Whereas, Thirty-eight percent (approximately 61 million) of women residing in the U.S. are members of a racial or ethnic minority populations and face disparities in obstetric outcomes¹; and

Whereas, Studies have shown poor obstetric outcomes (e.g., preterm birth), maternal morbidity, and inadequate prenatal care is higher among racial/ethnic minority women in the U.S.²⁻⁴; and

Whereas, Poor obstetric outcomes that disproportionately affect racial/ethnic minorities include the higher incidences of congenital abnormalities (e.g., spina bifida and anencephaly); fetal demise (11.3 per 1,000 for Blacks compared to 5.0 per 1,000 for Non-Hispanic Whites); preterm birth (16.3% Blacks compared to 10.2% non-Hispanic Whites)⁵; and fetal growth restriction (15.9 per 1,000 for Blacks compared 8.3 per 1,000 for non-Hispanic Whites)⁶;⁷; and

Whereas, The birth prevalence of spina bifida is 4.18 per 10,000 births among Hispanic women, versus 3.37 per 10,000 for non-Hispanic white women⁷,⁸; and

Whereas, Among Asian women, Indian and Pakistani women have the highest risk of low birthweight newborns at term⁹; and

Whereas, Disparities in preterm births account for 80% of the Black-White disparity in infant mortality (in the U.S. in 2006, Blacks had an overall preterm birth rate of 18.4% compared to the general population’s rate of 12.8%)¹⁰; and

Whereas, Polymorphisms in maternal and fetal genes for IL-1, IL-6 and other inflammatory factors may be associated with an increased risk of spontaneous preterm birth among Black women over other populations¹¹; and

Whereas, These polymorphisms could also modify the risk of preterm birth associated with genital infections among certain female minority populations¹²; and

Whereas, In 2009, the prevalence of severe maternal morbidity in the U.S. was 129 per 10,000, representing a 75% increase since 1999¹³; and

Whereas, Non-Hispanic Black women are twice as likely to experience severe maternal morbidity than Caucasians¹³⁻¹⁵; and
Whereas, Among all women, pregnancy-related hypertension rates are the highest in Non-Hispanic Black women. Among Asian women, Filipina and Samoan women have higher risk than women from other subgroups\textsuperscript{7}; and

Whereas, A report by the Centers for Disease Control and Prevention on Gestational Diabetes, found that Hispanic and Asian/Pacific Islander women at a greater risk for development of gestational diabetes (16.3\% and 12.1\% respectively) compared to Caucasian women (6.8\%)\textsuperscript{16}; and

Whereas, A report by the American Diabetes Association found that racial and ethnic minorities [Black (1.69), Hispanic (1.42), and Asian/Pacific Islander (1.25)] had higher rates of pregnant women with pre-existing diabetes compared to pregnant Caucasian women even after adjusting for maternal age\textsuperscript{17}; and

Whereas, Studies have shown that Asian women are at an increased risk for gestational diabetes, prolonged second stage of labor, and perineal lacerations compared to Caucasian women\textsuperscript{7,18-20}; and

Whereas, Research on Asian subgroups have shown that Filipina women had the highest risk of gestational hypertension/preeclampsia; Pacific Islander women had the highest risk of macrosomia; and Indian/Pakistani women had the highest risk of preterm delivery, gestational diabetes, and diabetes mellitus\textsuperscript{7,18-22}; and

Whereas, The complex etiologies of these disparities include social constructs and variations in access to health care\textsuperscript{23}; and

Whereas, Despite the 1998 FDA mandate to fortify cereal grains in the U.S., adequate intake of folic acid remains low in Hispanic groups\textsuperscript{24,25}; and

Whereas, Black women are also more likely to experience higher rates of maternal morbidity (e.g., hypertensive disorders of pregnancy), some of which may be attributable to genetic factors as well\textsuperscript{23}; and

Whereas, Studies have shown that maternal stress plays a role in preterm birth risk, in particular Black and Native Indian/Alaska Natives report undergoing chronic stressors during pregnancy\textsuperscript{26-28}; and

Whereas, Racial and ethnic minorities have a higher incidence of being overweight and/or obese pre-pregnancy, which have been shown to contribute to pregnancy complications such as preterm birth, fetal death, macrosomia, gestational diabetes and cesarean delivery\textsuperscript{29-31}; therefore be it

RESOLVED, That our American Medical Association work with stakeholders to encourage research on identifying barriers and developing strategies toward the implementation of evidence-based practices in ethnic minorities to prevent disease conditions that contribute to poor obstetric outcomes, maternal morbidity and maternal mortality. (Directive to Take Action)

Fiscal Note: Not yet determined

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References:


14. Andrea A. Creanga, MD, PhD; Brian T. Bateman, MD, MSc; Elena V. Kuklina, MD, PhD; William M. Callaghan, MD, MPH. Racial and ethnic disparities in severe maternal morbidity: a multistate analysis, 2008-2010 Am J Obstet Gynecol, 2014; 210 (5):435.


