

## **Infant Mortality and AAPIs**

The health of mothers, infants, and children is critical, both as a reflection of the current health status of a large segment of the US population and as a predictor of the health of the next generation. This section addresses a range of indicators of maternal, infant, and child health—primarily those that affect pregnant and postpartum women and those that affect infants' health and survival.

The infant mortality rate (IMR) is an important measure of a nation's health and a worldwide indicator of health status and social well-being. As of 1998, the US ranked 28th among industrialized nations in infant mortality. (CDC, 2002). From 1990 to 2000, critical measures of increased risk of infant death, such as low or very low birth weight, actually increased in the US. In addition, the disparity in IMRs between whites and specific racial and ethnic groups persists. (US DHHS, 2000). The draft national health objective for 2010 is no more than 5 deaths per 1,000 live births. (APIAHF, 2003).

Four causes account for more than half of all infant deaths: birth defects, disorders related to short gestation and unspecified low birth weight, sudden infant death syndrome (SIDS), and respiratory distress syndrome. (US DHHS, 2000).

## **Risk Factors and Challenges**

### *Birth Weight*

Low birth weight is a risk factor for infant mortality. Low birth weight may also indicate that women are not getting prenatal care or are getting prenatal care only in the late stages of pregnancy. The draft national objective for 2010 is no more than 5% low-birth-weight infants for all live births. (APIAHF, 2003).

### **SIDS Risk Factor**

Research has shown that a nonprone sleeping position (that is, sleeping on the side or back rather than the stomach) greatly decreases the risk of SIDS among healthy full-term infants. However, healthy *preterm* infants have been shown to be more vulnerable to respiratory problems when put to sleep on their backs. The American Academy of Pediatrics recommends that healthy full-term infants be put down to sleep on their backs. (US DHHS, 2000).

### **AAPIs in General**

- **Birth weight varies among groups.** The percentage of low-birth-weight infants among AAPIs in the US in 1996 was 7.1%. The rates varied among subgroups: Chinese, 5.0%; Japanese, 8.3%; Filipino, 8.0%; and Hawaiian and part Hawaiian, 10.1%. (APIAHF, 2003).

### **Asian Indians and Southeast Asians**

- **Cambodians and Asian Indians have low birth weights.** Data from California—where approximately one-third of all AAPIs in the US live—show that in 1994, 6.2% of all infants born there were low birth weight. The percentages of low-birth-weight infants varied among racial and ethnic groups. African-American mothers had the highest percentage of low-birth-weight babies (12.6%), followed by Cambodian mothers (9.7%) and Asian Indian mothers (9.1%). (Nelson and Dumbauld, 2000).
- **Hmong, Cambodian, Laotian, and Vietnamese women at risk for preterm births and low-birth-weight infants.** Preterm and low-birth-weight infants born to Hmong, Cambodian, and Laotian mothers in the US in 1992 are reflected in the aggregate rates of 12% preterm births and 7% low-birth-weight infants for all women in the category “Remaining Asian or Pacific Islander Total.” These rates are higher than for Vietnamese mothers (10% preterm, 6% low birth weight) and for whites (8% preterm, 5% low birth weight). (US DHHS, 2001a).

### *Breastfeeding*

Breastfeeding promotion and support have been recognized internationally as health care priorities. Breast milk contains nutrients and antibodies that infants need and contributes to the health of infants overall. In the US, the draft national objective for 2010 is 75% of mothers breastfeeding in the early postpartum period. Although national data on breastfeeding among

AAPI mothers are not available, data from California indicate the need for more breastfeeding promotion among AAPIs, particularly Southeast Asian women. (APIAHF, 2003).

### **Southeast Asians**

- The **lowest incidence of breastfeeding** among all ethnic groups in California is found among Southeast Asian mothers (Vietnamese, Cambodian, Laotian, Hmong, Mien). Only 36% of California mothers of Southeast Asian ethnicity breastfeed at all in the hospital, and most of those who do so supplement with infant formula. (APIAHF, 2003).

### *Diabetes*

- **Diabetes is a significant problem.** Pregnant AAPI women have high rates of complications due to preexisting diabetes and high rates of hospitalization for gestational diabetes. AAPI women are the only group with an increasing trend in death rates due to diabetes.

### *Hepatitis B*

- **Perinatal transmission of hepatitis B is common among AAPIs.** The federal government recommends that all pregnant women be screened for hepatitis B during an early prenatal care visit during each pregnancy. (APIAHF, 2003).
- **High rates of hepatitis B.** Every year, about 19,000 women infected with hepatitis B deliver infants in the US; nearly half of these women are Asian. (Horton, 1995).
- **Hepatitis B rates for Chinese, Koreans, Filipinos, Southeast Asians, and Pacific Islanders range up to 15%,** compared with 0.2% among the general US population. (Hahn, 1994).

### **Recommendation**

All pregnant women should be screened for hepatitis B during an early prenatal care visit during each pregnancy. If the mother is infected with the hepatitis B virus, her **newborn infant must get the first dose of hepatitis B vaccine within 12 hours of birth, along with an injection of hepatitis B immune globulin (HBIG).** This regimen will protect the newborn from getting hepatitis B. Carriers of live hepatitis B should not breastfeed their babies.

### *Prenatal Care*

Early prenatal care is associated with good birth outcomes and the prevention of low birth weight and infant mortality. Prenatal care includes risk assessment, medical management (and treatment, if appropriate), and health education. The draft national objective for 2010 is 90% of all pregnant women accessing early prenatal care. (APIAHF, 2003).

### **How to Mitigate Risk Factors**

Many infant mortality risk factors can be mitigated or prevented with good preconception and prenatal care. Counseling needs to be culturally appropriate and linguistically competent. Prenatal visits offer an opportunity to provide information about the adverse effects of substance use, including alcohol and tobacco, during pregnancy and can serve

as a vehicle for referrals to treatment services. (US DHHS, 2000).

### **APIs in General**

- **Varying rates among AAPI groups.** The rate of prenatal care for AAPI women in the US in 1996 was 81.2%. However, the rates varied for specific AAPI groups: Japanese, 89.3%; Chinese, 86.8%; Filipino, 82.5%; Asian Indian, 80.0%; Hawaiian and part Hawaiian, 78.5%; Vietnamese, 78.5%; and Korean, 76.7%. (APIAHF, 2003).
- **Early prenatal care.** In 1994, slightly more than three-fourths (77.1%) of all women who gave birth in California began prenatal care in the first trimester. The groups with the highest and lowest percentages of early prenatal care were both AAPI subgroups: 90% of Japanese women received early care, but only 51.5% of Samoan women did. (Nelson and Dumbauld, 2000).

### **Southeast Asians**

- **Low rates of prenatal care among Cambodian, Laotian, and Samoan women.** California data show that Cambodian (63.7%), Laotian (56.1%), and Samoan (45.7%) women in particular have low rates of early prenatal care and that the rate among AAPIs overall is low compared with whites. (Dumbauld et al., 1994). Nearly half of Cambodian- and Laotian-American women do not begin prenatal care during their first trimester, and they have higher-risk births because of this lack of care. (US DHHS, 2001a).

### **Pacific Islanders**

- **Low rates of prenatal care among Samoan and Guamanian women.** Rates of early prenatal care among Samoan (48.4%) and Guamanian (66.4%) women are very low. (NCHS, 1998).

### *Teen Pregnancy and Single Motherhood*

- **Low but rising rates of teenage pregnancy and single motherhood.** Rates of births to teens, births to unmarried women, and multiple births are lower among AAPIs than whites, although births to unmarried Asian women are rising. In 2001, there were 21.2 births per 1,000 unmarried women aged 15 to 44 years among AAPIs, versus 27.5 for non-Hispanic whites, 68 for African Americans, and 87.8 for Hispanics. (Ventura et al., 2003).
- **Laotians, Thais, and Guamanians have high teen pregnancy rates.** In California, the percentage of births to Asian mothers less than 18 years old varied widely in 1994. The highest rate was for Laotian mothers (9.5%), followed by Thai mothers (8.0%); the lowest rates were among Chinese and Korean mothers (3.0% each). The percentage of births to teenage mothers among Pacific Islanders ranged from a high of 6.7% for Guamanians to a low of 2.4% for other Pacific Islander mothers. (Nelson and Dumbauld, 2000).

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