MATERNAL AND CHILD HEALTH AND DISPARITIES FOR ASIAN AMERICANS, NATIVE HAWAIIANS, AND PACIFIC ISLANDERS

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Why does maternal and child health matter for realizing health justice in AA and NHPI communities?

- Health disparities begin before we are born and last a lifetime
- For several important indicators of maternal and child health, Asian American, Native Hawaiian, and Pacific Islander women suffer from poorer outcomes than the general population
- Even compared with white women, whose outcomes are comparatively worse than most of the developed world, AA and NHPI women and babies are not as healthy as they could be.

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The Reproductive Justice Framework

- RJ exists when all people have the social, political and economic power and resources to make healthy decisions about our gender, bodies and sexuality for our selves, our families and our communities.

- This includes the ability and resources to experience healthy pregnancies and to raise healthy children with dignity

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Objectives

- Today's webinar will:
  - Describe basic demographic information about the AA and NHPI population in the United States
  - Identify health insurance rates and types of insurance for AA and NHPI women, helping to contextualize the experience of seeking and receiving maternity care
  - Explain highlights of the available data regarding maternal and child health outcomes for AA and NHPI women and infants, and identify deficiencies in the data
  - Evaluate federal policies aimed at reducing disparities in maternal and child health which could have an impact for AA and NHPI women and infants

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DEMOGRAPHICS

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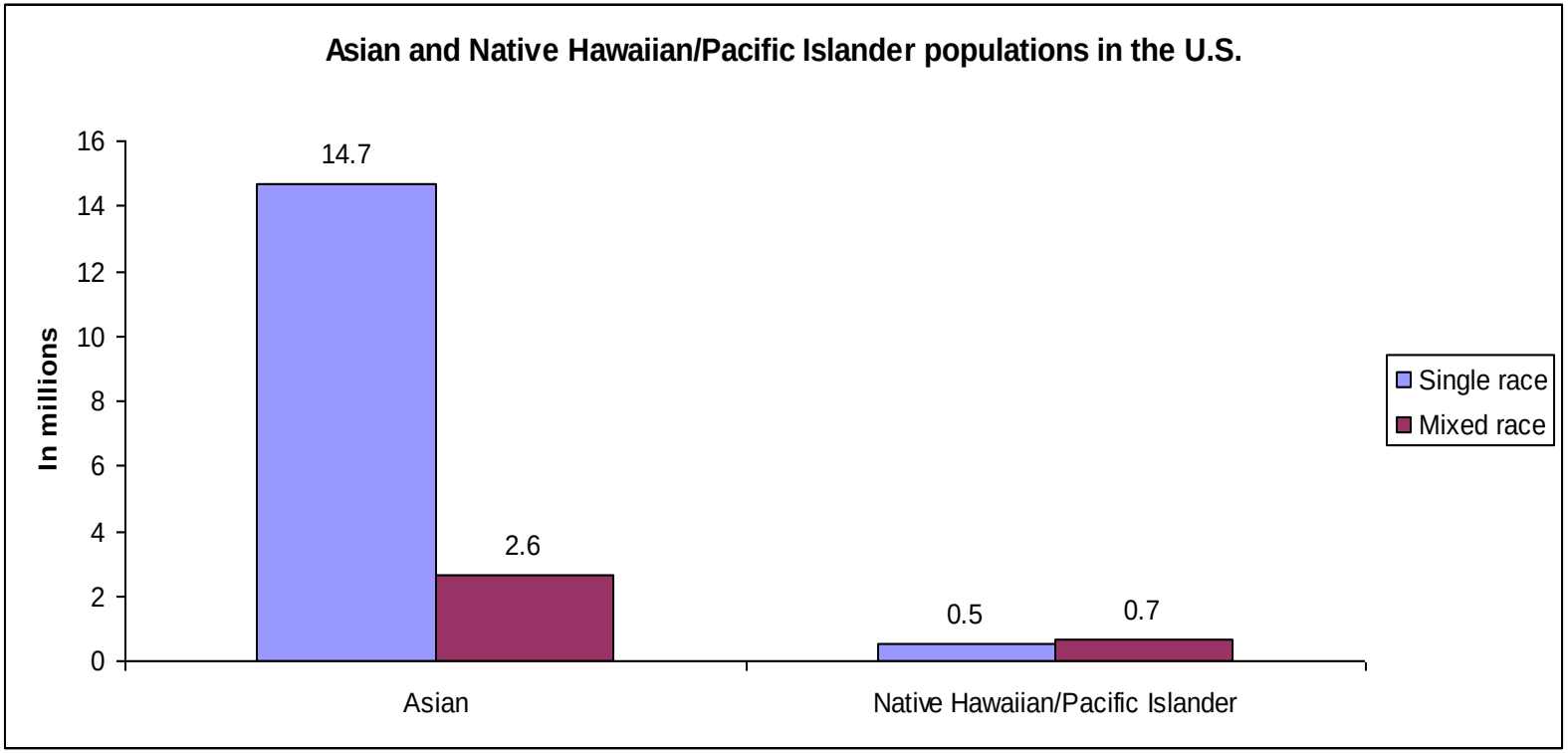
AA and NHPI Population



- Single-race Asians make up 4.8% of the U.S. population; combined with other races make up 5.6%.
- Single race NHPIs make up 0.2% of the U.S. population; combined with other races make up 0.4%.

Source: 2010 Census

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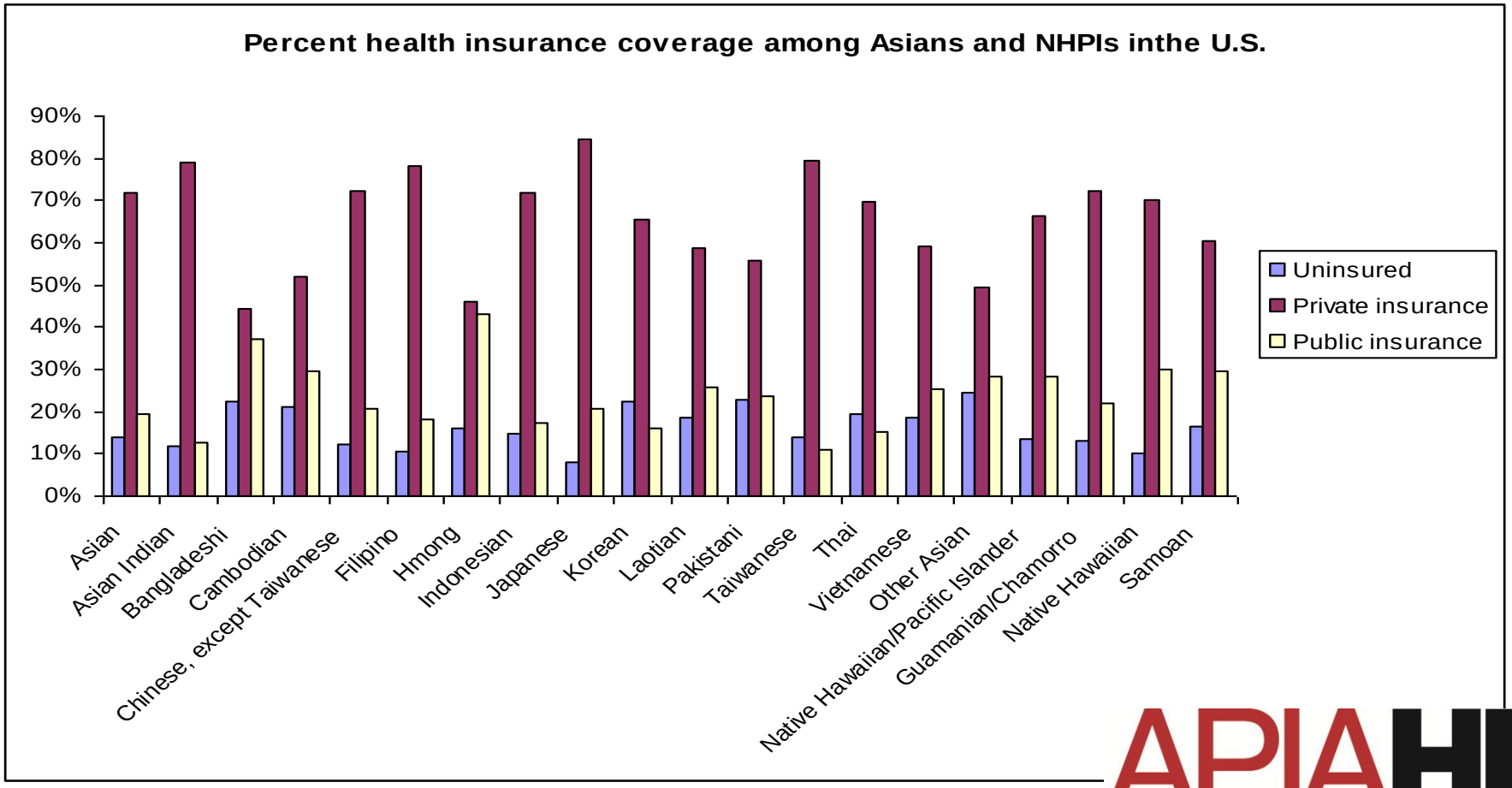
Health Care Coverage for AAs and NHPIs By Ethnicity



Source: 2009 American Community Survey 1-Year Estimates

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Birth Demographics

- Births declined by 1% for Asian American and Pacific Islander women in 2009. The general fertility rate (births per 1,000 women) also declined by 3-4%

- 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.

- The greatest number of births to AA and NHPI women occurred in California, New York, Texas, and Hawaii.

- 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

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How is race and ethnicity maternal and child data collected?

- Race is reported on birth certificates & death certificates
- The 2003 revision (not yet used in all states) allows the reporting of multiple races from each parent on birth certificates; only half of states use standard certificate
- Federal and state level data used to supplement birth certificate data are not always disaggregated by race that includes Asian and Pacific Islander.
- This limits the accuracy and granularity of publicly available data.

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INDICATORS

Prenatal Care

- Research has shown that subgroups of Asian American mothers are less likely than others to receive early and adequate prenatal care.

- 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% of whom did not receive early prenatal care). The rate increased from 2005, which was 21.7%.

- 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.

- 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.

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Low Birthweight

- In 2008, 8.3% of Asian American and Pacific Islander babies born in the United States were low birth weight.
- 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.
- 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.

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Infant Mortality

- Infant mortality in the Pacific Islands is high. In 2011, the rate was 9.42 deaths per 1,000 live births in American Samoa.

- In the Marshall Islands, the rate exceeded 22 per 1,000 live births.

- 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.

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Maternal Deaths and Complications

- Asian American women died due to pregnancy related causes at a higher rate than non-Hispanic white counterparts, at a rate of 11 deaths per 100,000 live births between 2005 and 2007.
- Nationally, 31.1% of pregnant women suffered complications during hospitalized labor and delivery in 2007.
- At this time, there are no statistics available for this measure disaggregated to AA and NHPI women, however, some research has shown that serious racial disparities in maternal morbidity cannot be explained by factors such as medical care or socioeconomic status.
- Studies of differences in outcomes between AA and NHPI subgroups have demonstrated significant unexplained differences in serious maternal morbidities such as hypertension and eclampsia.

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Gestational Diabetes

- The risk of gestational diabetes is higher for Asian American and Pacific Islander women than for all other groups. Some research has shown that Asian American women are 177% more likely to screen positive for gestational diabetes.

- In one study, Asian American immigrants had significantly higher GDM rates than their US-born counterparts, except among women of Japanese and Korean ancestry.

- Among AA and NHPI women, studies have shown that Filipina and Samoan women are at the highest risk for GDM, and Korean American women at the lowest risk; and Native Hawaiian and Filipino women are more likely to suffer poor outcomes related to the condition.

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Cesarean Delivery

- Between 1991 and 2008, the relative rate of primary cesarean section deliveries (those to first-time mothers) for Asian American and Pacific Islander women in California increased by 70.2%, and the overall rate in this population was 19% higher than the rate for white women.

- In addition, some research indicates that Asian American women who have white partners are more likely to give birth by cesarean.

- Researchers have not identified the causes of these disparities.

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Breastfeeding

- Infant feeding practices vary across Asian American, Native Hawaiian and Pacific Islander populations.
- According to the Surgeon General, Asian American and Pacific Islanders have among the highest rates of breastfeeding nationally, though geographic and subpopulation disparities exist.
- The California Department of Health has found that for all of California, exclusive breastfeeding initiation while in the hospital is 44.5% for Asians and 40.6% for Pacific Islanders, well below the rate for whites, 64%.
- In Hawaii, Samoan, Native Hawaiian and Filipino mothers reported the lowest breastfeeding estimates at 8 weeks.

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WHAT CAN WE DO

What we need for healthy women and babies

- Basic health care throughout the lifespan
- Comprehensive prenatal care
  - Includes routine clinical care, plus
    - Social/psychosocial services
    - Nutrition services
    - Health education/health promotion
    - High-risk referral when necessary
    - Translation, interpretation, and health literacy services

- Safe homes and communities

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Improving maternal and infant health

- Reducing the incidence of complications by improving the health care and health behaviors of women
  - Access to culturally competent and appropriate prenatal care, beginning preconception or in the first trimester
  - Social determinants: ensuring access to healthy food, safe communities, safe homes
  - Increasing access to contraception and reproductive lifespan planning
  - Reducing unplanned pregnancy; ensuring safe intervals between pregnancies
- Strengthening obstetric and neonatal health systems; training of diverse providers
  - Particularly for women in geographically isolated areas such as the Pacific Islands
  - Including translation, interpretation, and other language access services

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POLICY PROGRESS & RECOMMENDATIONS

The Affordable Care Act

- ACA Sec. 4302(a) intended to improve data collection:
  - DHHS to establish methods to uniformly collect, analyze, and report using race, ethnicity, sex, primary language, and disability status categories to document and monitor progress toward reducing disparities in health and health care
  - Applied to *any* "federally conducted or supported health care or public health program, activity or survey"
- Enforcement will help improve collection and reporting data on AA & NHPI health needed to establish baseline, track progress, and guide future action.

- Expands Medicaid for non-pregnant and childfree adults
- Insurance exchanges will increase access to private insurance
- Preventive services including contraception will be covered without co-pays.

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Building towards universal coverage: Beyond the ACA

- The ACA failed to remove the five-year waiting period imposed on newly-arrived legal immigrants to access public coverage programs, like Medicaid, AKA the “five-year bar.”
  - As such, no federal funds will be available to enroll this population into an expanded Medicaid program.
- States may still elect to expand their Medicaid program to immigrants under the five-year bar using state-only funds.
- Currently, CA, CT, DE, DC, IL, ME, MA, MN, NE, NJ, NM, NY, and WA provide Medicaid coverage for legal immigrant adults without a waiting period.

Figure 1. States that Cover Lawfully-Residing Immigrant Children and Pregnant Women with State-Only Funds

Source: Center for Children and Families, 2009.

Policy Opportunities to Improve Maternal and Child Health for AA and NHPI Women and Infants

- Health Equity and Accountability Act (HEAA) Title V (H.R. 2954 /S. 2474)
- Maternal Health Accountability Act of 2011 (H.R. 894 Sponsor John Conyers)
- Maximizing Optimal Maternity Services for the 21st Century Act (MOMS 21)(H.R. 2141)
- PREEMIE Reauthorization Act of 2011 (S. 1440/ H.R. 2679).
- Birth Certificate Enhancement Act of 2011 (H.R. 666 Sponsor Steve Cohen)
  - Helps states enact uniform birth & death certificates
- GEDI Act of 2011 (Gestational Diabetes) (H.R. 2194 & S 1440)
- Strong Start Initiative

Discussion and feedback

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