Disparities in OBGYN


Excellent for faculty overview and the flipped classroom. A general overview of changing demographics, the definition of health disparity (condition and outcome) vs. health care disparity (access and services) and the importance of this distinction because both require types require different solutions. Examples of key disparities are listed. While some of these diminish with adjustment for some social determinants of health, many remain and are thought to be related to factors at the patient, health system, and practitioner level. Ob/Gyns are encouraged to raise awareness about local disparities, develop quality improvement projects aimed at specific disparities, and work collaboratively with public health authorities and community leaders to decrease causes of disparities.


A general overview of the definition of health and health care disparities and etiology of racial and ethnic differences in health care including patient-level, provider, health care system and institutional level factors with a focus on women’s health. The authors provide suggestions to mitigate disparities and promote health equity including increasing awareness, promoting further research, diversifying the workforce, and ensuring cultural competence.


Excellent faculty development tool. Describes the use of a clinical screening tool to assess patients’ vulnerability to structural/systems issues affecting their care. This tool can quickly identify patients that would benefit from a comprehensive treatment plan to address these issues and connections with outside resources.


Almost 50% of women who desire postpartum tubal ligation and are unable to receive it have a repeat pregnancy in the following year. There are several barriers to immediate postpartum tubal ligation including the availability of providers, hospital staff, operating room time, etc. However, a potentially modifiable risk that disproportionately affects the underserved population is the need to have consent for tubal ligation signed at least 30 days prior to the procedure for those patients with government issued insurance. Though the intent when implementing this requirement was to protect the population of women with government insurance that may not be aware of the permanence of the procedure and to ensure they were not being coerced into the procedure, it has instead created an additional obstacle.

Significant disparities in breastfeeding initiation rates exist among African-American women and women in the Special Supplemental Program for Women, Infants, and Children (WIC). This disparity also exists for women with lower socioeconomic status. There are several factors that may contribute to this disparity. A multidisciplinary approach including government agencies is needed to provide more support in particular for women in underserved groups with lower initiation rates for breastfeeding.


Discusses the increase in adverse pregnancy outcomes for non-Hispanic black women regardless of adjustment for demographic factors.


Among women with a pre-pregnancy diagnosis of type 1 or 2 diabetes mellitus, publicly insured women were less likely than privately insured women to receive preconception counseling that has been proven to improve pregnancy outcomes.


This paper outlines concerning disparities in obstetrical outcomes and reviews links to disparities in health care access and variability in quality. The authors propose a systems-level approach for improving maternity care and provide direction for future research, policy strategies, and clinical care.


Racial disparities in endometrial cancer are well documented. Adoption of a public health critical race praxis can be applied to endometrial cancer disparities. Phase 1: is to place endometrial cancer disparities data in the context of societal racial stratification. Phase 2: apply this knowledge to current research on endometrial cancer disparities, focus on the perspective of Black women, and identify gaps. Phase 3: Fill the gaps with study designs that incorporate the complexity of race, history, and gender. Phase 4: act on modifiable influences of inequity. This strategy can be applied to many different health care disparities.
11. Amy NK. Barriers to routine gyn cancer screening for white and African American obese women. International Journal of Obesity 2006; 30:147-155. Despite being at higher risk than normal weight women for gyn cancers, obese women are less likely to receive cancer screening tests. Self-identified barriers in the medical care system contribute significantly to the delay in care and increase as BMI increases.

12. Hsu J. et.al Disparities in the management of ectopic pregnancy AJOG July 2017
Large population database used to identify over 60,000 women treated for ectopic pregnancy in a hospital setting. Medicaid recipients and uninsured women were less likely to receive methotrexate compared to commercially insured patients. Black and Hispanic women were less likely to undergo tubal conserving surgery than white women and Medicaid recipients. Authors conclude that there are inequities in healthcare delivery systems for the treatment of ectopic pregnancy based on race, ethnicity, and insurance type.

Editorial discussing the potential effect on the reproductive health of disproportionate beauty product exposures among vulnerable dark skinned women.

14. Exposure to toxic environmental agents. ACOG committee on health care for underserved women, ASRM and UCSF program on reproductive health and the environment.
A white paper describing reproductive risks of exposure to environmental toxins, the disproportionate effect on vulnerable populations, and recommendations for prevention.

While 7 reports assessed racial ethnic disparities in IVF outcomes, fewer than 65% of SART reported cycles included race/ethnic data. More consistent reporting needed.

Disparities exist in access to ART and in treatment outcomes and may be increasing. Unclear if outcome disparity is a result of biologic differences, SDH or a true disparity in care.

Health care disparities exist among different ethnicities for common benign gynecologic issues. Fibroid tumors are more common in black women. Endometriosis may be more common in Asian women. There is a higher rate of hysterectomy among black women. More research is needed to determine why these disparities exist.

19. Challenges for Overweight and Obese Women. Committee Opinion No. 591. American College of Obstetricians and Gynecologists. Obstet Gynecol 2014; 123: 726-30. There are many challenges to better health for overweight and obese women, particularly in the underserved community. Obese women in urban areas may live in food deserts where access to healthy choices are limited. This is further complicated by immediate access to fast-food. They also may not have safe neighborhoods for physical activity.

20. Health care for homeless women. Committee Opinion No. 576. American College of Obstetricians and Gynecologists. Obstet Gynecol 2013; 122: 936-40. Health care for the homeless is often a broken system. The homeless have identified these specific barriers to health care: 1) Social triaging; 2) Being stigmatized for being homeless; 3) Lack of care through the health system; 4) disrespectful treatment, and 5) feeling ignored by health care providers.

21. Health care for lesbians and bisexual women. Committee Opinion No. 525. American College of Obstetricians and Gynecologists. Obstet Gynecol 2012; 119: 1077-80. Lesbians and bisexual women encounter barriers to health care that include concerns about confidentiality and disclosure, discriminatory attitudes and treatment, limited access to health care and health insurance, and often a limited understanding as to what their health risks may be. Health care providers should give equitable treatment for lesbians and bisexual women and their families.

22. Health care for unauthorized immigrants. Committee Opinion No. 627. American College of Obstetricians and Gynecologists. Obstet Gynecol 2015; 125: 755-9. Undocumented immigrants are unlikely to have health insurance creating a barrier to access to healthcare. Providing access to quality health care for unauthorized immigrants and their children, who often are born in the United States and have US citizenship, is essential for improving population health.

23. Health care systems for underserved women. Committee Opinion No. 516. American College of Obstetricians and Gynecologists. Obstet Gynecol 2012; 119: 206-9. Underserved women commonly do not have health insurance limiting their access to healthcare. Passage of the Patient Protection and Affordable Care Act has made health insurance coverage possible for underserved women who could otherwise not afford health insurance. However, having this coverage does not ensure increase access and there is a constant threat to end the ACA.
Women in rural areas have decreased access to health care. Among other health disparities, they are more likely than their urban counterparts to receive routine preventive measures such as cervical cancer screening and mammography. Health care professionals should be aware of the disparities and advocate to reduce the disparities in rural women.

Gender nonconforming youth are an underserved population often seen in OB/Gyn practices who often require increased psychosocial support and resources and a better understanding of medical and surgical treatment options.

Study of participants results on IAT for people who inject drugs and potential for increased discrimination due to addition stigma.

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https://www.servicewomen.org/reports/
Service Women’s Action Network report on inequity and limited access to reproductive care from contraception to termination to infertility.

30. Reduction of Peripartum Racial/Ethnic Disparities (+AIM)
Extensive website from the Council on Patient Safety in Women’s Health including multiple patient safety bundles for maternal health.