



COMMUNITY CONDITIONS & INTERPERSONAL FACTORS

Concentrated Disadvantage, Racial Residential Segregation, Violence, and
Patient/Provider Interactions



The neighborhoods women live in shape their daily experiences, opportunities, and behaviors with profound implications for their health and that of their children. Relationships between members of a household, neighborhood, or broader community also influence women's health in important ways.



Concentrated Disadvantage

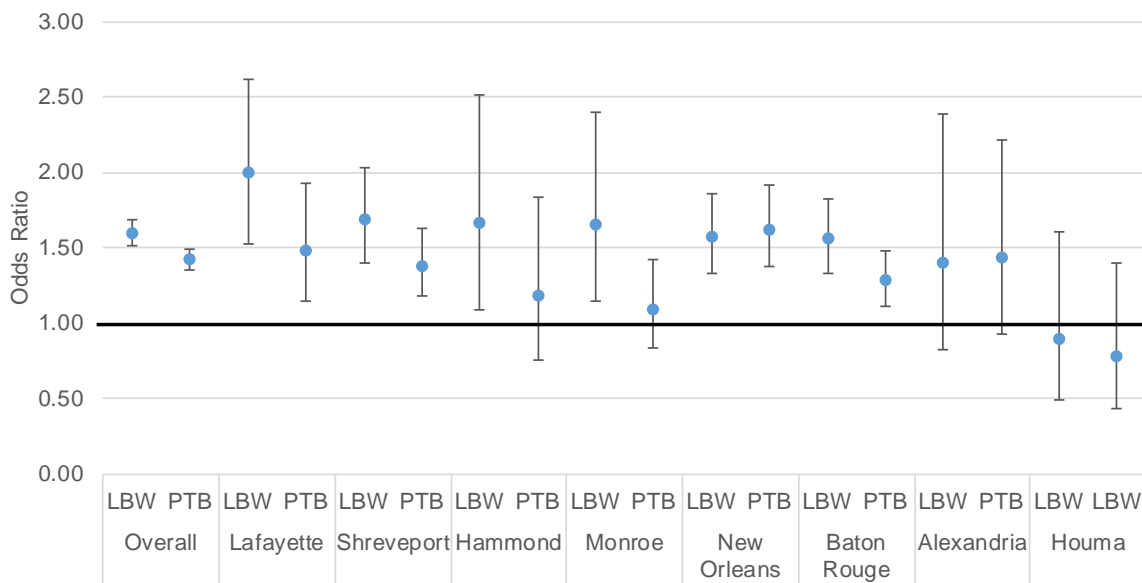
Locally, neighborhoods and interpersonal contexts can be a source of support for pregnant women and their children, but under certain conditions, they can also induce stress. These local contexts are often shaped by the larger structural forces discussed in Section I.

Research has found a connection between adverse neighborhood and interpersonal environments and birth outcomes. Neighborhoods with high poverty, crime and violence both outside and within the home, few job opportunities, and limited transportation options contribute to the health risks faced by Black women and may impact the level of support they receive. In addition, inadequate access to high quality comprehensive health care, parks, healthy food, and other resources may place them at higher risks for an adverse birth outcome.⁴²⁻⁴⁴

Poverty is a substantial contributor to poor health, and women living in impoverished neighborhoods are more likely to experience adverse birth outcomes.^{45,46} Impoverished neighborhoods are often characterized by other factors that together shape the resources

and opportunities available to residents, which in turn influence the health of the community. **Concentrated disadvantage** captures the cumulative impact of not only poverty but also other aspects of community well-being including use of public assistance, female-headed households, unemployment, and number of children in the neighborhood.⁴⁷ Women in communities where concentrated disadvantage is high are more likely to have higher rates of low birth weight babies.⁴⁸ Data from eight of Louisiana's nine major metropolitan areas (Alexandria, Baton Rouge, Hammond, Houma, Lafayette, Monroe, New Orleans, and Shreveport), utilizing US Census tract as our definition of neighborhood as is commonly done in US-based studies⁴⁹, show that women living in areas of high concentrated disadvantage are at a greater risk of delivering low birth weight or preterm babies (**Figure 7**).

Figure 7. Risk of adverse birth outcomes among women living in high concentrated disadvantage areas relative to women in areas of low concentrated disadvantage.



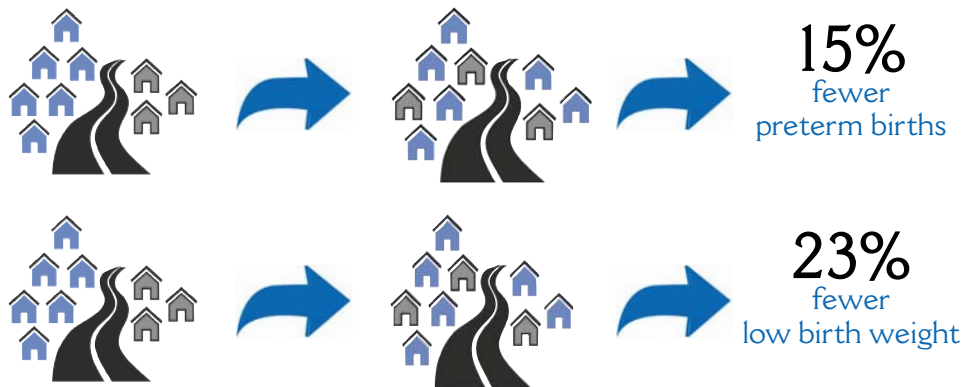


Racial Residential Segregation

Housing discrimination is still evident in segregated areas, and Blacks remain the most highly segregated racial group regardless of socioeconomic status (SES). More institutional forms of housing discrimination such as affordable housing, bank loans, and real estate transactions may also limit the housing choices for racial and ethnic minorities in the U.S.⁵⁰⁻⁵² Racially segregated communities, often characterized by poor economic, health, and social investments, are associated with poorer birth outcomes, particularly low birth weight and very low birth weight.^{53,54} State and national research has observed adverse birth outcomes

among minority mothers living in segregated neighborhoods and neighborhoods with high concentrated disadvantage, regardless of maternal education level, socioeconomic status, and adequate prenatal care. Both Black and Hispanic women living in neighborhoods with high levels of racial isolation are at higher risk of having a low birth weight infant.⁵⁴ Women living in highly segregated cities are 18% more likely to have a preterm birth and 30% more likely to have a low birth weight baby compared to women in less segregated cities.

Figure 8. Birth Outcomes Based on Racial Residential Segregation



If highly segregated cities became more integrated, there would be 15% fewer preterm births in these cities. If highly segregated cities became more integrated, there would be 23% fewer low birth weight infants in these cities.





Violence

The statewide and neighborhood conditions described in preceding sections can be viewed as forms of structural violence, or the systemic ways in which social structures harm or otherwise disadvantage individuals by constraining individual agency as a result of unequal distributions of power and resources.⁵⁵

Structural violence is often intertwined with behavioral violence, or individuals committing acts of violence. Both contribute to an unhealthy environment for women, particularly those who experience physical, sexual or emotional violence prior to or during pregnancy. These women are more likely to experience an adverse birth outcome.⁵⁶⁻⁵⁹ The home and the neighborhood can be sources of violence. Violent crime in the neighborhood has been associated with risk for low birth weight infants,⁶⁰ while intimate partner violence may lead to both low birth weight and infant mortality.⁶¹ Young Black women in particular face disproportionately high levels of intimate partner violence, with rates as high as 40%.⁶²⁻

⁶⁴ Black women are also more likely to be victims of pregnancy-

associated homicide,^{65,66} including intimate partner homicide.⁶⁷ Since Hurricane Katrina in 2005, local providers have reported seeing more patients struggling with domestic violence⁶⁸, with implications for both the victim and her children. Prenatal exposure to violence may make children more susceptible to stress later in life.⁶¹

Data collected in New Orleans' urban areas show that women living in high-crime areas are more likely to experience adverse birth outcomes (Figures 9a, 9b). According to the Pregnancy and Risk Assessment Monitoring System (PRAMS) only half of the 6.9% of women in Louisiana who reported being abused by their husband or intimate partner said that the abuse stopped during pregnancy.

Figure 9a. Low birth weight rate by census tract
Orleans Parish, Louisiana 2011-2012

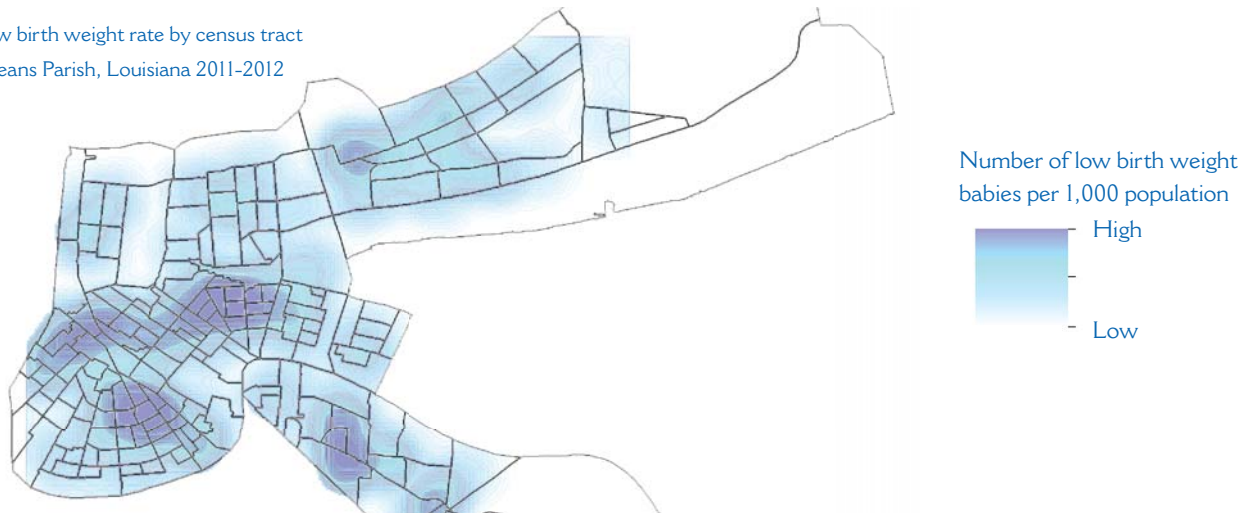


Figure 9b. Violent crime rate by census tract
Orleans Parish, Louisiana 2011-2012





Patient/Provider Interaction

The interpersonal context between patients and medical providers may contribute to racial disparities in adverse birth outcomes. Patients who trust their health care providers report higher levels of satisfaction and, in turn, are more likely to adhere to medical advice and return for follow-up appointments.

Studies suggest that for many Black women, perceived racism may be at the root of low levels of physician trust.⁶⁹⁻⁷⁰ Perceived racism may not only affect the delivery of health care, but also the quality of care. For example, compared to White women, Black women in Louisiana less frequently report receiving health behavior advice from their prenatal care providers, and women who receive insufficient health behavior advice are at a higher risk of delivering a low birth weight infant.³⁸

in birth outcomes suggests that the source of these discrepancies may be attributed more to the quality and delivery of care than merely the accessibility of care.⁷¹ Research has even shown that provider knowledge of race-based medical findings may negatively affect their treatment of patients within those racial groups.⁷² As indicated in the Louisiana Public Health Institute Interpregnancy Care Study, an evaluation of care of reproductive age women who are between pregnancies, patients expressed anxiety about being transparent with healthcare providers.

Even though nearly 81% of Black women receive prenatal care at some point during their pregnancies, the persistent racial gap



I think people need to be stop being so judgmental, then women would be more open and honest about their history before pregnancy and whenever they find out. You know whenever you find out you're pregnant and they ask you what have you done up until that point it's important for you to be honest about it, but when your doctor is sitting there judging you about everything that you say, it's really hard to be honest about it and if there was less judgment and less people being so harsh on you, then it would be easier to be honest. I think that's really important.

– Client, LPHI IPC Study



One of the biggest barriers is the way women are treated by the system – they are put down and need to be treated respectfully.

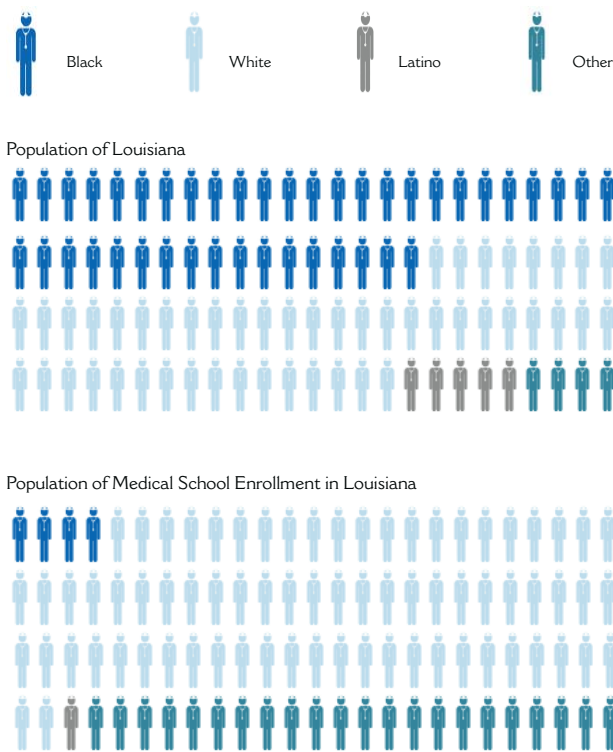
– Midwife, LPHI IPC Study





Racial disparities in birth outcomes are often reinforced by differences in the quality and delivery of health care, including patient-physician interactions. Due to the percentage of non-White student enrollment in medical schools, patients' options for non-White health care providers are few. In Louisiana, Blacks and Latinos are by far the lowest ethnicities enrolled in medical schools, at 4% for Blacks and just 1% for Latinos (Figure 10). Nationally, about 6% of medical students are Black, and 5% are Latino.⁷³

Figure 10. Proportion of the population of the state of Louisiana overall and population enrolled in medical school in Louisiana by race, 2014.



Black mothers in Louisiana report that their medical providers are discussing issues like smoking, illegal drug use, alcohol use, and HIV testing during pregnancy with them more often than White mothers report discussing these issues with their physicians (Figure 11). These data may indicate physician implicit bias, unintended biases in decision-making as a result of cultural stereotypes even if not consciously endorsed, and may help explain some of the racial disparities in health and birth outcomes throughout the state.

Figure 11. Percentage of women who reported talking to a health care worker about pregnancy health topics.

