Addressing Racial and Ethnic Health Disparities in Infant Mortality

Additional Barriers to Care

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Editorial

In 2013, the Centers for Disease Control and Prevention reported that the infant mortality rate among African Americans had dropped (http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6205a1.htm#tab). It was an amazing and hopeful finding. In addition, they attributed this drop to breastfeeding. It was Christmas in July! We should take a moment to celebrate this tremendous success and commend the community organizations that helped make it happen. Your work has been amazing. Of course, there is still much to do and several more issues we need to address before racial/ethnic disparities in infant mortality can be eliminated. A partial list follows.

Trauma History

Psychological trauma is not something we usually think about as being related to breastfeeding. But it can be a barrier. And there are racial/ethnic group differences in percentages of women who've experienced trauma. Black women are significantly more likely to report a history of trauma than White women. For example, in a national survey of 1,581 pregnant women, Black women had more lifetime posttraumatic stress disorder (PTSD) and trauma exposure than White women. When looking at current prevalence of PTSD, Black women were four times more likely to have PTSD than other women in the sample. This rate did not vary by socioeconomic status and it was explained by greater trauma exposure (Seng, Kohn-Wood, McPherson, & Sperlich, 2011).

Women's history of trauma is difficult for them. It also has some serious implications for the health of their babies. PTSD in pregnancy can lead to several serious complications including low birthweight and shorter gestation. For example, in one study of 839 pregnant women, women with PTSD in pregnancy had babies that weighed an average of 283 g less than babies of women without PTSD. PTSD was a stronger predictor of low birthweight for African American babies than it was for other babies in the sample (Seng, Low, Sperlich, Ronis, & Liberzon, 2011).

Our data from the Survey of Mothers' Sleep and Fatigue indicated that breastfeeding can help women who have a trauma history. We examined the impact of previous sexual assault on women's postpartum experience. Our sample included 994 sexual assault survivors. As expected, women who had been sexually assaulted had more sleep problems, anxiety, depression, anger, and irritability. But when we added feeding method to the analyses, we found that exclusive breastfeeding actually attenuated the effects of the trauma on all of these variables (Kendall-Tackett, Cong, & Hale, 2013). With so many mothers having a history of trauma, these findings are good news. But we need to be realistic in recognizing that a trauma history can be a barrier to breastfeeding, even though it can lessen the impact of trauma.

PTSD is often related to a history of interpersonal violence. It can also be caused by the woman's birth experience. Here, too, African American women are more vulnerable. In the Childbirth Connection's Listening to Mothers survey, 9% of the total sample met full criteria for PTSD following traumatic childbirth experiences, and 18% of the total sample had posttraumatic stress symptoms. When these numbers were broken out by ethnicity, 26% of Black women had posttraumatic stress symptoms following their births, compared to 18% for the full sample and 14% of Hispanic women (Beck, Gable, Sakala, & Declercq, 2011). This raises the question of why Black women were more likely to have traumatic births. Perhaps part of the answer lies in how birth was handled for them. And that's related to the next issue.

Weight Bias

Our maternity care system treats women with higher body mass indexes (BMIs) in some very discriminatory ways, often shunting them off into high-risk maternity care whether they need it or not; these decisions are simply made based on women's weight—with or without other health risks. This practice differentially impacts Black women because there are significantly higher percentages of women of color who fall into "overweight" and "obese" categories, as you can see in Figure 1.

Women with higher BMIs are more likely to experience high-intervention births, including elective procedures. For example, in a meta-analysis of 11 studies, cesarean sections were 1.5 times more likely in women with BMIs $>$ 26 and 2.25 times more likely in women with BMIs $>$ 30 (Poobalan, Aucott, Gurung, Smith,

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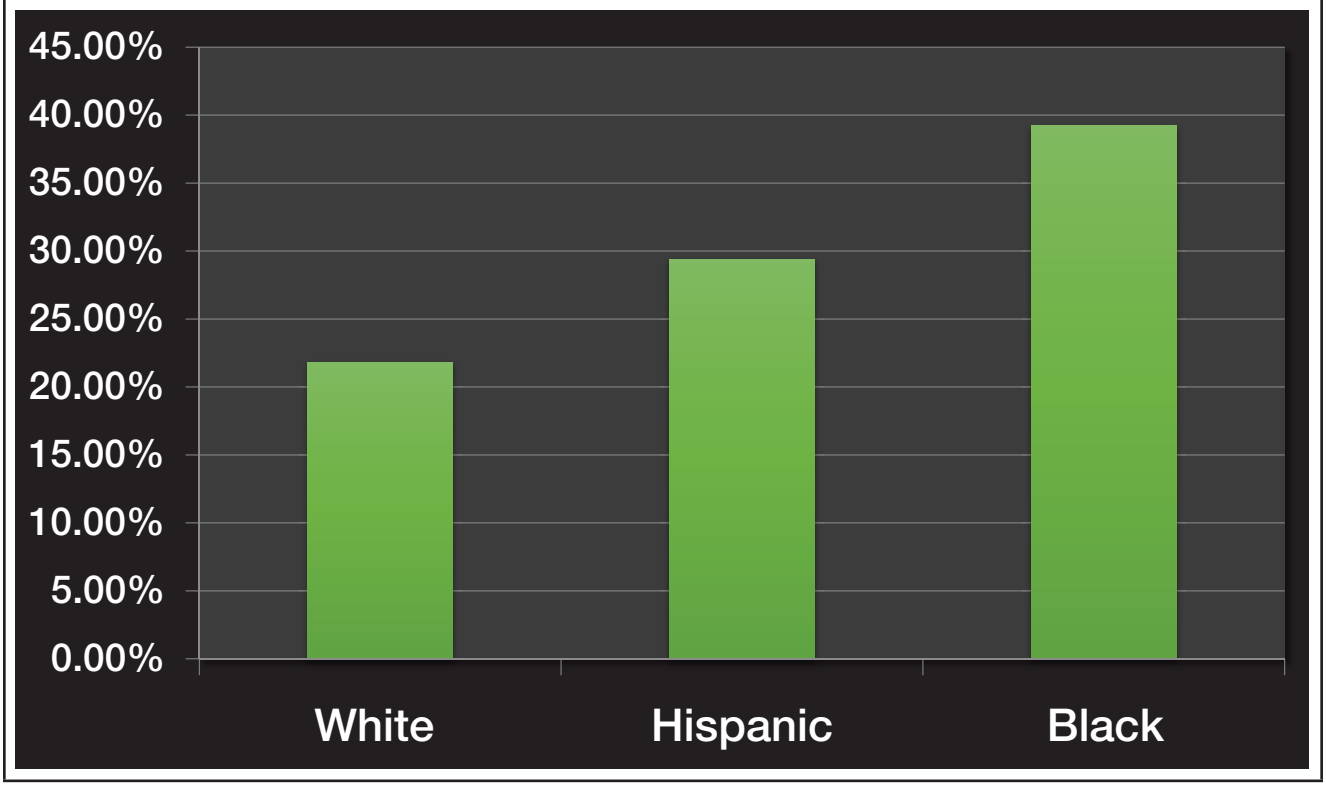
Figure 1. U.S. Obesity Rates by Ethnicity



Source: Centers for Disease Control and Prevention. (2010). *Compared with Whites, Blacks had 51% higher and Hispanics had 21% higher obesity rates*. Retrieved from http://www.cdc.gov/Features/dsObesityAdults

& Bhattacharya, 2009). Someone reading this finding might assume that high BMIs made labor difficult and therefore these mothers ended up with cesarean sections. That assumption would be only partially correct. Heavier women are also more likely to have *elective* cesareans than their thinner counterparts. In the Poobalan et al. (2009) study, obese women were almost twice as likely to have elective cesareans compared to women with lower BMIs. If women with higher BMIs are encouraged to have elective cesareans, there will be more Black women having cesareans. This demographic reality could account for the higher rate of birth trauma and could also have a negative impact on breastfeeding.

Sleep

Several recent studies have found a link between experiences of everyday discrimination and sleep problems in ethnic minorities. For example, in a study comparing Black and White adults, Blacks had shorter sleep duration and lower sleep efficiency. It took Blacks 25 minutes to fall asleep, compared to 16 minutes for Whites. Slow-wave sleep was similarly affected: 3.6% of total sleep was slow-wave compared to 6.8% for Whites (Mezick et al., 2008). Slow-wave sleep is the deeper stage of sleep. A smaller percentage is associated with more daytime fatigue and pain. This difference persisted even after controlling for socioeconomic status. Both of these sleep problems indicate chronic hyperarousal.

In another study of 97 Black and White adults, perceived unfair treatment for both groups was associated with poorer sleep quality, more daytime fatigue, shorter sleep duration, and a smaller proportion of rapid eye movement (REM). Overall, Blacks had lower sleep time and poorer sleep efficiency compared to Whites (Beatty et al., 2011).

These ethnic differences in sleep problems will likely be compounded when talking about sleep in new mothers. Fortunately, exclusive breastfeeding helps mothers to get more sleep (Kendall-Tackett, Cong, & Hale, 2011). But sleep may still continue to be an issue that impacts Black mothers' health and well-being and may need to be separately addressed if breastfeeding is going to continue.

In summary, we have found that the causes of ethnic health disparities can be complex and daunting. Breastfeeding helps with many of these problems, but it can also be derailed if these other issues are not addressed. By protecting, promoting, and supporting breastfeeding, we can continue to decrease our infant mortality rate. But we need to recognize that health disparities do not lend themselves to quick fixes. Rather, interventions must take into account the whole of women's experiences to be effective.

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