Commentary: Weathering Chicago

Arline T Geronimus

Rich-Edwards, Buka, Brennan, and Earls\(^1\) analyse citywide birth certificate data from Chicago for 1994 through 1996. They find increased risk of low birthweight with advancing maternal age (beginning at age 15) for black mothers in their unadjusted data, and an even steeper increase with maternal age among socioeconomically disadvantaged women, black or white. Previous researchers taking similar empirical approaches have arrived at generally similar findings for African American mothers, using birth certificate data from New York City (1987–1993)\(^2\) and Michigan (1989)\(^3\). Studies using other indicators of infant health show similar patterns. For example, in Harlem in 1990, and Michigan (1989)\(^4\) Studies using other indicators of infant health show similar patterns. For example, in Harlem in 1990, and Michigan (1989)\(^4\) Studies using other indicators of infant health show similar patterns. For example, in Harlem in 1990, and Michigan (1989)\(^4\) Studies using other indicators of infant health show similar patterns. For example, in Harlem in 1990, and Michigan (1989)\(^4\)

The consistency of recent findings for African American mothers, on average, and for those residing in high-poverty areas across US cities, in particular, suggests that they represent an underlying regularity. Independent of parity, African American mothers who bear children beyond their late teens or early 20s are more likely to experience poor birth outcomes, even when they have children at the most socially approved ages. That ‘delayed’ childbearing to the mid-20s or early 30s is accompanied by this increased risk for many African Americans is truly alarming. Investigative efforts are needed to discover the underlying mechanisms.

Understanding mechanisms requires moving beyond the empirical focus on birth outcome alone. As Rich-Edwards and colleagues conclude: ‘efforts to improve birth outcomes must safeguard and enhance the health of disadvantaged women long before they become pregnant.’\(^1\) This is a monumental task for which much scientific groundwork remains to be done. Unfortunately, probably little more can be learned from analysing birth certificate data. Infant health may be used to proxy maternal health, but it cannot replace direct inspection of the health of girls and women. Moreover, the maternal information available on birth certificates—socioeconomic, health, or behavioural—is not sufficiently rich or reliable. Geocoding birth certificate data has enabled description of important geographical differences, suggesting the role of residential context. However, for the task of explicating underlying mechanisms and social processes, geocoding is a grossly insufficient remedy for the lack of socioeconomic data.\(^5\)

Population variation in maternal-age patterns of birth outcome should be placed in the broader investigative contexts of women’s health and structural health inequality. As Rich-Edwards et al. suggest, taking a cumulative life-course approach is likely to be constructive. The theory of ‘weathering’ provides a model.\(^3,4\) The cumulative life-course approach has sparked interest among social epidemiologists concerned with diseases of middle to old age,\(^6\) but there is no reason that it should not be applicable to the reproductive ages as well. Substantial percentages of African-American women in their 20s or early 30s already suffer from chronic disease. African-American women in some high-poverty urban areas report rates of health-induced disabilities at age 35 or 55 that are comparable to the national

University of Michigan.

Correspondence: Arline T Geronimus, Dept. HBHE, 1420 Washington Heights, Ann Arbor, MI 48109–2029, USA. E-mail: arline@umich.edu


averages for 55 and 75 year old women, respectively. And, primarily as the result of chronic disease, African-American women in these locales are as likely to die by age 45 as white women nationwide are to die by age 65.4

Growing interest among social epidemiologists in the impact of residential environments7 and residential segregation8 on chronic disease prevalence could also illuminate why risk of poor maternal and infant health rises so rapidly with maternal age in racially segregated, high-poverty urban areas such as those in Chicago. Coming to understand the processes by which social stratification is reflected in geography and how that might impact local population health over the life course seems a promising way to gain purchase on this important question. In fact, the connections seem so obvious that one wonders why the infant health impact of maternal age has been so rarely systematically studied in either the context of a cumulative life-course approach or from the perspective of the impact of place on health, especially given recent keen interest in both of these perspectives.6,7

A number of circumstances may help create these lacunae. To the extent that the research focus is on newborns, it may be natural to overlook the potential importance of a cumulative life-course approach or the impact of residential place. After all, newborns have not accumulated much life experience nor resided in a neighbourhood in the conventional sense. Focusing on infants may also fuel lingering conceptual confusion over whether maternal age is best construed as a ‘risk factor’ for the infant or as a structural marker that represents social processes influencing fertility-timing norms across populations.

But even augmenting the focus on newborns to include girls and women will fall short of taking full advantage of the cumulative life course approach, if the widespread construction of women’s reproductive health as being heavily influenced by a universal biological developmental process continues to overwhelm the possibility that the health of a young woman in a structurally marginalized group may be better illuminated by understanding the cumulative impact of her experiences from conception to her current age.5 Perhaps at some level we prefer to avoid conceptualizing maternal age as a cumulative life course issue—especially when considering racial inequality. To do so would be to confront the possibility that in our rush to see teen childbearing as a major social and public health problem we have succumbed to thinking that is overly simplistic or self-serving or outright wrong.9 This possibility is threatening to social and public health programmes and the premises that underlie them.10 It may be nearly inconceivable to some. Teen motherhood has become an ideological lightening rod that diverts highly charged cultural ideas on race/ethnicity, responsibility, sexuality, gender, and youth from striking less politically acceptable targets. But shying away from re-examining its relationship to the health of girls, women, and infants risks suppressing growth in our field.

References