

BIRTH EQUITY FOR MOMS AND BABIES

Advancing social determinants pathways for research, policy and practice

BACKGROUND

Founded by President Franklin D. Roosevelt in 1938 to drive the discovery of a polio vaccine, March of Dimes succeeded in this mission and provided all children with access to this lifesaving therapy. Throughout his 12 years in the White House, President Roosevelt continued his crusade to improve the lives of children by proposing economic solutions across the nation to ensure fair wages, decent housing, appropriate medical care and quality education (Franklin D. Roosevelt Presidential Library and Museum, no date). President Roosevelt's pursuit of economic and social equality and the human rights work of First Lady Eleanor Roosevelt offer critical insight for the current work of March of Dimes (Glendon, 2001).

The mission of March of Dimes today is to lead the fight for the health of all moms and babies. Nearly half a million babies in the U.S. are born prematurely each year. Women of color are up to 50 percent more likely than white women to give birth prematurely, and their children can face a 130 percent higher infant death rate than children born to white women (March of Dimes Perinatal Data Center, 2018). In this country, black women have maternal death rates over three times higher than women of other races (Callaghan, 2012). In addition to the human toll, the societal cost of premature birth is at least \$26 billion per year (Institute of Medicine, 2007).

APPROACH TO GENERATING CONSENSUS

In response to the rising rates of preterm birth as well as persistent racial and ethnic disparities, the March of Dimes Prematurity Collaborative (Collaborative) was formed in 2017 to achieve equity and demonstrated improvements in premature birth. Equity is justice and fairness (Braveman, Arkin, Orleans, Proctor & Plough, 2017; March of Dimes, 2018).



It implies equal rights, but it is not the same as equality. Equity requires directing more resources to groups that have greater needs due to a history of exclusion or marginalization (March of Dimes, 2018). In 2018, the Collaborative expanded its focus to include the health of moms because strategies used to address premature birth and its associated disparities can help prevent other maternal health problems.

Recent trends in prematurity and maternal death demand a deeper examination into causes and contributors of disparities for Native American and African-American women, the groups of women with the most disparate birth and maternal outcomes (Centers for Disease Control and Prevention, 2018 a,b). Psychosocial and economic factors, along with physical environments that affect maternal and birth outcomes, should be considered in any examination into root causes of birth and maternal disparities (Schroeder, 2007). This consensus statement examines social factors that contribute to birth and maternal health outcomes, including prematurity and offers guidance to:

- Articulate and advance core health equity beliefs as benchmarks for achieving the best outcomes for all women and babies, such as reducing preterm birth inequities
- Create a call to action with equity-focused recommendations for work across and beyond the Collaborative based upon core beliefs, current data and research

SOCIAL DETERMINANTS OF HEALTH

Social determinants of health represent the systems (including health, economic and educational systems) and structures that are responsible for the majority of birth inequities (March of Dimes, 2018; World Health Organization, 2005). Inequities in these systems contribute to inequities in birth and maternal health outcomes.

Access to medical care is an important factor that can improve birth and maternal health. However, access to medical care does not fully explain the striking racial disparities in birth and maternal outcomes. Research has well documented the nation's historical legacy of unequal treatment in health care for women of color and the role of provider implicit bias (Smedley, Sith & Nelson, 2003). Although income is another factor that can predict access to care and health outcomes, there are nuances for some women. For example, socio-economic status is not a predictor for healthy birth outcomes among college-educated African-American women (McGrady, Sung, Rowley & Hogue, 1992; Schoendorf, Hogue, Kleinman & Rowley, 1992). One explanation is that chronic stressors that persist across the life cycle are qualitatively different and far more extreme for women of color and contribute to poor birth and maternal outcomes across generations (Geronimous, 1996; Jackson, Phillips, Hogue & Curry-Owens, 2001; Shonkoff et al., 2012). Investments in social policies and programs, such as jobs and housing, is one remedy that, when enacted and sustained, has demonstrated improvements in determinants of health (Bradley, Elkins, Herrin & Elbel, 2011).

A CALL TO ACTION

Preventable maternal and infant deaths are human rights issues violating a woman's and an infant's right to thrive, be free from discrimination and have access to quality health care. Calls for systematic changes to address fundamental social needs and improved standards of care are imperative for saving lives. Changes should also include improvements to maternal death surveillance systems (maternal birth and death certificates, linked data sets, expanded data sources, etc.). Nonetheless, with past indications of equity solutions to society's most pressing problems, we recommend upstream solutions for birth equity by:

CORE BELIEFS

The following core beliefs have become fundamental to the equity work of the Collaborative:

- We believe that health is a human right. Therefore, we expect health and quality, accessible and affordable health care for everyone that is supported by equitable conditions across all sectors representing the social determinants of health (education, transportation, housing, etc.).
- We believe that ALL mothers and babies — regardless of race, ethnicity, culture, language or national origin; poverty or socioeconomic status; gender identity or sexual orientation; disability; and region or place (urban and rural) — must have every opportunity for optimal maternal and birth outcomes.
- We embrace birth equity as a directive for confronting inaccessible and inadequate prenatal and maternal health care. It challenges inequities in the distribution of power, income, wealth and other related factors (housing, employment, transportation) that cause or contribute to persistent unfair conditions.
- We believe that the experience, expertise and leadership of researchers, practitioners and policymakers from historically underrepresented communities should be prioritized for birth equity solutions, including provision of commensurate funding levels to advance equity for moms and babies.
- We believe that undoing historic and contemporary patterns of racial and gender discrimination is imperative to disrupt implicit and explicit bias, miseducation and exclusionary customs and practices that can have dire health consequences for expectant mothers and babies as they



- Expanding the scope of research on social determinants of health as fundamental drivers for population maternal and infant health
- Engaging in health system reform, including re-educating providers on implicit racial bias, to better serve highest-risk populations
- Empowering communities through inclusion, education, social activism and advocacy
- Advancing work to change social and economic conditions (poverty, employment, low wages, housing, education, etc.) underlying health inequities

CONCLUSION

Achieving birth equity means that all moms and babies have the opportunity to attain good health and that conditions for optimal births are assured for all. Because equity requires doing things differently to realize different results, it is imperative that we study social factors that predict birth outcomes and that we implement policies to make a true and measurable impact on social determinants of health.

CORE BELIEFS (continued)

permeate systems of care; practice and treatment; education and research; public policies; communications; and access to funding and resources.

- We respect the authoritative knowledge and assets among affected women, families and communities. We regard their intersectional perspectives as paramount for the conceptualization and conduct of equity-driven research and its translation into maternal, paternal and child health education, practices and policies that are just and fair.
- We believe that pursuit of explanations for racially disparate birth and maternal outcomes must employ social science disciplines and methods to best examine social and economic disadvantages as well as community and population assets for maternal mental and physical health.
- We believe that scientific examination of biological, clinical, social and environmental contributors to prematurity and maternal mortality must be inclusive of an equity framework. This is essential to accelerate and translate reproductive health research and medical breakthroughs into innovative and accessible health care practices and policies that are equitable and beneficial for ALL expectant mothers and their infants.

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