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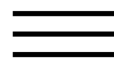

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Racism, Sexism, and Social Class: Implications for Studies of Health, Disease, and Well-being

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One of the most persistent and pressing public health problems in the United States today remains among the most poorly understood: the excess rates of low birthweight (LBW) and infant mortality among children born to black women.[1–5] Although both the incidence of LBW and the infant mortality rate in the United States have been declining for many decades, in any given year, black women are twice as likely as white women to experience the sorrow and loss of their babies' deaths before they reach one year of age (Figure 1).[6–10]

To explain these trends, researchers have invoked two well-known facts. One—recorded since the advent of collecting vital statistics—is that infant mortality rates, in the aggregate, are higher among poor and less educated women.[11–19] The second is that black women in the United States have persistently endured higher levels of poverty than white women;[6,20] according to the 1990 census, 34% of black women and 11% of white women were living below the poverty line.[20] The usual inference drawn from these facts is that the high rates of LBW and infant mortality among black women are attributable to their high rates of poverty.

Yet closer inspection of the data reveals an unusual and disturbing pattern among black women. Although their rates of LBW and infant mortality do rise as their levels of poverty and education decrease, the gradient is much less steep than that observed among white women (Tables 1 and 2).[4] One consequence is that although rates of infant mortality and LBW are highest among both black and white poor and less educated women, the black/white ratio of infant mortality rates is *lowest* among women who have not completed high school (rate ratio = 1.7) and is *highest* among women with a college education (rate ratio = 2.0).[1] Bluntly stated, black women have problematic birth outcomes regardless of their socioeconomic position, they fare worse than white women at every economic level, and their disadvantage persists even among the most highly educated black women.[2,4,21]

The flip side of this "black paradox" is the "Hispanic paradox," which should be labeled more appropriately as the "Mexican paradox" because it involves birth outcomes among Mexican-American and Mexican-born women.[22–25] Despite comparable sociodemographic factors (Table 3), the LBW and infant mortality rates among Mexican-American and Mexican-born women apparently are lower than among black women, at every economic level and at all levels combined (Tables 1 and 2).[22–26] The reported birth outcomes of Mexican-American women, however, are on a par with those of white women, and even poor and less educated Mexican-American women have low rates of infant mortality.[10,22–26]

To date, these paradoxes of consistently adverse birth outcomes among black women and favorable birth outcomes among Mexican-American and Mexican-born women remain unexplained. Although some evidence suggests that the "Mexican paradox" may be spurious and result from the underascertainment of infant deaths among Mexican-Americans,[10] the fact remains that blacks experience higher rates of infant mortality than whites for all leading causes of death except congenital anomalies.[9] Only a small proportion of excess black infant deaths can be accounted for by the major known risk factors for infant mortality, such as inadequate prenatal care, higher parity, and little education. Knowledge about the causes of these risk factors is also incomplete. Preterm delivery, for example, is the third leading cause of infant mortality, by virtue of being the predominant cause of LBW infants.[9] Very little is known, however, about what triggers preterm delivery.[27,28] Factors identified to date include infections, incompetent cervix, and other maternal conditions related to pregnancy, such as preeclampsia, abruptio placenta, and cocaine use.[27–29] Yet even taking these into account does not explain black/white differences in infant mortality.

Far from being isolated gaps in our knowledge, these paradoxes represent a larger problem: a persistent inability to explain a myriad of racial/ethnic, particularly black/white, differences in health.[7,30–33] One recent national study, for example, found that among people 35 to 54 years old, the overall black mortality rate was 2.3 times higher than the white mor-

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