Disparities in Maternal Child Health
In
Onondaga County

A Perinatal Perspective

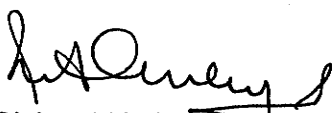
- Serious disparities exist

- This is a local reflection of a national problem in urban counties

- Non – white mothers more likely to have: (see attached)
    - Less paternal involvement
    - More teen pregnancy
    - More Medicaid use
    - More "Clinic" use
    - Less "adequate" prenatal care
    - More smoking
    - More B.V. & Preeclampsia
    - More Low, Very Low and Extremely Low Birth Weights 2lbs or less.
    - Less breast feeding
    - More (2x+) Infant Mortality (as per county)
    - More Maternal & Child Mortality (Nationally)

- What to do?

    - Medically
        - Better Women's Health Care – preconceptional care
        - Additional Prenatal/Perinatal Resource(s)
        - Better Maternal/Child Health Ambulatory resource - 'MIRACLE" Continuity Project till school entry
        - Augmented BV Dx/Rx
        - ACOG principles (attached)
    - Societally
        - Education, Universal Insurance
        - Improve Equity



Richard H. Aubry
04/10/07

January through December 2006 Data
Provided by the Statewide Perinatal Data System
(Not for release without permission.)
Please contact the CNY Perinatal Data System at (315) 464-5706.

Onondaga County Residents

	White	Black	Other	Multiple	Total
Overall Births	3953 73.6%	826 15.4%	366 6.8%	227 4.2%	5372
Teens Only	162 46.2%	133 37.9%	27 7.7%	29 8.3%	351
AMA Only	727 83.2%	73 8.4%	57 6.5%	17 1.9%	874
Early Prenatal Care	82.3%	55.1%	69.9%	65.6%	76.6%
Late/No Prenatal Care	3.1%	7.7%	6.0%	7.0%	4.2%
Adequate Prenatal Care	85.8%	67.9%	77.1%	74.9%	82.0%
Prenatal Care Provider					
Private	79.1%	31.7%	55.2%	41.9%	68.7%
Clinic	20.3%	67.3%	44.5%	57.7%	30.8%
None/Unknown	0.6%	1.0%	0.3%	0.4%	0.5%
Medicaid Payor	33.5%	82.0%	53.6%	72.7%	44.0%
Cesarean Section	32.5%	27.2%	27.6%	27.8%	31.2%
Low Birthweight (500-2499g)	7.2%	11.6%	6.0%	13.7%	8.0%
Singletons	5.2%	9.6%	5.3%	10.5%	6.1%
VLBW (500-1499g)	1.5%	2.5%	1.6%	2.2%	1.7%
Singletons	1.0%	1.9%	0.8%	1.4%	1.2%
ELBW (500-999g)	0.5%	1.3%	0.5%	1.8%	0.7%
Singletons	0.4%	0.8%	0.3%	0.9%	0.5%

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Onondaga County Residents

	White	Black	Other	Multiple	Total
Maternal Age at Delivery	3953	826	366	227	5372
Teen (<19)	162 4.1%	133 16.1%	27 7.4%	29 12.8%	351 6.5%
Advanced (>34)	727 18.4%	73 8.8%	57 15.6%	17 7.5%	874 16.3%
Father not on BC	10.4%	39.2%	13.1%	27.3%	15.7%
Smoking During Pregnancy	17.8%	23.1%	14.2%	29.5%	18.9%
Breastfeeding	68.8%	46.3%	70.1%	60.0%	65.1%
Bacterial Vaginosis	14.0%	30.8%	16.7%	27.8%	17.3%
Pre-eclampsia	1.9%	3.5%	0.8%	0.9%	2.0%
Chronic Hypertension	4.4%	5.1%	2.7%	3.5%	4.3%
Diabetes, Pre-pregnancy	1.0%	0.8%	1.4%	0.9%	1.0%
Diabetes, Gestational	5.3%	2.7%	7.1%	4.4%	5.0%
PROM	8.9%	7.5%	10.7%	10.6%	8.9%
PPROM	7.0%	5.6%	5.5%	9.3%	6.7%

(3)
(Both Sides)

Evaluation of Bacterial Vaginosis Screening & Treatment During Pregnancy In The Syracuse Healthy Start Project

Richard H. Aubry, MD, MPH – State University of N.Y.,Syracuse
Emily Koumans, MD, MPH – CDC, Atlanta

March 14, 2007

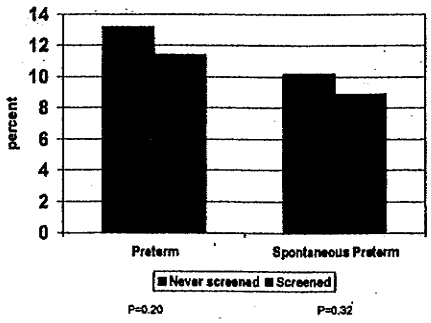
"TO BV or Not to BV"

The Question

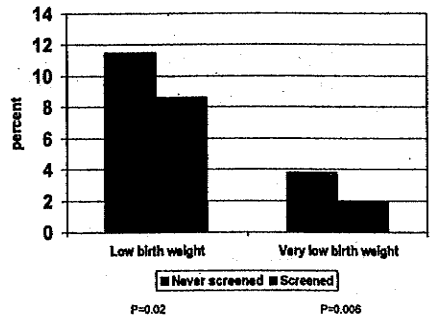
"To BV, or not to BV: that is the question:
Whether 'tis nobler in the mind to suffer The
slings and arrows of outrageous Vaginosis,
Or to take Flagyl against a sea of bacteria, and by
opposing, end preterm delivery?"

J. Folk, M.D., M-F-M Division Upstate Medical University
"with apologies to W. Shakespeare"

Preterm and spontaneous preterm delivery by screening group (N=2829)



Low birth weight and very low birth weight by screening group (N=2829)



Provisional Data

Committee Opinion

Number 317, October 2005

Racial and Ethnic Disparities in Women's Health

ABSTRACT: Significant racial and ethnic disparities exist in women's health. These health disparities largely result from differences in socioeconomic status and insurance status. Although many disparities diminish after taking these factors into account, some remain because of health care system-level, patient-level, and provider-level factors. The American College of Obstetricians and Gynecologists strongly supports the elimination of racial and ethnic disparities in the health and the health care of women. Health professionals are encouraged to engage in activities to help achieve this goal.

Health disparities can be defined as "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" (1). These differences can be assessed according to a variety of factors including gender, race or ethnicity, education, income, disability, geographic location, or sexual orientation (2). Although significant health disparities occur between men and women and among certain groups of women based on the factors mentioned previously, disparities are most likely to be experienced by women who are members of racial and ethnic minority groups. For example, disease and premature death occur disproportionately in minority women compared with non-Hispanic white women (3).

Approximately 44 million women in the United States, nearly one third of all women in this country, are members of racial and ethnic minority groups. African-American women and women of Hispanic origin together comprise roughly one quarter of the total population of U.S. women (4). The Hispanic population accounted for 22% of the 4 million births in the United States in 2003 (5). The largest segment of the immigrant population in the United States is from Latin America (6).

It is important to note that race and ethnicity are primarily social characteristics much more than they are biologic categories. However, race and ethnicity can provide useful information to women's health care providers about environmental, cultural, behavioral, and medical factors that may affect their patients' health. Also, the frequency of certain genetic variations may differ between racial or ethnic groups. For instance, there is an increased frequency

driven by market forces; the ultimate goal of the health care business is to maximize profit. For these reasons, this health care system contributes to a lack of access for citizens who are either uninsured or underinsured. The varying geographic availability of health care institutions also may contribute to racial and ethnic disparities in health care.

Access to health insurance coverage and care and utilization of care is significantly different for minority women. The following examples illustrate this point:

- Hispanic and African-American women are more likely to be uninsured than white women. In 2001, 16% of white women, 20% of African-American women, and 37% of Hispanic women 18–64 years of age were uninsured (18).
- Asian-American and Hispanic women are most likely to have not received preventive care in the past year. In 1998, 29% of Asian-American women and 21% of Hispanic women received no preventive services in the previous year compared with 16% of white women and 7% of African-American women. (19).
- The proportion of Asian-American women obtaining Pap tests was considerably lower than that for white women. Only approximately one half (49%) of Asian-American women reported receiving a Pap test in the previous year compared with 64% of white women (19).
- Non-Hispanic black, Hispanic, and American Indian women are more than twice as likely as non-Hispanic white women to begin prenatal care in the third trimester or not at all (5).

Evidence suggests that factors such as stereotyping and prejudice on the part of health care providers may contribute to racial and ethnic disparities in health (17). Additionally, cultural differences between the health care provider and patient can cause communication problems between the patient and the provider and can lead to an inaccurate understanding of the patient's symptoms. Ambiguities between health care providers' and patients' understanding and interpretation of information may contribute to disparities in care (17). For example, language and literacy barriers interfere with physician–patient communication and can contribute to culturally derived mistrust of the health care system and to reduced adherence to health care provider recommendations. Use of traditional or folk remedies can interfere with science-based treatments. There also are lifestyle risk factors, such as unhealthy diets, low levels of physical activity, and alcohol and tobacco use, which contribute to morbidity and mortality and are more prevalent among certain populations (3).

ACOG Recommendations

The American College of Obstetricians and Gynecologists strongly supports the elimination of racial and ethnic disparities in women's health and health care as well as gender disparities in health and health care. The elimination of disparities in women's health and health care requires a comprehensive, multilevel strategy that involves all members of society. Our goal as health care providers and leaders must be to optimize individuals' health status and the quality of health care. We encourage health professionals to engage in the following activities:

1. Advocate for universal access to basic affordable health care (20).
2. Improve cultural competency in the physician–patient relationship and engage in cross-cultural educational activities to improve communication and language skills (21).
3. Use national best practice guidelines to reduce unintended variation in health care outcomes by gender, race, and ethnicity.
4. Provide high quality, compassionate, and ethically sound health care services to all. Engage in dialogue with patients to determine their care expectations, and counsel patients regarding the benefits of preventive health care and early screening, intervention, and treatment.
5. Advocate for increased public awareness of the benefits of preventive health care and early screening and intervention.
6. Encourage and become active in recruiting minorities to the health professions.
7. Advocate for improved access to programs that develop fluency in English among non-English speaking populations.
8. Acquire team-building skills to help attract and retain qualified nurses and other health professionals for provision of quality services to underserved women.

Onondaga County Health Department

Syracuse Healthy Start Justification

	White	Black	2010 Goals
Infant Deaths per 1,000 live births	6.6	15.0	4.5
Early Prenatal Care	87.8%	68.2%	90%
Birth Weight < 2,500 grams	7.0%	13.2%	5.0%

2004-2006 Provisional Data