Racism and health impacts for mothers and babies

Annual Conference of the Perinatal and Maternal Mortality Review Committee (PMMRC)
13 June 2017

Donna Cormack
Ngā mihi

- Tēnei te mihi aroha ki ngā whānau kua pāngia e ēnei momo mate

- Te Rōpū Rangahau Hauora a Eru Pōmare, Department of Public Health, University of Otago, Wellington
- Te Kupenga Hauora Māori, University of Auckland
- The views expressed in this presentation are the author’s own
Context of persistent inequities

Inequities in Māori maternal health
- Higher maternal mortality
- Less likely to have caesarean sections
- Less likely to be induced, have epidural or episiotomy
- Differences in access to care
- Differential exposure to health-damaging factors and environments

Inequities in Māori infant health
- Higher proportion of low birth weight babies
- Higher perinatal mortality

Inequities in Māori health
- Stark inequities in health determinants, exposures and outcomes
- Differential quality of care
- Historical context
- Ongoing colonial practices and process
Racism as a health determinant

- Racism is a complex system rooted in unequal power relations by race/ethnicity that involves “shared social cognition (prejudice), as well as social practices (discrimination), at both the macro level of social structures and the micro level of specific interaction and communicative events” (van Dijk 1993)

- Racism produces inequities that manifest as disadvantage for some groups and privilege for others

- Study of the impacts of racism on health have increased in recent years internationally and in Aotearoa New Zealand
Prevalence of racism

Source: Harris et al, 2012a
Pathways to health

- Racialised structuring of societal resources and health determinants (e.g. poverty, unsafe environments, employment, and incarceration)
- Direct physical and psychological effects from racially motivated violence and racial harassment
- Racism as a stressor, impacting on health through chronic exposure to racial discrimination (e.g. physiological, psychological and behavioural effects)
- Health care access and quality

(Sources: Ahmed et al, 2007; Krieger, 2000; Mays et al, 2007; Paradies et al, 2015; Williams & Mohammed, 2013)
Pathway: resources and determinants

- Exposure to health-protective or health-damaging factors is racialised in Aotearoa New Zealand

Source: Ministry of Health 2015

Figure 4: Neighbourhood deprivation distribution (NZDep 2013), Māori and non-Māori, 2013

Note: Crude rates and prioritised ethnicity have been used – see ‘Ngā tapu ae ngā raraunga: Methods and data sources’ for further information.

Source: Atkinson et al 2014
Pathway: resources and determinants

Figure 1.19: Perinatal related mortality rates (per 1000 births) by deprivation quintile (with 95% CIs) 2007–2014

Source: PMMRC 2016
Pathway: chronic stressor

- Racism as a chronic stressor that has physiological, psychological and health behaviour impacts

- Maternal racial discrimination has been associated with poorer birth outcomes in overseas research (e.g. low birth weight, pre-term birth)

- Recent study by Hobbs et al (2017) linking maternal racism to increased risk of infant hospitalisation in first year of life in Aotearoa New Zealand
Pathway: chronic stressor

- Study by Bécares & Atatoa-Carr (2016) found associations between mother and partner’s experiences or racism and pre- and post-natal mental health

### Table 4

<table>
<thead>
<tr>
<th></th>
<th>Prenatal perceived stress</th>
<th>Prenatal depression</th>
<th>Postnatal depression$^a$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Coeff. (95 % CI)</td>
<td>O.R. (95 % CI)</td>
<td>O.R. (95 % CI)</td>
</tr>
<tr>
<td>Nobody experienced personal attack</td>
<td>Reference</td>
<td>Reference</td>
<td>Reference</td>
</tr>
<tr>
<td>Mother experienced personal attack</td>
<td>1.32 (0.69–1.95)$^{***}$</td>
<td>1.44 (1.06–1.95)$^*$</td>
<td>1.43 (0.97–2.06)</td>
</tr>
<tr>
<td>Partner experienced personal attack</td>
<td>0.41 (–0.09–0.92)</td>
<td>1.32 (1.02–1.69)$^*$</td>
<td>1.16 (0.84–1.60)</td>
</tr>
<tr>
<td>Both experienced personal attack</td>
<td>2.09 (1.28–2.90)$^{***}$</td>
<td>1.85 (1.30–2.63)$^{***}$</td>
<td>1.66 (1.09–2.54)$^*$</td>
</tr>
<tr>
<td>Nobody treated unfairly</td>
<td>Reference</td>
<td>Reference</td>
<td>Reference</td>
</tr>
<tr>
<td>Mother treated unfairly</td>
<td>1.60 (0.97–2.24)$^{***}$</td>
<td>1.85 (1.39–2.46)$^{***}$</td>
<td>1.71 (1.22–2.40)$^{***}$</td>
</tr>
<tr>
<td>Partner treated unfairly</td>
<td>0.40 (–0.15–0.95)</td>
<td>1.42 (1.08–1.86)$^{**}$</td>
<td>1.12 (0.80–1.57)</td>
</tr>
<tr>
<td>Both treated unfairly</td>
<td>2.28 (1.42–3.14)$^{***}$</td>
<td>1.88 (1.31–2.71)$^{***}$</td>
<td>0.92 (0.55–1.53)</td>
</tr>
</tbody>
</table>

$^a$Additionally adjusted for prenatal depression

*p < 0.05, **p < 0.01, ***p < 0.001; Models adjust for maternal age, equivalised household income, maternal education, mother’s and partner’s ethnicity, and area deprivation
Pathway: chronic stressor

- Study by Thayer & Kuzawa (2015) linking racism to maternal evening cortisol in pregnancy

Fig. 1. Relationship between number of reported exposures to ethnic discrimination maternal evening cortisol in late pregnancy (figure presents mean and 95% CI) (** = P < 0.001; * = P < 0.01).
Pathway: health care access and quality

- Increasing recognition of the impacts of racism on healthcare

06/07 NZHS: associations between racism and negative patient experience

Source: Harris et al, 2012b
Racial/ethnic bias and healthcare

“Societal racism interacts with clinicians’ perception of patient race and common social-cognitive processes to influence clinicians’ implicit and explicit beliefs about, feelings towards, and expectations of patients independent of other patient and clinician characteristics” (van Ryn 2011, et al: 204).
Racial/ethnic bias and healthcare

- Racial/ethnic biases may impact on both the healthcare encounter (through influencing both provider and patient behaviour or feelings) and decisions about care (by both the provider and the patient) (van Ryn & Fu 2003)

- Racial/ethnic biases may be explicit and conscious, or implicit and automatic
Racial/ethnic bias and health inequities

Figure 1. Model of paths through which provider implicit bias may contribute to health disparities.

Source: Zestcott et al, 2016
Implicit racial/ethnic bias

- Studies with health providers have shown pro-White bias among a range of health providers (Paradies et al 2014)
- Some associations with clinical decision-making, but not consistent (Hall et al 2015)
- Associations with measures of the health care encounter, e.g. communication, outcomes of interactions
- Potential that it activates ‘stereotype threat’
Evidence of provider stereotypes

- Research has demonstrated that health providers have stereotypes about Māori patients (e.g. McCreanor and Nairn 2002; Johnstone & Read 2000; McLeod et al 2004; Penney et al 2011)

- *I feel that they are getting the appropriate services they need, just not using them, medication is the answer – but they just don’t take their pills – if cannabis was prescribed, I’d bet they’d bloody take that* (Psychiatrist quoted in Johnstone & Read, 2000)
Evidence of provider stereotypes

- *It’s a cultural thing… in that if you’ve got a Pacific Islander who tells you that he’s sore, he’s really sore … they don’t come to hospital until things become unbearable* (Surgeon quoted in McLeod et al 2004)

- *It has frequently been recorded that parturition among primitive and uncivilised races is easier and more rapid than in civilised countries. This rule holds good for the Maoris, with whom labour is soon over, and the mother almost immediately returns to her usual duties. According to one authority, labour seldom exceeds two hours; generally it is much shorter* (Goldie 1899 quoted in Robson 2007).
Addressing racial/ethnic bias

Racial/ethnic bias can be addressed at system, organisation and clinician levels:

- Perspective taking and empathy
- Counter-narratives and counter-storying
- Improving environments
- Monitoring by ethnicity and auditing care
- Critiquing systems
- Being open to alternative explanations

Sources: Burgess et al, 2010; Devine et al, 2012; van Ryn et al, 2011; van Ryn 2016

Personal-level racial/ethnic bias is always within the context of societal racism
Take home points

- Importance of a critical understanding of determinants of health and drivers of ethnic inequities
- Importance of interrogating role of providers and systems
- Shift the focus from ‘race/ethnicity’ as a risk to the processes that make it risky to be a Maori mum and baby in Aotearoa New Zealand?
- Ask the question: ‘how might racism be operating here’? (Jones 2016)
We need to be able to imagine a future that is different and better.
Acknowledgements

- Ricci Harris, James Stanley, RuruhiRa Rameka, Sarah-Jane Paine
- Funders: Te Kete Hauora, Ministry of Health, HRC
- Collaborators: Martin Tobias, Li-Chia Yeh, James Stanley, RuruhiRa Rameka, Laia Becares, Natalie Talamaivao, Roimata Timutimu, Joanna Minster, Melissa McLeod, Rhiannon Jones
- Advisors: Mona Jeffreys, Saffron Karlsen, James Nazroo, Yin Paradies, Bridget Robson, Robert Templeton, David Williams
- For studies using NZHS data, the Crown is the owner of the copyright of the data and the Ministry of Health is the funder of the data collection for the New Zealand Health Survey.
- For socially assigned and ethnic density work, Donna Cormack, Ricci Harris, and James Stanley were funded on a grant from the Health Research Council of New Zealand. Laia Bécares was funded by an ESRC/MRC Interdisciplinary Postdoctoral Fellowship.

Special thanks to all the people who made and released these awesome resources for free: Presentation template by SlidesCarnival
References

References

References