

Midwifery and Health Disparities: Theories and Intersections

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In the past decade, the reduction of health disparities has become an important policy agenda in the United States. Clinicians in practice, however, may be unfamiliar with the prevailing causal theories and uncertain about what they can do to help to reduce inequalities in health. The purpose of this article is to provide women's health care clinicians with an overview of the definitions, measurement issues, and theories that fall under the rubric of health disparities. The intersecting roles of genetics, race/ethnicity, environment, and gender are discussed. The article also provides practical suggestions for interventions and health policy change that can be implemented by clinicians in practice. *J Midwifery Womens Health* 2009;54:57–64 © 2009 by the American College of Nurse-Midwives.

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A health disparity/inequality is a particular type of difference in health or in the most important influences on health that could potentially be shaped by policies; it is a difference in which disadvantaged social groups (such as the poor, racial/ethnic minorities, women, or other groups which have experienced social discrimination) systematically experience worse health or greater health risks than more advantaged social groups. Pursuing health equity means pursuing the elimination of such health disparities/inequalities.¹

—Paula Braveman, MD, MPH

INTRODUCTION

The reduction of health disparities has become an important policy agenda in the United States. Healthy People 2010 identifies the elimination of health disparities as a primary goal,² and the National Institutes of Health (NIH) has incorporated health disparities research into its Strategic Plan.³ Just over a decade ago in his foreword to the book *Midwifery and Childbirth in America*, Dr. Charles Mahan⁴ wrote that midwives were the answer to reducing many of the disparities in women's health care. As an obstetrician and public health scholar, it was obvious to him that midwives' "special gifts" include an insight into the many dimensions of women's lives that are causal mechanisms for disparities in health. Unfortunately, his optimistic prediction has yet to be realized. The incidence of adverse perinatal outcomes continues to increase in the United States, and fewer midwives are employed within the domain of public health or in practices focusing specifically on care for women of racial and ethnic minorities.⁵

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In light of the large body of evidence supporting the effectiveness of midwifery care in poor and vulnerable populations,⁵ there is a contradiction between the evidence and supportive health care policy. This is particularly troublesome when one considers that caring for disparate populations is one of the factors involved initially in legitimizing nurse-midwifery in the United States.⁶ Diers⁷ speculated that one reason the midwifery profession has not been more successful is because midwives have yet to link their excellent outcomes of care with the processes that produce them. In many ways, the differences between midwifery and physician care remain invisible and have not been effectively communicated to policy makers.^{5,7}

We are poised, however, on the cusp of change. Several states have already enacted health care reform legislation, and others are likely to follow. Midwives have an unprecedented opportunity to lead the way toward developing a system of care that is equitable and of high quality. Clinicians who practice outside the sphere of public health, however, may not be aware of the large body of work that addresses the root causes of health inequalities. The principal aim of this article is to increase understanding of health disparities among practicing clinicians by providing an overview of the current issues, definitions, and causal theories. In addition, suggestions for interventions and directions for health policy change that may be useful in practice are discussed.

DEFINITIONS

The terms "health disparities," "health inequalities," and "health equity" are often used interchangeably, but little consensus exists about their actual meaning. The definitions of these terms can have important implications for health policy. How the terms are defined determines which activities will receive support from governmental and agency resources and which measurements are monitored.¹

In contrast to Paula Braveman's definition above,¹ the NIH defines health disparities as "differences in the

incidence, prevalence, mortality, and burden of disease and other adverse conditions that exist among specific population groups in the United States.”² This overarching biomedical focus has been criticized by the Institute of Medicine (IOM) in recent years.⁸ The NIH has responded by mandating the inclusion of women and minorities as research subjects in most funded studies. However, the individual institutes within the NIH vary considerably in their interpretation of this definition in terms of funding research. For example, while the National Cancer Institute (NCI)⁹ uses the NIH definition, the National Institute for Nursing Research (NINR)¹⁰ expands upon it considerably by including the role of socioeconomic factors and the risk and protective factors of culture in their institute-specific definition.

Defining exactly who experiences health disparities can be problematic. Definitions usually include racial and ethnic minorities, but these categories are not mutually inclusive. For example, some members of racial or ethnic minorities, such as Asian or Pacific Islanders, may only experience a disparity on one particular indicator of health when compared to whites, or have no disparity at all when compared to a different racial or ethnic group.¹¹

The concepts of “race,” “ethnicity,” and “minority” are also difficult to define. These terms overlap in that they reflect cultural, historical, socioeconomic, and political dimensions of a common genealogy or ancestry. Race has long been thought to have more of a biologic connection to genealogy, while ethnicity is rooted in the idea of a cultural group.^{12,13} “Minority,” a term often used synonymously for race/ethnicity, is even less specific. While a sociologic minority constitutes a subordinate group by definition, a minority group may or may not be characterized by racial or ethnic features.¹⁴ For example, a person defining themselves as either gay, lesbian, or transgender may fit this description.

MEASUREMENT OF HEALTH DISPARITIES

The measurement of health disparities is relatively new. During the past 2 decades, major improvements in computer technology and multivariate statistical techniques have significantly increased researchers’ ability to measure disparities in health and to monitor trends. However, there is a lack of consensus among researchers about various aspects of measurement.⁷ The current literature describes three areas that still need refinement: 1) development and clarification of the concepts used as variables in analysis; 2) testing for reliability and validity of the instruments used in measurement; and 3) the integration of theoretical approaches used in the analysis.^{1,11,13,15}

First, most of the concepts used in health disparities research are abstract, complex, and not directly observable or measurable. For example, variables such as *race* and *ethnicity* are generally self-reported and classifications can be imprecise. Changing demographics in the United States has contributed to the complexity of defining and measuring race and ethnicity. An increase in the number of immigrants and persons of mixed race has rendered previous categories of measurement inadequate.^{13,15} Moreover, these classifications are often treated as markers of other complex and interrelated factors, such as discrimination, health behaviors, culture, skin color, and so forth.¹¹ Therefore, a clarification of how these terms are defined and used within a study is important in the interpretation of research findings.

Second, health disparity research is concerned with comparing groups of people. In order for these comparisons to be valid, the concepts must have similar meanings both within groups and between groups.¹¹ While instruments to measure these variables have been developed, testing for reliability and validity is still in progress in many instances. Therefore, it is important to recognize that more research on measurement is needed in order to determine the extent and causes of health disparities.^{1,11,13,15}

Third, there is disagreement among scientists in terms of how measurement should be approached. Until recently, most researchers in the field have used the “social group approach” to compare differences in health. This method is based on relevant social factors, such as income, wealth, education, occupation, or membership in an ethnic or racial group; it has been guided by the assumption that the relevant differences are those between the historically better-off and worse-off social groups.¹ In the United States, attention has typically been focused on racial/ethnic differences in health care, and standard approaches have involved comparing other racial/ethnic groups to whites, particularly those of European origin.¹³ Other researchers, however, argue that choosing particular social groups a priori prejudices the causes of health inequalities and can mask variation between the different social groups.¹⁶ This “new” approach compares health between the sickest and healthiest individuals in a society without consideration of wealth or social status. It is important that clinicians note which approach was used when evaluating research reports, because the methods of data collection, analysis, and interpretation can substantially effect the significance and/or magnitude of the health disparity that was measured. The National Center for Health Statistics (NCHS)¹⁵ has issued methodologic guidelines for this purpose that can be helpful to researchers and consumers of research alike. These points are summarized in [Table 1](#).

THEORETICAL PERSPECTIVES

Few would argue that “biologic givens,” such as age, sex, and heredity have a role to play in individual differences in

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Table 1. Summary of National Center for Health Services (NCHS) Guidelines for Health Disparities Measurement^a

- 1) The reference point from which the disparity was measured should be explicitly identified and the supporting rationale for choosing that point should be provided.
- 2) If comparisons are made between two groups, the more favorable group rate should be used as the reference point.
- 3) Disparities should be measured in both absolute and relative terms in order to understand their magnitude.
- 4) When relative measures are used to compare disparities across different indicators of health, all indicators should be expressed in terms of adverse events (e.g., those that *did not* have a mammogram).
- 5) Pair-wise comparisons can be used to describe disparities between one or more individual groups and a specific reference point.
- 6) Summary measures can be used for a domain of several groups and comparisons made over time or across indicators, geographic areas, or populations.
- 7) Keep in mind that all summarization involves a loss of information.
- 8) If groups are weighted for comparison, the purpose and application should be taken into account, because weighted measures provide more information about the impact of disparity on the population as a whole.
- 9) The size of the groups and the number of affected persons should be taken into account when assessing the impact of disparities.
- 10) Each measure of disparity should be reported in confidence intervals, if at all possible.

^aAdapted from National Center for Health Statistics.¹⁵

health. These are factors in which individuals and their health care providers have little or no control. In terms of population health, however, much of the contemporary debate is centered on the relative influence of factors upon which either the individual or society does have some level of control. For example, health policy initiatives, such as childhood immunization and water quality regulation, are examples of societal controls that extend beyond the individual level. Over the last several decades, a large body of work from the disciplines of epidemiology, sociology, and public health has improved our understanding of the etiology of differences in population health.¹⁷ Moreover, recent research in physiology has intersected with the study of social determinants of health by providing a way to measure the physical effects of embodied stressors. The following section provides an overview of several widely cited theories that appear in the health disparity literature.

THE SOCIAL DETERMINANTS OF HEALTH

The impact of poverty on health has been known since the 19th century, and it is well established that people who have low levels of income and education experience the greatest burden of poor health.¹⁷ The Whitehall studies of British civil servants in 1970s¹⁸ were among the first to show that excess morbidity and mortality among the lower social classes was not simply a result of cumulative behavioral risk factors, such as exercise, obesity, smoking, and blood pressure. Instead, these studies provided evidence that the structure and quality of social relations within and outside of the workplace had a significant impact on health. Expanding upon this earlier work, British medical epidemiologist Richard Wilkinson hypothesized in the early 1990s that the distribution of resources and the degree of income inequality in a society were major determinants of differing levels of health in the population.¹⁹ He described a social gradient in which people at the lowest rungs of the social ladder were at least twice as likely to die sooner than those at the top. These effects

were not limited to the poor, however. Even among the middle class, lower-ranking individuals suffered significantly more disease and earlier death than higher-ranking persons. Wilkinson argued that that income inequality affects health through one's perception of place in the social hierarchy. Feelings of shame, worthlessness, and envy intersect with health by inducing a physiologic stress response. In response to the prolonged stress associated with material deprivation, poorer people adopt unhealthy behaviors, such as tobacco and alcohol use, high-carbohydrate diets, and physical inactivity to counter the feelings of stress and inadequacy.^{18–20} The impact of these stressors, however, can be mediated by “social cohesion,” a construct that Wilkinson defined as “the quality of social relationships and the existence of trust, mutual obligations, and respect in communities or in the wider society.”¹⁹

While Wilkinson's hypothesis has been extensively tested, it has also been critiqued by his peers^{17,21,24} for avoiding the political issue of what produces income inequality in the first place. The essential criticism is that by placing too much emphasis on the influence of social cohesion and psychosocial factors, Wilkinson's model risks “blaming the victim” (i.e., the individual or community) for their poor health.^{17,21} Lynch et al.¹⁷ followed up this critique by offering an expanded model of Wilkinson's hypothesis which included the influence of a multilevel public infrastructure. These authors point out that jurisdictions or societies with the highest levels of income inequalities have the lowest level of health and social resources, such as health insurance, support for families, social welfare for children, elderly, unemployed, and disabled persons, and education.¹⁷ This model is particularly applicable to the United States, where millions of uninsured persons have little or no access to needed health care services.

The Theory of Allostasis

Although not an explanatory model of health disparities per se, the theory of allostasis has been widely used by

health disparities researchers to document measurable physiologic effects of chronic environmental and social stressors on human health. Allostasis is a complex theory which expands upon Selye's earlier concept of homeostasis and offers a framework for understanding how the body responds to stress. McEwen defines allostasis as "achieving stability through change"—i.e., a fundamental process through which organisms dynamically adjust to both predictable and unpredictable events.^{22,23} Through allostasis, multiple physiologic systems interact to protect the body by responding to both internal and external stressors. The cumulative physiologic result of the response to stressors is referred to as allostatic load, meaning the wear and tear on the body that results from repeated cycles of stress.²³ Individuals vary in terms of their exposure and response to particular stressors because of genetic risk factors, early life experiences, behavioral choices, socioeconomic status, and so forth. Allostatic overload is either a state in which health is lost because of overwhelming physical challenges or stressors are sufficiently chronic to result in a sustained allostatic state. If overload is not relieved, serious pathophysiology can result.²³ Readers interested in exploring this theory in depth are referred to the works by McEwen²² and McEwen and Wingfield.²³

Wilkinson, Marmot, and others have used these concepts to show that frequent anxiety, insecurity, social isolation, low self-esteem, and lack of control over work and home life can raise blood glucocorticosteroid levels and blood pressure, resulting in negative effects on both the cardiac and immune systems.^{18–20} There is evidence from these studies that the lower a person is in the social hierarchy of an industrialized country, the more likely they are to endure a high allostatic load. These stressors accumulate across the lifecourse and may contribute to a variety of health problems, such as hypertension, stroke, preterm delivery, and early death.^{18–20,22,23,27,31}

Embodiment and the Ecosocial Theory

Harvard professor Nancy Krieger²⁴ incorporates aspects of both the social and biologic determinants of health into what she calls "Ecosocial theory." The Ecosocial perspective "brings the body back into context" by offering new insight into the ways that social, political, and economic conditions shape genetic expression, the distributions of disease, and health inequalities.²⁴ These social, political, and/or economic conditions and constraints have health consequences that are literally incorporated biologically or "embodied" throughout the lifecourse.^{24,25} Embodiment occurs through the cumulative interplay of social, biologic, and environmental exposure, creating susceptibility and resistance at multiple levels. The ecosocial theory proposes that human biology is not "innate," nor does the psyche solely govern the body. Biologic species develop through this engaged interaction with dynamic ecologic systems. As Krieger and Davey Smith²⁵

point out, "Genes do not interact with environments—only organisms do, with consequences for gene regulation and expression." These organisms (i.e., human beings) are influenced by their ability to exercise their own agency. Individual agency, however, depends on the socially structured opportunities available; therefore, health inequalities are ultimately a consequence of who has power—either power over another or the power to act in one's own interests.²⁴

Consider the following example of low birth weight (LBW) as an "embodied inequality." Before and during the pregnancy, maternal exposures to factors such as malnutrition, toxic substances, domestic violence, smoking, infections, racial discrimination, inadequate medical and dental care, and so forth, are socially patterned and highly correlated with low socioeconomic status.²⁴ Maternal exposures to these factors result in a higher proportion of LBW infants, who may be growth restricted, small for gestational age, and/or premature. LBW often results in significant morbidity and/or mortality during the neonatal period; for those who survive past infancy, the consequences of LBW include a greater risk of cardiovascular morbidity and mortality and non-smoking-related cancers in middle age. Finally, the high cardiovascular disease risk of older adults is reflective of the prevailing social conditions of their mothers years before.²⁴ Hence, social circumstances become embodied as intergenerational influences.

Krieger, Davey, Smith, and others are collaborating with geneticists in order to test their theory that social, political, and economic conditions shape genetic expression and intergenerational influences on health.²⁵

THE ROLE OF GENETICS IN HEALTH DISPARITIES

Given the dominant medical model of health, it is not surprising that a tremendous amount of energy and resources have been devoted to finding genetic causes for health disparities.²⁶ Clinicians should appreciate, however, that there is little empirical evidence to date that racial or ethnic differences explain broad epidemiologic patterns, such as hypertension or preterm birth in African Americans.^{12,26,27} According to geneticist Mike Bamshad,²⁸ many health-related disparities are probably only modestly affected by genetics; rather, social and environmental factors have a stronger influence. Moreover, efforts to locate a "preterm birth gene" have been unsuccessful, while racial disparities in infant mortality have widened and the US international ranking in infant mortality has declined.²⁶ If empirical evidence is lacking, why then is so much effort being directed at discovering genetic explanations? Jones²⁹ points out that by "introducing an aura of inevitability, genetic arguments reduce the obligation to intervene and prevent or reduce disparities." Moreover, the powerful financial interests that are driving the science of molecular genetics are unlikely to support social

programs to reduce poverty or increase access to health care.^{26,28}

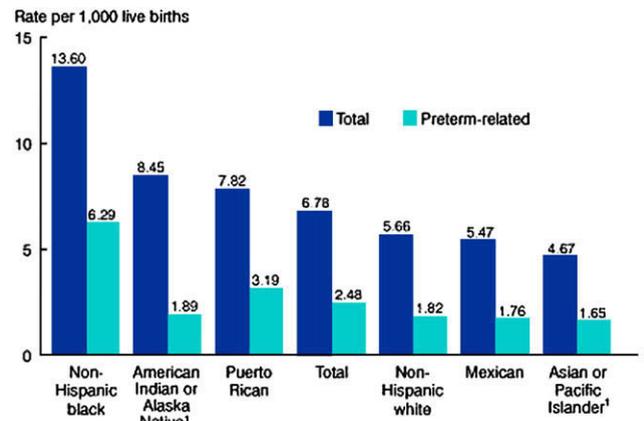
It is important to recognize that the above approach to genetic research differs from that proposed by the Ecosocial theorists. While the medical model approach suggests that genetics are the cause of health differences, the Ecosocial theorists²⁵ argue that studying genetics may actually help us to tease out the causal mechanisms of health disparities. They posit that the ability to predict the consequences of social inequalities will help us to intervene and to better prevent disparities in health.

THE ROLE OF RACE AND ETHNICITY IN HEALTH DISPARITIES

Although race is a predictor of poorer health for some racial and ethnic minorities when compared to whites, it is too simplistic to describe health disparities solely in terms of white/nonwhite differences. While it is clear that race and socioeconomic status (SES) are two “related, but not interchangeable systems of inequality,” the racial category can also reflect “oppression, exploitation, and inequality” despite high SES.³⁰ This is particularly true in the case of African Americans, who have significantly higher rates of preterm birth, infant, and maternal mortality, and poorer general health than whites across all levels of SES^{30,31} (Fig 1).

In the early 1990s, Arline Geronimus proposed the “weathering” hypothesis to account for the early deterioration in health among blacks. She posited that the “stress inherent in living in a race-conscious society that stigmatizes and disadvantages blacks may cause disproportionate physiological deterioration,” particularly in women.³¹ In the most recent of her series of studies, Geronimus et al.³¹ tested this hypothesis by using the allostatic load algorithm developed by McEwen et al. The researchers found that both poor and nonpoor black women had the highest allostatic load scores, respectively, when compared with black men, white women, and white men. Moreover, the differential in scores increased with age.³¹ These findings provide evidence to support Geronimus’ hypothesis that racial inequalities in health are not explained solely by the increased incidence of poverty in specific racial groups.

American Indians and Alaska Natives are also vulnerable to poor health and poor birth outcomes. Jones²⁹ studied the historical trajectory of American Indian and Alaska Native health and reports that disparities have persisted since Columbus landed more than 500 years ago. Although government subsidies for health care have been substantial, expenditures per capita average \$1351 for American Indians and Alaska Natives compared to \$3766 per capita for the general population.²⁹ American Indians and Alaska Natives living in urban areas are particularly at risk, because services are limited in comparison to those available on reservations. In terms of maternal child health, American Indians and Alaska Natives have



NOTE: Preterm-related deaths are those where the infant was born preterm (before 37 completed weeks of gestation) with underlying cause of death assigned to one of the following *International Classification of Diseases, Tenth Revision* categories: K550, P000, P010, P011, P015, P020, P021, P027, P070-P073, P102, P220-P229, P250-279, P280, P281, P360-P369, P520-P523, P77.
¹ Includes persons of Hispanic and non-Hispanic origin.
 SOURCE: CDC/NCHS, National Vital Statistics System.

Figure 1. Total and preterm-related infant mortality rates by race and ethnicity of mother: United States, 2004.

a significantly higher rate of infant mortality compared to whites, and higher rates of teen births, late or minimal prenatal care, smoking, and alcohol abuse.³²

Cultural factors appear to mitigate the negative effects of racial and ethnic discrimination for some groups.³⁰ For example, both native-born Asians and most Asian immigrants have maternal and infant mortality statistics that are comparable or better than American whites. In the case of Hispanics, salutary effects in first generation immigrants, such as a traditional diet, social support, active lifestyles, and low levels of substance abuse, have been shown to diminish the negative effects of poverty and racism.³³ This effect has been described as the “Latina paradox” in maternity care—i.e., that first generation Mexican immigrant mothers have equal or better birth outcomes relative to whites.³³ However, this health advantage has a tendency to decline over time as acculturation increases, particularly in Asian and Hispanic populations.³⁰ Moreover, once the protective effect has declined, cultural explanations can be distorted into “victim-blaming” if historical and social contexts of group membership are unexplored.^{27,29,30}

THE ROLE OF ENVIRONMENT IN HEALTH DISPARITIES

Environmental mechanisms play a major role in health disparities in urban settings, particularly for those individuals living in industrial neighborhoods. Air pollution, noise, traffic congestion, the use and storage of hazardous materials, illegal dumping, and poor enforcement of environmental regulations all contribute to unhealthy living conditions in urban areas.³⁴ Women and children living in these areas have less access to safe places to exercise or play and less access to fresh fruits and vegetables. High rates of asthma, rare cancers, liver damage, lead exposure, immune system disorders, and poor birth

outcomes are more common in these environments. Morrello-Frosch and Shenassa³⁴ argue that there is a convincing link between environmental stressors, allostatic load, and adverse maternal child health outcomes.

Environmental hazards also plague rural residents. Forestry and farm workers are exposed to a variety of toxic agricultural chemicals, which also can contaminate wells and ground water.³⁵ These pollutants may include pesticides, agricultural runoff, and inorganic chemical compounds, and have been linked to neurologic problems, birth defects, learning disabilities, and cancer.³⁴⁻³⁷ Exposure during pregnancy is particularly hazardous. Quackenbush et al.³⁶ reported that health care providers, including midwives, felt that they did not have enough knowledge to properly screen and to counsel clients about how to avoid exposure to potentially harmful pesticides.

Because of widespread industrial and agricultural pollution, women and children in any environment may be affected by the toxins present in food, including breast milk.^{38,39} Agricultural hormones, antibiotics, persistent organic pollutants, mercury, and pesticide residues are some of the many substances that are widely present in the food supply. While organically produced foods are becoming more widely available, their cost is often prohibitive for lower social classes.³⁸ Babies living in poverty are at greater risk than more affluent children for exposure to environmental contaminants in breast milk.³⁹ Poor maternal nutrition, smoking, and residence in polluted neighbors are some of the factors that contribute to a higher risk for exposure to toxins in these infants.³⁹

THE ROLE OF GENDER IN HEALTH DISPARITIES

While the terms sex and gender are often used synonymously, they have essentially different meanings in health disparities research. Biologically determined differences between men and women, such as sexual organs, chromosomes, and hormones, are referred to as sex characteristics.⁴⁰ The concept of gender, however, is used to describe the characteristics of women and men which are socially constructed. While people are born male or female, they learn to behave as men and women as they grow up in a particular society. Therefore, what is considered to be “appropriate” male or female behavior varies in different social contexts. Moreover, gender influences the opportunities and resources available to men and women in a particular society and their ability to make decisions and exercise human rights. Gender stratification is pervasive in both developed and developing countries, and it is a significant public health consideration. Differences in income, resources, benefits, and power relationships can have a major impact on health, both within groups of women and between groups of women and men.⁴⁰

Gender differences in health can be categorized into two distinct dimensions. The first encompasses the biologically specific health needs of women and men (usually

related to the reproductive system). Examples of these disparities for women include the extremely high rates of maternal mortality in developing countries and the disproportionate burden that women assume for family planning. The second dimension includes disparities that arise from inequitable gender relations. These include gendered patterns of employment, domestic violence, harmful traditional practices (such as female genital mutilation), and the poor health and poverty of many female-headed households.⁴⁰ Lesbian, gay, and transgender persons experience disparities on both dimensions. Their reproductive needs may be misinterpreted or ignored by health care providers, and they are also significantly likely to experience discrimination and psychological distress. Moreover, relatively little research has been done on the health care needs of lesbians.⁴¹

Even in the United States, women bear the “double-duty” of pregnancy accompanied by full-time employment, the bulk of the responsibility for family planning, and disproportionate exposure to domestic violence in comparison to men. Moreover, when race, ethnicity, and socioeconomic status intersect with gender, many more women experience significant disparities in health. As Kofi Annan has said, “The face of poverty is a woman’s face.”⁴²

IMPLICATIONS FOR CLINICAL PRACTICE

No matter in what setting they practice, midwives and other women’s health care clinicians encounter a variety of individuals who are experiencing disparities in health. This situation requires that women’s health care providers be creative, resourceful, and always vigilant for ways they can better assess and intervene to reduce disparity. It is important to recognize that even seemingly minor interventions can make a difference; in fact, it is often the “little things” that count most! For example, women of low SES have been shown to eat high-carbohydrate, high-fat diets.^{19,34} Something as simple as teaching them to read and decipher food-labels can be an important first step in helping them to make better dietary choices. Another suggestion for reducing disparity is to inquire about sexual orientation and tailor health care interventions accordingly. This change in practice could help to bring about health equity for lesbians.⁴¹ While it is not an exhaustive list, Table 2 provides suggestions for relatively simple interventions at the individual and community level.

Clinicians can exercise a great deal of influence at the “systems” level as well. Remember that a legislator’s job is to serve his/her constituents. Do not be afraid to bring health issues, personal stories, and research evidence to the attention of your Senators and Representatives at both the state and federal levels. Well-designed research can provide strong evidence for funding needed programs or for informing practice changes. The better clinicians are able to interpret research results and articulate the findings to legislators, the more likely the policy makers are to

Table 2. Recommendations for Practice Interventions to Reduce Inequalities in Health

Reducing Psychosocial Stress

- Ask the women in your practice what THEY think would most meet their needs
- Employ support staff from the neighborhood and/or cultural group
- Insist on face-to-face female interpreters
- Begin group prenatal care in your practice
- Address high stress levels by teaching simple relaxation techniques
- Inquire about sexual orientation, financial situation, housing, and significant relationships
- Assure that the mother has a support person for the birth
- Before the birth, discuss the need for a minimum of two postpartum visits
- Decorate the office setting with art and posters that match the population served
- Develop culturally relevant educational materials that suit the literacy level of the population

Environmental Interventions

- Inquire about working conditions, rest breaks, and leave time
- Be proactive about documenting the need for medical leave when appropriate
- Determine if the woman is exposed to household, workplace, or agricultural chemicals
- Provide testing for chemical exposures through the state environmental lab
- Educate all women about environmental chemical exposure
- Conduct a thorough nutritional assessment at the initial visit
- Provide culturally-specific dietary advice
- Encourage label-reading of food products
- Discourage fast foods by suggesting cheap, easy, at-home alternatives
- Inquire about cooking skills—many young women do not know how to cook!
- Know the resource groups in your location, such as shelters, emergency food sources, etc.

Community-Level Interventions

- Open a birth center in an underserved community
- Consider volunteering your services on a weekly or monthly basis
- Give a free talk in the community on a timely women's health issue
- Organize a new moms' support group at your health center
- Encourage women who successfully breastfeed to help women in their community
- Recruit a community leader to teach a culturally relevant cooking class

introduce and support programs that will actually help to reduce health disparities.

CONCLUSION

At this critical juncture in history, health care reform looms large in the political landscape of the United States. Millions of un- and underinsured citizens and immigrants have minimal or no access to health care. Our public health system is underfunded and overtaxed. Community programs with proven effectiveness have been cut or elimi-

nated. If reducing health disparities is to be more than rhetoric, midwives and other women's health care providers must lead the way in addressing reproductive health issues. As we learn more and begin to understand the root causes of health disparities, and if we exert political will as a professional group, we will be better positioned to assist in developing evidence-based policies in both national and international areas.⁴² If midwifery strives to serve the mainstream of women rather than be marginalized as a "boutique" profession, we would do well to follow the example of our foremothers and return to our roots as advocates for social justice in health care.

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