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MATERNAL AND CHILD HEALTH OF ASIAN AMERICANS, NATIVE HAWAIIANS, & PACIFIC ISLANDERS

Good health begins before we are born and can last a lifetime. Likewise, health disparities can begin even before birth. Disparities in access and utilization of health care exist for Asian American, Native Hawaiian, and Pacific Islander (AA and NHPI) women and infants, but do not completely explain disparities in outcomes. Issues such as quality of care, access to culturally and linguistically appropriate services, and women's health across the lifespan also have a significant impact on the health of mothers and babies. Family characteristics, socioeconomic and geographic contexts, as well as the role of racism in health care[1] may also account for variation in outcomes. However, data about these variables cannot tell the whole story. Like many health matters, individual experience and cultural traditions surrounding pregnancy and childbirth are meaningful and important to many AA and NHPI families. The health care system must care for childbearing families with appropriate attention to those concerns. This fact sheet covers several important indicators of maternal and child health, including prenatal care, low birth weight, and infant mortality, to begin to give context to the most important outcomes for AA and NHPI mothers and their babies.

DEMOGRAPHIC OVERVIEW OF ASIAN AMERICAN, NATIVE HAWAIIAN, AND PACIFIC ISLANDER BIRTHS IN THE UNITED STATES

- According to the most recent Census data, AAs and NHPIs make up almost 6% of the total United States population, totaling 18.4 million people.[2] With a 43% increase in the last decade, this group has had the largest population growth. The largest AA and NHPI subgroups in 2010 were Chinese (3.5 million), Asian Indian (2.9 million), Filipino (2.6 million), Vietnamese (1.6 million), Korean (1.5 million), Japanese (0.8 million), and Native Hawaiian and Other Pacific Islanders (0.5 million).[3]
- In 2009, the birth rate (births per 1,000 population) declined to 16.2 per 1,000 for all Asian American and Pacific Islander women. This represents a 1% decline from the birth rate in this population in 2007 and a 3.7% decline from 1980.[4] The birth rate for Asian American and Pacific Islander women is higher than for all other groups except Hispanic women.[5] The greatest number of births to AA and NHPI women occurred in California, New York, Texas, and Hawaii.[6]
- AA and NHPI mothers tend to be older on average than mothers of other races. The highest rate of births occurred among AA and NHPI women aged 30-34 years, older than for other groups.[7]
- Teen birth rates overall are the lowest for AA and NHPI women, although significant disparities in subpopulations exist. For example, data from California reveals that the rate of teen births to Cambodian women is 11.3%, higher than the overall rate of Asian and Pacific Islander births to teens of 5.6%. Further, Cambodian teens born outside of the United States were more likely to be mothers than other teens- 96% of Cambodian teen mothers were born outside the U.S. compared to 65% of all Asian American and Pacific Islander teen mothers, and 35% of all teen mothers.[8]

PRENATAL CARE

Early prenatal care is associated with healthy birth outcomes and preventing low-birth weight, preterm birth and infant mortality. The U.S. Department of Health and Human Services' Healthy People 2020 objectives include increasing the number of women who receive early and adequate prenatal care by 10%.[9] Healthy People 2020, led by the U.S. Department of Health and Human Services, provides science-based, 10-year national objectives for improving the health of all Americans by establishing benchmarks and monitoring progress over time.[10]

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450 Sutter Street, Suite 600
San Francisco, CA 94108
(P) (415) 954-9988
(F) (415) 954-9999

National Policy Office
1828 L Street, NW, Suite 802
Washington, DC20036
(P) (202) 466-7772
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Adequate prenatal care must be comprehensive, and include medical/clinical services, social services, nutrition services, health education and health promotion, as well as high risk referral when indicated.[11] Research has shown that subgroups of Asian American mothers are less likely than others to receive early and adequate prenatal care.

In 2006, only 63.2% of mothers residing in Guam began prenatal care during the first trimester compared to a 83.2% prenatal care participation rate in the U.S. mainland.

- In a study of all California births between 1999 and 2001, the percentage of births in Asian subgroups including Cambodian, Filipino, Indian, Korean, Laotian, Thai, and Vietnamese without prenatal care during the first or second trimester was significantly higher than non-Hispanic whites.[12]
- As of 2005, California data reveals that while early and adequate prenatal care has improved among Asian American and Pacific Islander women in the state, the rate remains below that of white women and below the Healthy People 2020 objective.[13]

This disparity in prenatal care utilization among Asian American and Pacific Islander women exists in communities across the United States.

- In Pennsylvania, 31.5% of Asian American and Pacific Islander mothers did not received prenatal care in the first trimester in 2009. This is significantly higher than for the white population (16.2%) and higher than the rate for Asian American and Pacific Islander women in 2005, which was 21.7%.[14]
- In 2006, only 63.2% of mothers residing in Guam began prenatal care during the first trimester compared to a 83.2% prenatal care participation rate in the U.S. mainland.[15]
- Despite having health insurance coverage at about equal rates to the state average, prenatal care is inadequate for about half of Pacific Islanders giving birth in Utah, largely due to late entry into prenatal care.[16]
- Adequate prenatal care utilization in the U.S.-affiliated Pacific Islands in 2001 ranged from 76% in Palau to 17.5% in the Northern Mariana Islands.[17]

There are also differences between Asian American, Native Hawaiian and Pacific Islander subgroups. In a study comparing outcomes for AA and NHPI mothers in California and Hawaii, researchers found considerable variability between subgroups.[18]

- Marshallese, Hmong, and Tongan women were the least likely to receive prenatal care starting in the first trimester.
- Most subgroups, except Samoans and Native Hawaiians, were more likely to receive early prenatal care if they reported a single race/ethnicity.

LOW BIRTH WEIGHT

Low birth weight is defined as weight of less than 2,500 grams (~5.8 pounds) at birth, regardless of gestational age.[19] Low birth weight is a cause of infant mortality as well as long-term disability and developmental delay. Low birth weight is a major cause of infant death for AA and NHPI babies. Risk factors for low birth weight often indicate poor health status of a woman prior to and during pregnancy, including smoking, poor nutrition, and exposure to stress or violence in the home.[20] The national Healthy People 2020 objective is to have no more than 7.8% of live births be of low birth weight, representing a 5% improvement over the current baseline.

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San Francisco, CA 94108
(P) (415) 954-9988
(F) (415) 954-9999

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- In 2008, 8.3% of Asian American and Pacific Islander babies born in the United States were low birth weight.[21] California data show that 8% of Asian American and Pacific Islander births in the state are low birth weight.[22]
- In Washington State, the percentage of low birth weight babies born to Asian American or Pacific Islander women was higher than for all other groups except African Americans.[23]
- In some states, mothers reporting more than one race in addition to Asian or Pacific Islander are less likely to give birth to a low birth weight baby.[24]

In Hawaii, Samoan and Native Hawaiian women are nearly twice as likely to report smoking during pregnancy than women of other ethnicities.

Smoking during pregnancy is a major and preventable cause of low birth weight, as pregnant women who smoke are twice as likely to deliver a baby with low birth weight. Smoking rates are generally very low among AA and NHPI women, however disparities in subgroups exist. For example in Hawaii, Samoan and Native Hawaiian mothers reported the highest rates of smoking during the last 3 months of pregnancy. Black, Japanese, White, Korean, and the "All Others" race group in Hawaii also reported higher estimates of smoking during pregnancy, while Chinese and Filipino mothers reported the lowest estimate.[25]

INFANT MORTALITY

Infant mortality is defined as the death of a live-born baby within the first year of life. The infant mortality rate is used as an indicator to compare the health of populations between and within countries because it is "related to the underlying health of the mother, public health practices, socioeconomic conditions, and availability and use of appropriate health care for infants and pregnant women."[26]

The rate of mortality for Asian American and Pacific Islander babies is 4.78 per 1,000 live births, lower than what is found the general population.[27] However, the infant mortality rate for Asian Americans and Pacific Islanders was twice as high for mothers under 20 years old, as compared to mothers ages 25-29 years old.[28] The leading causes of infant mortality in Asian American and Pacific Islander populations are congenital abnormalities and low birth weight, though substantial disparities exist within the population.[29]

- Infant mortality in the Pacific Islands is high. In 2011, the rate was 9.42 deaths per 1,000 live births in American Samoa.[30] In the Marshall Islands, the rate exceeded 22 per 1,000 live births.[31]
- The estimated infant mortality rates for 2003 were significantly higher for American Samoa compared to the U.S. (9.82 v 6.75 deaths per 1000 live births, respectively). [32]
- In California, neonatal mortality rates were 1.36 times higher in the Laotian population and 1.89 times higher for the Thai community compared to their non-Hispanic white counterparts.[33]

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(F) (415) 954-9999

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