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*Current Commentary*

# Racial and Ethnic Disparities in Reproductive Health Services and Outcomes, 2020

*Madeline Y. Sutton, MD, MPH, Ngozi F. Anachebe, MD, PharmD, Regina Lee, MD, and Heather Skanes, MD*

**Racial and ethnic disparities in women's health have existed for decades, despite efforts to strengthen women's reproductive health access and utilization. Recent guidance by the American College of Obstetricians and Gynecologists (ACOG) underscores the often unacknowledged and unmeasured role of racial bias and systemic racial injustice in reproductive health disparities and highlights a renewed commitment to eliminating them. Reaching health equity requires an understanding of current racial–ethnic gaps in reproductive health and a concerted effort to develop and implement strategies to close gaps. We summarized national data for several reproductive health measures, such as contraceptive use, Pap tests, mammograms, maternal mortality, and unintended pregnancies, by race–ethnicity to inform health-equity strategies. Studies were retrieved by systematically searching the PubMed (2010–2020) electronic database to identify most recently published national estimates by race–ethnicity (non-Hispanic Black or African American, Hispanic or Latinx, and non-Hispanic White women). Disparities were found in each reproductive health category. We describe relevant components of the Affordable Care Act (ACA) and the Preventing Maternal Deaths Act, which can help to further strengthen reproductive health care, close gaps in services and outcomes, and decrease racial–ethnic reproductive health disparities. Owing to continued diminishment of certain components of the ACA, to optimally reach reproductive health equity, comprehensive health insurance coverage is vital. Strengthening policy-level strategies, along with ACOG's heightened commitment to eliminating racial disparities in women's health by confronting bias and racism, can strengthen actions toward reproductive health equity.**

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See related editorial on page 218.

Despite significant strides in women's reproductive health, disparities in access and outcomes remain, especially for racial–ethnic minorities in the United States.[1–4] Reports document decades-long racial–ethnic disparities in several areas of reproductive health, including contraceptive use, sexually transmitted infection care and human papillomavirus vaccination among younger women aged 18–25 years,[5] reproductive cancers,[6] preterm deliveries and low-birth-weight neonates, and maternal morbidity and mortality.[7] Data suggest that the disproportionate risk for women of color for reproductive health access and outcomes expand beyond individual-level risks and include social and structural factors, such as fewer neighborhood health services, less insurance coverage, decreased access to educational and economic attainment, and even practitioner-level factors such as racial bias and stereotyping.[1,4,8] The Center for Reproductive Rights describes this racial–ethnic gap as a human rights issue and suggests that, "several U.S. policies may exacerbate these disparities by disproportionately burdening access to health care for women of color."[4] Solutions that lead to increased access for women must remove these social and structural barriers so that women, especially underserved racial and ethnic minority women, may access and utilize reproductive health services as needed without clinician bias or other obstacles.[9]

Healthy People 2020, the science-based national guidance document, considers improved health care access by making the elimination of health disparities

*From the Department of Obstetrics and Gynecology, Morehouse School of Medicine, Atlanta Georgia.*

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*Corresponding author: Madeline Y. Sutton, MD, MPH, Department of Obstetrics and Gynecology, Morehouse School of Medicine, Atlanta, GA; email: mysutton2019@gmail.com.*

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and improvement of health for all groups an overarching goal for the United States, including for reproductive health.[10] Policy-level interventions, which are often based on political will, can help move the needle toward health equity by leveling the field and reducing how often subjective bias, including individual racial bias and structural racism, factor into health care accessibility, acceptability, decision-making, and affordability.[11] The Patient Protection and Affordable Care Act (ACA) is an example of a social-structural-policy–level intervention that helps facilitate national prevention goals by increasing health care access for millions of previously uninsured and underinsured persons.[12–14] Although legal challenges continue to threaten the potential for fully expanded reproductive health access and services for women (Appendix 1, available online at http://links.lww.com/AOG/C152), the ACA has provided large gains for women who would otherwise be without health care or have copays as an access barrier.[12–14] However, because federal and state rulings continue to diminish portions of the ACA that allow access to contraceptives, optimal health parity for reproductive access and services will require a fully comprehensive national health insurance reform strategy that removes barriers and strengthens access. In some cases, even when medical insurance is available among women in the same socioeconomic strata, persistent, unexplained disparities persist and suggest that racism and other social and clinician-level issues are factors; life-course approaches to understanding women and their contexts are needed by clinicians and care systems to optimize care.

The health of persons of color in the United States has been adversely affected by centuries of social and structural factors, such as unequal access to educational and employment opportunities, lack of health care access, redlining (structural racism in the U.S. housing system that forced people of color into specific neighborhoods and has contributed to stark and persistent racial disparities in wealth and financial well-being), distrust of physicians, a segregated health care workforce, negative perceptions of the health care system, and disproportionate engagement with a legal–justice system that is rooted in racism and that disproportionately incarcerates non-Hispanic Black or African American and Hispanic or Latinx compared with non-Hispanic White (hereafter referred to as Black, Hispanic, and White) peoples.[2,4,7,8,15–19] These all negatively affect reproductive health outcomes and require multipronged anti-racist approaches to tear away these centuries-old systems of racism. Women of color must be listened to with empathy and solidarity, so that care and treatment responses can be appropriate; this requires a more racially and ethnically diverse workforce, anti-racist education at every level of clinical training, and increased inclusion of doulas and other patient advocates in maternal care. Additionally, clinicians should ensure that patients are fully informed regarding treatment and care options. This requires cultural humility, mindfulness, transparency, and acknowledgement of the historical injustices that have occurred and a commitment to relegate them to history. Educational trainings of all obstetrician–gynecologists (ob-gyns) regarding these social and historical contexts are warranted to strengthen patient care. Therefore, the purpose of this commentary is to update regarding reproductive health disparities in the United States and inform national health-equity efforts.

## REPRODUCTIVE HEALTH DISPARITIES, ACCESS, SERVICES, AND OUTCOMES

Nearly one in three women aged 19–64 years, approximately 27 million women, were uninsured, and another 45 million delayed or avoided health care because of cost in 2010, before the ACA was implemented nationally.[20] By 2018, after implementation of the ACA, an estimated 10.8 million women were uninsured, a decrease compared with 2010.[21] However, gains have stalled in recent years. Having health insurance improves the chances that women will have a regular source of care and access.[22–25] By including a package of women's preventive services as recommended by the Department of Health and Human Services,[14] access through the ACA includes Pap tests, mammograms, and some contraceptives without copays for women; this improves comprehensive care and access for all women and may ultimately help reduce reproductive health disparities. A recent review confirmed that, since implemented in 2010, the ACA has resulted in improvements in overall coverage, access to health care, affordability, preventive care use, mental health care, use of contraceptives, and perinatal outcomes for women.[23–25] However, huge challenges to coverage, access, and affordability remain for women throughout the country, and particularly in 14 mostly southern states that have not expanded Medicaid eligibility and continue to lack access through the ACA.[26–28] This coverage gap disproportionately affects disenfranchised populations in the southern states and likely contributes to the wide racial–ethnic health disparities in health access and several health outcomes for women.[27,28]

For this commentary, we reviewed and summarized (Table 1) recent national estimates for several

reproductive health measures using a PubMed review (2010–2020), including services (contraceptive use,[29–37] Pap tests,[38–40] mammogram screening,[39–45] late or no prenatal care,[46–48] chlamydia screening,[49–54] human immunodeficiency virus [HIV] treatment[55–60]) and outcomes (unintended pregnancy,[61–63] induced abortions,[64–66] preterm births,[67–69] breastfeeding initiation,[10,70–73] maternal mortality,[15,74–82] cervical cancer,[83–85] endometrial cancer deaths,[86,87] HIV diagnoses[88,89]) by race–ethnicity (Black, Hispanic, and White, as classified by the authors of the studies, and examined, because we are exploring racial–ethnic disparities). By highlighting the current racial–ethnic disparities in reproductive health, our goal was to show that there are opportunities to strengthen access and care for women, toward improved reproductive health equity (Fig. 1), as underscored recently with a renewed commitment from the American College of Obstetricians and Gynecologists to eliminate these disparities.[8] For the three topics below (contraceptive access, maternal mortality, and HIV diagnoses), we considered focused strategies using multilevel approaches, including addressing racism, which may work synergistically to improve clinician awareness, and access and outcomes for women. If time reveals improved access and outcomes for women of color for the three issues discussed below, lessons learned could inform other reproductive health disparity issues summarized in Table 1 and ultimately lead us toward reduced reproductive health disparities.

## Focused Strategies

### Contraceptive Access and Use

Cost is a known barrier to contraceptive access and use for some women.[29,30] High contraceptive costs affects consistent use, which subsequently affects risk to reproductive autonomy[31] and rates of unplanned pregnancies. Highly effective long-acting reversible contraceptive (LARC) methods, such as the intrauterine device and dermal implants, have higher upfront costs.[29,30,32] Providing contraceptive access by removing cost barriers can be a highly effective means of increasing reproductive autonomy for all women regardless of race–ethnicity and social status.[33,34] Pharmacy-level barriers also exist and can lead to some women not obtaining even prescribed or over-

**Table 1. Estimated Rates of Selected Reproductive Health Measures by Race–Ethnicity, 2020**

| | Percentages or Rates for Women by Race–Ethnicity | | |
|---|---|---|---|
| Measure | Non-Hispanic Black or African American | Hispanic or Latina | Non-Hispanic White |
| Access and services | | | |
| Contraceptive use (% of all females 15–49 y)[37] | 59.9 | 64.0 | 67.0 |
| Pap tests (% of women 18–64 y who report having a Pap test within the previous 3 y)[38] | 79 | 74 | 73 |
| Mammogram screening (% screened among women 40 y and older who had a mammogram in the past 2 y)[39] | 78 | 72 | 72 |
| Late or no prenatal care (% of mothers among those who gave birth)[48] | 10.0 | 8.0 | 5.0 |
| Chlamydia screening (% of nonpregnant females 15–21 y tested for chlamydia during physician office visit)[54] | 5.8 | 4.9 | 3.9 |
| HIV treatment (% of females 13 y and older with a viral load test result of fewer than 200 copies/mL at the most recent test during 2015)[59] | 55.5 | 61.6 | 59.6 |
| Outcomes | | | |
| Unintended pregnancy (per 1,000 females 15–44 y)[61] | 79 | 58 | 33 |
| Induced abortions (per 1,000 females 15–44 y)[66] | 25.1 | 11.7 | 6.6 |
| Preterm births (less than 37 wk of gestation) (% of live births)[69] | 14.1 | 9.7 | 9.1 |
| Breastfeeding initiation (% of mothers ever initiating breastfeeding)[71] | 74.0 | 82.9 | 86.6 |
| Maternal mortality (pregnancy-related deaths per 100,000 live births)[74] | 40.8 | 11.5 | 12.7 |
| Cervical cancer (age-adjusted rate per 100,000 women)[85] | 8.3 | 8.9 | 7.3 |
| Endometrial cancer deaths (per 100,000 women, age-adjusted)[86] | 9.0 | 4.6 | 4.0 |
| HIV diagnoses (rate of diagnoses per 100,000 population of women)[55] | 23.1 | 5.2 | 1.7 |

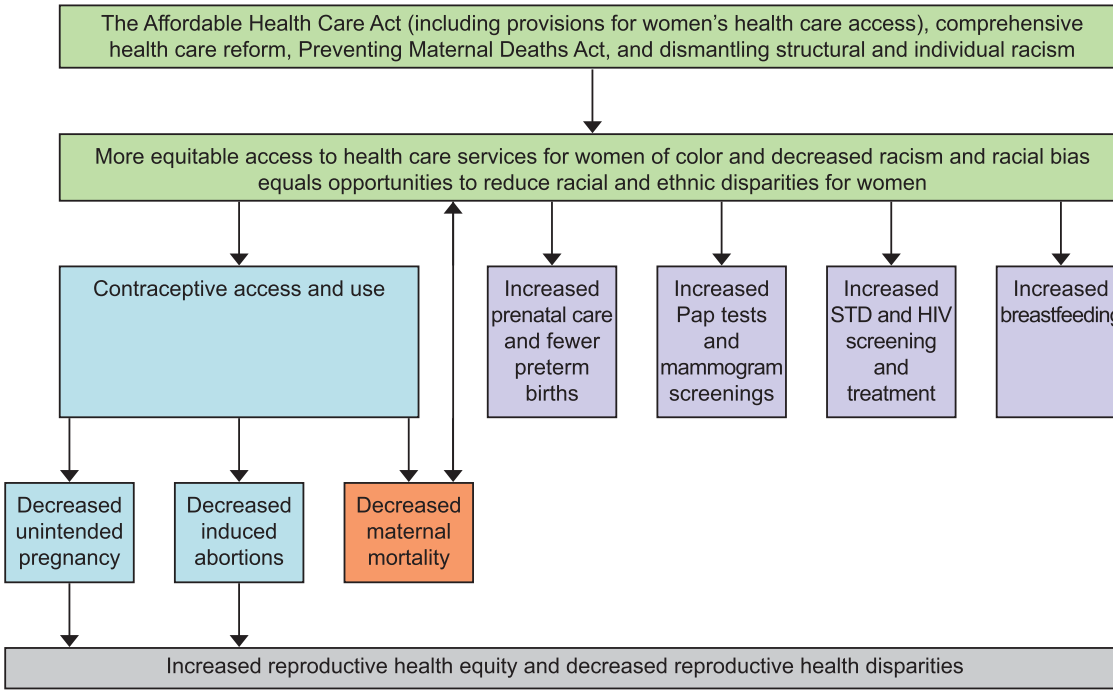


**Fig. 1.** Conceptual model of expanded health care access, including reduced health care professional bias, and potential effect on racial and ethnic reproductive health disparities. STD, sexually transmitted disease; HIV, human immunodeficiency virus.

*Sutton. Racial and Ethnic Disparities in Reproductive Health. Obstet Gynecol 2021.*

the-counter hormonal contraceptives. Increased reproductive access–focused training for pharmacists is important as part of expanded access for women.[35]

Having health insurance is associated with an increase in the likelihood of receiving family planning services,[36] which can strengthen reproductive autonomy[31] and decrease unplanned pregnancies. Contraceptive use among females aged 15–49 years is statistically more common among White females (67%) compared with Black females (59.9%).[37] Strengthening access to comprehensive health insurance can help close this gap in contraceptive access and use (Fig. 1), as evidenced by data from a state with expanded Medicaid access.[90]

When considering LARC and permanent sterilization, clinicians must be aware of the historical legacy of abuse and eugenics in which women of color have been disproportionately sterilized without their consent (compared with White women) as a result of explicit bigotry. Data suggest that women of color are offered LARC more often sometimes owing to implicit biases.[91] Awareness of historical and modern-day racial injustices often contribute to the lower rate of contraceptive use among Black and Hispanic women; there is a distrust by some patients that has yet to be acknowledged by many clinicians.[92] To combat this, patient-centered shared decision making is a vital component of all contraceptive counseling.[93]

Laws that have restricted women's access to family planning and reproductive health services have also contributed to rising maternal mortality rates.[81] Policy-level interventions are warranted to save women's lives. Especially with as many as 50% of pregnancies in the United States being unintended, preventing unintended pregnancies will help prevent maternal deaths. The Preventing Maternal Deaths Act, signed into law in 2018, supports state maternal mortality review committees to review every pregnancy-related death and, based on their findings, develop recommendations for how to prevent future maternal deaths; this will allow care gaps can be identified and closed.[15,82] (Fig. 1).

## Maternal Mortality

Maternal mortality disparities have been documented for decades in the United States.[74] These disparities are a public health failure that have recently generated increased attention and policy shifts, especially because approximately 60% of pregnancy-related deaths are preventable.[74] Persistently, women of color have been disproportionately affected by maternal mortality; Black women and American Indian or Alaska Native women

are 3.3 and 2.5 times more likely to die from pregnancy-related causes than White women, respectively.[74] When individual recent cases were reviewed, clinician-level biases and racism often contributed to delayed or absent care that led to deaths.[75–79] Establishment of management protocols by hospitals and medical practices for the management of conditions such as postpartum hemorrhage,[80] hypertensive disorders of pregnancy, and maternal cardiovascular disease will lessen the disparate care provided to women of color, increase standardized care, and improve maternal morbidity and mortality. Such protocols are necessary in both the inpatient and outpatient arenas, at the hospital or health care system level, as well as in independent medical practices.

### Human Immunodeficiency Virus Diagnoses

In women, those who are Black and Hispanic account for 75% of new diagnoses of HIV.[55] Given that 85.2% of women diagnosed with HIV acquire it through heterosexual contact, comprehensive and accessible gynecologic care, including HIV and sexually transmitted infection prevention and treatment programs, are essential to decrease the rates of HIV infection.[55–60] Barriers to accessing such care by Black and Hispanic women need to be eliminated by providing high-quality, culturally sensitive, accessible care in local communities.

Multiple approaches are needed to address these alarming HIV diagnosis disparities, including addressing disproportionate poverty through microfinance interventions, ensuring equitable access to educational and career opportunities and reproductive health care access, and increasing access to biomedical prevention interventions, such as pre-exposure prophylaxis.[88,89] Data show that Black women are less likely to be prescribed pre-exposure prophylaxis, a known, evidence-based approach to HIV prevention, compared with White women and men.[94] Increasing pre-exposure prophylaxis bias-awareness is one additional strategy to increase pre-exposure prophylaxis uptake among at-risk Black women who are HIV-negative.[95] Improving linkage and retention in HIV care for Black women who are HIV-positive are also important strategies to address HIV disparities. Educational strategies regarding HIV-prevention tools with clinicians and also with all sexually active women are warranted.[91] Although HIV screening for sexually active women during gynecology visits is supported without copays, fewer than 20% of sexually active women reported receiving an HIV test during the past year in a recent report.[96] Offering routine HIV screenings should be fully incorporated during obstetrics and gynecology visits; early diagnosis is vital for timely treatment and decreased morbidity and mortality (Fig. 1).

## CONCLUSION

Racial–ethnic disparities in reproductive health access, services, and outcomes are prevalent and require heightened awareness and strategies to close these long-standing disparity gaps. Specifically for contraceptive access, preventing maternal deaths, and decreasing HIV infections, developing and strengthening policies and laws that include a focus on dismantling structural racism and implicit bias are crucial as part of the solution. Because race and ethnicity are social constructs, dismantling the structures developed based on race–ethnicity will require social solutions.[97] Upstream federal-level solutions for structural racism will require the Departments of Justice, Education, Labor, and Housing and Urban Development to dismantle current systems that are rooted in a legacy of unequal treatment and move toward anti-racist judicial, educational, income (especially with hourly, low-wage jobs, which disproportionately decrease flexibility and access for women, especially women of color), and housing solutions; legislative advocacy by local and national clinicians will be vital to these efforts.[98–102] Commitment from downstream leadership, followed by implementing policy-level platforms, will help strengthen the ability of ob-gyns and other clinicians to provide necessary services, improve outcomes for women, and reduce racial–ethnic reproductive health disparities.

In addition, these persistent disparities will require multiple levels of partnerships and collaborations to improve outcomes for women of color. For communities, including schools and community-based service organizations, increasing awareness and empowering women through peer education and media campaigns that are transparent regarding historical injustices while also informing regarding evidence-based services, are vital. Some community-based approaches have successfully engaged low-income Hispanic and Black women in accessing cervical and breast cancer screening services.[103–106] Health care and professional organizations should hold clinicians and hospitals accountable by encouraging standardized, patient-informed approaches for clinical care and developing strategies to measure and reduce racial–ethnic disparities by linking services provided to measurable health outcomes and performance standards. At the systems level, this can help reduce reproductive health disparities by providing incentives[107] for identifying and removing

clinician barriers, with the goal of improved access and outcomes for patients.

Finally, as ob-gyns, we must continue to hold ourselves accountable for the improved health of our patients by addressing the racism and biases that contribute to reproductive health disparities. With renewed commitment and action from the American College of Obstetricians and Gynecologists,[108] we can help facilitate the dismantling of systemic racism that contributes to reproductive health disparities by helping to strengthen the current national health plan for women's health provisions or advocating for a more comprehensive universal health care system or both, increasing the diversification of our workforce, training our residents and fellows to understand the role of racism as it affects patients' care and how to address it, understanding our own biases, and advocating for our patients to help them feel safer in their communities that may be unjustly affected by structural racism and health inequities.[9] By doing so, we will greatly improve reproductive health equity and decrease the excess burden for Black, Hispanic, and Native American women in the United States.

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