ethnic Disparities in Obstetrics and Gynecology

Table 1 presents examples of key disparities in obstetrics and gynecology, derived from national or state-level estimates. Although the existing literature is replete with examples of differences in outcomes in black and white women, more work is needed to explore disparities

among American Indian, Alaska Native, and Asian women. In addition, more granular data collection on ethnicity would help to elucidate the heterogeneity of health outcomes within the broad categories of Asian, Hispanic, and other groups.

### Understanding the Causes of Health Disparities

Many health disparities are directly related to inequities in income, housing, education, and job opportunities. Although many disparities diminish after taking these factors into account, some remain because of factors at the patient, health care system, and practitioner levels (6). Analysis in the context of these differences is a part of a framework endorsed by the Institute of Medicine in their

**Table 1.** Select Examples of Disparities in Obstetric and Gynecologic Health and Health Care ←

Disparities in Health Outcomes	AI/AN	Asian	Black	Hispanic	White
Infertility in last 12 months (% of women) <sup>a</sup>	N/A	10	12	9	7
Unintended pregnancy (% of pregnancies) <sup>b</sup>	N/A	N/A	69	56	42
Preterm birth (% of live births) <sup>c</sup>	13	10	17	12	10
Fetal death (/1,000 live births + fetal deaths) <sup>d</sup>	N/A	N/A	11	5	5
Maternal death (/100,000 live births) <sup>e,f</sup>	N/A	8	26	5	7
Gonorrhea (/100,000 population) <sup>g</sup>	96	18	570	N/A	24
Cervical cancer (/100,000 population) <sup>h</sup>	7	7	10	11	7
Breast cancer deaths (/100,000 population) <sup>i</sup>	15	11	31	15	22
Diabetes-related deaths (/100,000 population) <sup>j</sup>	22	11	33	13	24
Disparities in Health Care Access and Services					
Birth control provided in past year (% of women aged 15–44 years) <sup>k</sup>	N/A	N/A	29	29	37
Pap testing within 3 years (% of women aged 21–65 years) <sup>l</sup>	79	75	85	79	83
Mammography within 2 years (% of women aged 50–74 years) <sup>l</sup>	69	64	73	70	73
Ever received infertility treatment (% of women) <sup>a</sup>	N/A	N/A	11	12	16
Prenatal care in first trimester (% of births) <sup>c</sup>	69	84	75	76	89
Cesarean delivery (% of births) <sup>c</sup>	29	34	36	32	32

Abbreviations: AI/AN, American Indian or Alaska Native; N/A, data not available.

<sup>a</sup>Bitler M, Schmidt L. Health disparities and infertility: impacts of state-level insurance mandates. *Fertil Steril* 2006;85:858–65.

<sup>b</sup>Finer LB, Zolna MR. Shifts in intended and unintended pregnancies in the United States, 2001–2008. *Am J Public Health* 2014;104(suppl 1):S43–8.

<sup>c</sup>March of Dimes. PeriStats. Available at: <http://www.marchofdimes.org/peristats/Peristats.aspx>. Retrieved September 1, 2015.

<sup>d</sup>MacDorman MF, Gregory EC. Fetal and perinatal mortality: United States, 2013. *Natl Vital Stat Rep* 2015;64 (8):1–24.

<sup>e</sup>California Maternal Quality Care Collaborative. Racial disparities. Available at: <https://www.cmqcc.org/focus-areas/maternal-mortality/racial-disparities>. Retrieved September 2, 2015.

<sup>f</sup>Data is limited to the state of California but represents the most recently available data. National data have not been updated since 2010.

<sup>g</sup>Racial disparities in nationally notifiable diseases—United States, 2002. Centers for Disease Control and Prevention (CDC). *MMWR Morb Mortal Wkly Rep* 2005;54:9–11.

<sup>h</sup>Human papillomavirus-associated cancers - United States, 2004–2008. Centers for Disease Control and Prevention (CDC). *MMWR Morb Mortal Wkly Rep* 2012;61:258–61.

<sup>i</sup>Kohler BA, Sherman RL, Howlander N, Jemal A, Ryerson AB, Henry KA, et al. Annual report to the nation on the status of cancer, 1975–2011, featuring incidence of breast cancer subtypes by race/ethnicity, poverty, and state [published errata appear in *J Natl Cancer Inst* 2015;107(7). pii: djv177; *J Natl Cancer Inst* 2015;107(5). pii: djv121]. *J Natl Cancer Inst* 2015;107:djv048.

<sup>j</sup>Kochanek KD, Murphy SL, Xu J. Deaths: final data for 2011. *Natl Vital Stat Rep* 2015;63(3):1–120.

<sup>k</sup>Martinez G, Chandra A, Febo-Vasquez I, Mosher W. Use of family planning and related medical services among women aged 15–44 in the United States: National Survey of Family Growth, 2006–2010. *Natl Health Stat Report* 2013;6:1–16, 20.

<sup>l</sup>Cancer screening - United States, 2010. Centers for Disease Control and Prevention (CDC). *MMWR Morb Mortal Wkly Rep* 2012;61:41–5.

2003 report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (6).

### **Patient-Level Factors**

Race and ethnicity represent social rather than biological constructs that can provide useful information about how environmental, cultural, behavioral, and medical factors can affect patient health. The frequency of certain genetic variations may differ between racial or ethnic groups but generally are related to a common ancestral lineage. For instance, there is an increased frequency of mutations for certain genetic diseases (eg, sickle cell disease) in individuals of African descent. Genetic polymorphisms associated with increased susceptibility to disease also may vary in frequency in different racial and ethnic groups (7). Another consideration is the issue of gene-environment interaction and epigenetics. Genetic variations, even those that do not vary in frequency among racial or ethnic groups, may enhance susceptibility to an environmental exposure that occurs more frequently in a particular racial or ethnic group. Thus, although race and ethnicity are primarily social constructs, the effect of common ancestral lineage on the segregation and frequency of genetic variations in combination with the influence of cultural factors on environmental exposures cannot be ignored and should be considered a potential contributor to health disparities.

Variation in patient preferences, attitudes, and adherence to treatment plans may explain some, but certainly not all, observed differences. For example, racial and ethnic minorities may be less likely to undergo prenatal genetic screening, but this difference is partially explained by differences in value placed on the information obtained from such testing (8). Studies suggest the likely effect of experiences of racism and life stressors on obstetric and gynecologic outcomes (9). Behaviors that affect health status, such as physical activity and dietary practices, may vary by race and ethnicity and, therefore, contribute to differences (10).

### **Health Care System-Level Factors**

The United States is the only developed country that does not consider health care a right of citizenship; instead, health care is driven by market forces. Thus, the health care system in the United States contributes to poor access for citizens who are either uninsured or underinsured. Although the Affordable Care Act likely will help to reduce disparities in health care access, estimates suggest that minority women, who are disproportionately of low socioeconomic status, may be adversely affected in states that do not expand Medicaid coverage. As of 2013, 59% of uninsured African Americans, who otherwise would be eligible for Medicaid under the expansion, lived in states with no plans to expand Medicaid coverage (11). Additionally, undocumented immigrants are ineligible for the coverage benefits afforded by the Affordable Care Act (12). Varying geographic availability of health care

institutions also may contribute to racial and ethnic disparities in health care (13, 14). Each of these factors must be contextualized in terms of broader structural inequalities that permeate society, such as economic disparities, racism, gender oppression, and unequal educational opportunities (15).

### **Practitioner-Level Factors**

Evidence suggests that factors such as stereotyping and implicit bias on the part of health care providers may contribute to racial and ethnic disparities in health (6). For example, social and demographic biases have been shown to affect practitioners' recommendations for long-acting reversible contraceptive methods to women at risk of unintended pregnancies (16). It is unclear whether these biases also affect practitioners' recommendations for cesarean delivery or referrals for infertility. Subtle ambiguities in practitioners' and patients' interpretations of medical information because of cultural and language differences also contribute to disparities in care (6). Culturally derived mistrust of the health care system may result from legacies such as coercive sterilization of poor women of color (17) and can decrease adherence to clinician recommendations.

### **Proposed Solutions to Reduce Disparities in Obstetrics and Gynecology**

Successful interventions to reduce health disparities are likely to be multifactorial and incremental in nature, taking aim at root causes of suboptimal outcomes and care. Addressing social determinants of health is critical to reducing inequities in health status. Studies suggest that race and language concordance between patients and practitioners may improve communication and outcomes (18). Obstetrician-gynecologists should support diversity at all levels of the health care system. Further research to investigate the role of biology, genetics, and environment and target therapies that specifically benefit minority women also will be required. Lastly, obstetrician-gynecologists and other health care providers must acknowledge the role they play in perpetuating health care disparities and must advocate for a system of more culturally and linguistically appropriate care for all.

The following are suggested actions that obstetrician-gynecologists can take to address disparities in their practices and local communities:

- Raise awareness of health disparities among colleagues, practice staff, and administrators through grand rounds presentations, office staff meetings, and resident and student lectures.
- Recommend and support quality improvement projects that identify and develop initiatives to target specific disparities within local health care systems.
- Educate staff and colleagues about community resources for women with limited access to health care.

- Work collaboratively with local public health authorities to address disparities in environmental exposures, health education and literacy, and women's health services and outcomes (eg, breast and cervical cancer screening, maternal and infant mortality).
- Encourage health system leadership to advocate for local, state, and national policies to improve women's health care and reduce disparities.

## Conclusion

Racial and ethnic disparities in obstetric and gynecologic outcomes and care are prevalent and persistent. In order to provide the best care possible for all women, obstetrician–gynecologists must be keenly aware of the existence of and contributors to health disparities and be willing to work toward their elimination.

## For More Information

*These resources are for information only and are not meant to be comprehensive. Referral to these resources does not imply the American College of Obstetricians and Gynecologists' endorsement of the organization, the organization's web site, or the content of the resource. The resources may change without notice.*

ACOG has identified additional resources on topics related to this document that may be helpful for ob-gyns, other health care providers, and patients. You may view these resources at [www.acog.org/More-Info/RacialEthnicDisparities](http://www.acog.org/More-Info/RacialEthnicDisparities).

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