



The Reality of Maternal Mortality

“A Black woman having a baby is like a Black man at a traffic stop with the police.”
(Felicia Ellis, *Aftershock*, 2022)

This paper explores the racial disparities of maternal mortality, with a focus on the disparities between Black and White women. This topic is important because it is not gaining enough attention on a national scale and it highlights the fact that institutional racism is still very well prevalent in the medical world (e.g., Tuskegee syphilis study, sterilization of Puerto Rican women or the exploitation of Henrietta Lacks’ (HeLa) cells). I hope to bring knowledge on how racism and medical implicit bias can affect people’s quality of life specifically women of color.

Keywords: Black maternal healthcare; Racial bias in maternal care; Race and Maternal Mortality; Eugenics

Introduction

Imagine being 35 weeks pregnant, excited to meet your little one, your partner talking about who the baby will look like more, until you start experiencing chest pains. You visit the Emergency Room explaining your concerns, but the doctors dismiss you because it may be from the pressure of the growing uterus and a minor heartburn. Still worried but reassured by medical professionals telling you are alright to go home, you leave the

hospital with your partner also trying to reassure you. Then, the pain becomes sharp for the next couple of hours, and you knew something was very wrong this time. You visit the hospital again later that night, but rather than receiving help, you get questioned if you take drugs because “you fit the profile” of someone who takes drugs. Highly offended by the comment, you try to stay calm and still complain about your chest pains. Doctors simply prescribed you medication and tell you to come back if you still feel the pain. No medical history background asked, no diagnostics testing done. You and your baby die from pulmonary embolism.¹ If they had just believed your concerns, checked your oxygen or respiration rate, you might be alive with your baby.

This scenario was fictionally created to show how common it is for Black women to experience situations where implicit bias exists while seeking healthcare. Implicit bias is the unconscious/unintentional practice of

bias judgements that affect decisions.² For example, the aftermath of the War on Drugs created an image for society to believe Black people are dangerous and are drug addicts³ or the stereotype of Black people having higher pain tolerance because of a medical myth that Black people “have thicker skin.”⁴ These stereotypes/ideologies allow implicit bias to continue to be practiced in healthcare settings and Black women’s concerns to be repeatedly ignored from professionals, putting Black women’s holistic health at risk. In this essay, I discuss why we are seeing an increasing trend of Black maternal death, as well as different policies that place Black women at a disadvantage when accessing healthcare needs and the history of Black childbearing in the United States. By explaining why we are seeing such trends, I will also speak to possible policies that can be implemented to decrease Black maternal mortality.

As an Asian woman, I will never understand what it is like to be a Black

¹ When a blood clot gets stuck in an artery in the lung causing blood flow disruption of the lung.

² See The National Institute of Health for additional information:

<https://diversity.nih.gov/sociocultural-factors/implicit-bias>

³ This was discussed in the film “13th” by Ava DuVernay.

⁴ This was discussed in the film “*Race: The Power of an Illusion*” (Adelman, 2003).

woman, nor will I ever know the struggles Black women face across different intersections of intersectionality. As an ally of the Black community, I and other members of society have a duty to educate ourselves on how the effects of racism can impact one's life and help advocate for policy changes.

Coverage Gap

Over the years, the United States has been seeing an increasing trend in maternal mortality, specifically Black maternal mortality. Black women are three times more likely to die from pregnancy-related causes compared to White women (Centers for Disease Control and Prevention, 2022). Judith Solomon (2021) the author of, *Closing the Coverage Gap Would Improve Black Maternal Health*, introduces the idea of what the coverage gap is and how this negatively affects pregnant Black women. She stated,

But the Medicaid coverage gap – in which adults with low incomes have no pathway to affordable coverage because their state is one of 12 that has refused to expand Medicaid - puts continuous health coverage out of

reach for over 800,000 women of reproductive age (Solomon, p.1).

Those who are not insured in the twelve states that have decided to not expand Medicaid will have a difficult time finding healthcare at an affordable cost. The privilege to have health insurance is a classism issue because, depending on socioeconomic status, there are different levels to accessible healthcare and health insurance. For example, those who earn a higher income are more likely to have access to employer provided health insurance whereas those who earn a lower income may not offer employer provided health insurance or cannot afford a private health insurance. Not only is this a classism issue but when we factor in race/ethnicity, many people of color experience discrimination when accessing healthcare. This leads to disparities in health outcomes between different race/ethnic and socio-economic groups. This may cause Black pregnant mothers to seek care in other states, placing a huge inconvenience and financial burden to seek constant care outside of the state in which they may live.

For the 12 states⁵ that have not expanded Medicaid, living below the poverty line or those making less than \$17,800 a year per person puts more women of reproductive age at risk of being uninsured compared to the expansion states. In 2019, of 810,000 women of reproductive age with incomes below the poverty line, 29 percent were Black women and 33 percent Latinas who had no affordable healthcare (Solomon). Expectant Black mothers who reside in those twelve states are at risk of receiving less care, which eventually puts their fetus and their own lives at stake. Moreover, states that have not expanded Medicaid puts those 65 percent of Black pregnant mothers in huge medical debt for receiving the absolute minimal to no prenatal and intra/postpartum care. Solomon mentions Medicaid pays for more than 65 percent of births to Black mothers; therefore, expanding Medicaid will help address the Black maternal health problem. Removing Medicaid can put more women - not just uninsured Black women - at risk because of the

burden of the cost to receive care. According to Solomon, if people in the coverage gap were to get pregnant, they become eligible for Medicaid but may not get the necessary preconception care. Uninsured people may delay their prenatal care until they apply for and enroll in Medicaid.

Prenatal care is crucial for a healthy delivery as it addresses any potential concerns related to pregnancy, possible birth complications, and risk factors. These have been interconnected with negative pregnant outcomes and higher pregnancy-related risk factors especially for Black women (Kendall, 2021). Unaffordable healthcare causes higher potential negative outcomes and financial burden on Black women who are seeking to become pregnant.

The Disparities

Various research has examined social disparities in maternal mortality for decades by race/ethnicity, socioeconomic status, nativity, immigrant status, marital status, area deprivation, urbanization level, and cause of death.

⁵ According to Holahan et al. (2021), the 12 states that have not expanded Medicaid are: Alabama, Florida, Georgia, Kansas,

Mississippi, North Carolina, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming.

Singh (2020) collected national vital statistics data from 1969 to 2018 and results showed “with the rate increasing from 9.9 deaths/100,000 live births in 1999 to 17.4 in 2018...Black women in 2018 have 2.4 times higher maternal mortality than White women” (p. 1). This demonstrates to the public that not only is the United States seeing an increasing trend in maternal mortality in general, but Black women are more likely to die from childbirth. Singh continues to report that women who are unmarried, have U.S.-born status, have lower education, and have rural residence were associated with 50-144 percent higher mortality risks. Black pregnant women who are unmarried, of U.S.-born status, with lower education, and living in rural areas have also largely faced additional marginalization due to the institutionalized racism and sexism embedded into our society. This can lead to further complications in maternal health outcomes. To further explain, Kendall states,

Social and environmental risk factors that influence poor maternal health outcomes disproportionately impact marginalized communities. Poverty-based risk factors, from housing

instability to increased exposure to toxins because of subpar housing to increased exposure of violence, contribute to higher stress levels and lower access to quality healthcare, including comprehensive mental health services (p.231-232).

It is important to note that in many cases social and environmental risk factors are deeply connected to institutionalized racism entrenched in policies that segregate communities. For example, institutionalized racism has constructed policies such as segregation and redlining, which result in members of the Black community, especially Black women, to have less education or live in rural areas where education and healthcare access is difficult. Kendall’s (2021) statement of social and environmental risk factors to lack of housing further illustrates how these policies have affected the Black community negatively causing resource scarcity. Redlining is one example where it was difficult for Black families to purchase homes in “affluent” areas because of racial prejudices. This resulted in lower financial status among Black populations, causing them to live

in low-income areas with limited access to healthcare.

The issue of maternal mortality is more racially rooted than any other social disparities. Walker and Boling (2023) showed Black women are more likely to die during childbirth than Hispanic, Asian/Pacific Islanders, American Indian/Alaska Native women in the U.S. as well as women in Mexico, where nearly half its residents live in poverty: “A Black woman with a college degree is more likely to die during childbirth than a teenage White woman” (p. 2). If a well-educated Black woman is more likely to die from childbirth than a teenage White woman, then society needs to see maternal mortality as a race disparity issue as much as a socioeconomic issue. Macdorman et al. (2021) analyzed the 2016-2017 National Vital Statistics System’s mortality data, examining the cause of death literals (actual cause of death written on the death certificate) with racial/ethnic differences. Macdorman et al. found several results in that the mortality rate for non-Hispanic Black women was 3.55 times higher than for non-Hispanic White women. They also found the leading cause of death was preeclampsia,

eclampsia, and postpartum cardiomyopathy with rates five times higher than those for non-Hispanic Black women (Macdorman et al.). Black maternal mortality rates from obstetric embolism and obstetric hemorrhage were 2.3 to 2.6 times greater than those who are non-Hispanic White women, accounting for 59 percent of the non-Hispanic Black-non-Hispanic White women disparity. The results show a substantial rate of Black mothers dying from cardiovascular-related deaths compared to White mothers. The healthcare system needs to increase its attention to this issue, as preeclampsia and eclampsia are easily preventable diseases with the right care and monitoring. Black women are all too often ignored or overlooked by healthcare professionals when reporting a symptom such as pain, causing the Black community to be hesitant when seeking care.

The Unspoken History

It is evident in U.S. history that Black women have been denied autonomy in the deeply personal process of reproduction and childbearing. Owens and Fett, authors of *Black Maternal and*

Infant Health: Historical Legacies of Slavery (2019), speak on the history of enslaved women and childbearing:

Continuing up through the Civil war, White women's childbearing built free patriarchal lineages while southern laws forced enslaved Black women to bear children who would build capital for enslavers (p. 2).

It is clear enough to say Black women during slavery had no autonomy when it came to childbearing. Oftentimes, after enslaved mothers gave birth, their children (who were often a product of rape) were immediately taken away from their biological mothers for financial profit. Enslaved Black women frequently had to take care of their master's children by breastfeeding, cleaning, cooking, and changing, rather than taking care of their own children. This allowed society to continue a cycle where Black women are exploited physically, emotionally, sexually, and financially.

One cannot say race does not play a role in our healthcare system today without discussing the significant history

of racial inequalities in childbearing for Black women. We must understand how the relationship between the medicine we know today and slavery interconnect. To give a few examples, Francois Marie Prevost, a slaveholding surgeon, performed countless cesarean section surgeries on enslaved women. James Marion Sims, a gynecologist who created Vesicovaginal Fistula Repair,⁶ experimented on enslaved women in Alabama (Owens & Fett). Surgical techniques were developed even though Black women were unwilling subjects to these painful experiments. During the slavery period, we did not have the advanced pain medication that is used in surgeries today. Black women endured an immense amount of pain so that white physicians could acquire new medical knowledge for future generations of medical students. Owens and Fett also highlighted an important point: the advanced medicine of gynecology we know today is due to many Black women sacrificing their bodies unwillingly. Black women like Henrietta Lacks⁷ contributed immensely

⁶ Vesicovaginal Fistula Repair is a surgery that closes the opening of the vagina.

⁷ Henrietta Lacks is a Black woman whose cells (HeLa cells) were taken without informing her or her family and used for

to the medicine we know today due to the exploitation of her cells. We continue to witness a higher maternal death rate for Black women compared to any other racial group.

Hood Feminism

Mikki Kendall, author of *Hood Feminism*, dedicates a chapter in her book to Black maternal mortality, reproductive justice, and eugenics. She writes,

Higher abortion rates in low-income communities are sometimes connected by anti-choice groups to eugenics as well. Because of environmental racism, limited access to prenatal care, and subpar nutrition and housing for many in marginalized communities, the risk factors for having a child with a serious disability are higher than average (p.226).

Kendall argues a correlation with higher abortion rates because there is limited access to resources that help carry a fetus to term. Having good prenatal care is the foundation to a healthy term pregnancy. If this foundation is not laid, the risk of fetal death and possible maternal death

will only be apparent. Kendall's argument of lack of resources tremendously impacts how a woman will do throughout the pregnancy and continues to state how lack of resources is what we should address about reproductive justice.

Kendall points to tennis athlete Serena Williams' story as an example that wealth "does not protect Black mothers" (p.220). Serena Williams had the means to access top quality healthcare because of her financial status as a world star tennis player, but she still faced a near-death experience because her pain and concerns were overlooked by medical staff. This further proves my argument that this is a racial issue more than socioeconomic issue. Kendall also says,

For Black communities in the United States, even when factors such as physical health, access to prenatal care, income level, education, and socioeconomic status are controlled for, Black women are still far more likely to experience maternal mortality rates that hark back to the days when Black motherhood was seen as a

medical research purposes and financial profit. See *The Immortal Life of Henrietta Lacks* by R. Skloot.

problem to be solved with sterilization (p.231).

The writer makes a connection that because Black women lack access to resources, we are seeing higher rates of Black maternal mortality; that is the sterilization issue of today. The history of forced sterilization in the United States is another form of discriminatory practice that has existed since the 1940s, beginning with Puerto Rican women and then Black women in the 1950s. The infamous eugenics movement triggered women to be sterilized involuntarily by threatening Black women's welfare benefits if not sterilized. The eugenics movement's goal was to decrease the reproduction of groups that were deemed to be "undesirable". Such groups were largely people of color. Black women were mainly targeted to be sterilized to permanently prevent them from giving birth. Both these issues highlight the systemic racism and sexism in our healthcare system and how this prolongs health disparities in communities that are still racially marginalized.

For a Better Future

The national conversation and efforts to correct inequalities in maternal mortality in the United States have not been communicated enough. Walker and Boling showed the challenges journalists faced when reporting health disparities as the result of social inequalities. Journalists felt they could not adequately cover the topics from a racial perspective because of tight deadlines, limited staffing, training, and time. Researchers and health professionals such as surgeons, doctors, nurses, and more have come together to discuss ways to decrease the disproportionate rate of maternal death. Lister et al., researchers of *Black Maternal Mortality – The Elephant in the Room* (2019), argue there are three central issues to the unbalanced death rates: First, Black women are more likely to have pre-existing cardiovascular morbidity that increases the risk of maternal mortality; second, Black women are more likely to experience adverse pregnancy outcomes putting them at risk for long term cardiovascular disease; and third, the racial bias and perceived racial discrimination of healthcare professionals reduces the essential health care Black women receive. Lister et al. offer several

recommendations: Women with a heart condition should be cared for by a team of “cardio-obstetrics” during their pregnancy; Black women who experience pregnancy complications should have a primary provider in the immediate postpartum care; hospitals that serve Black women should have extra resources available. Lister et al. propose expanding coverage outside of the immediate postpartum period to ensure that those at greatest risk for a cardiovascular event are immediately connected to the healthcare system. Lister et al. point out that many reproductive age women have OBGYNs as their primary care provider, which gives them the unique position to join with skilled physicians who specialize in cardiovascular disease to prevent or manage postpartum complications. Most postpartum follow-up visits are six to eight weeks after giving birth. Immediate coverage after postpartum can significantly decrease the risk of complications.

Many healthcare providers are trained and educated on how to therapeutically communicate with patients. It is part of their duty as healthcare professionals and their ethical responsibility to provide

autonomy and more. We are seeing healthcare providers forget to practice their therapeutic communication skills. Serena Williams’ story is an example of how crucial it is to have effective and continuous communication with providers and patients. Lister et al. reference two studies illustrating how effective communication between healthcare providers and patients can allow the patient to feel more trusted with medical staff. In the first study,

204 African American pregnant patients and their 21 ethnically diverse providers demonstrated that patient-provider communication had a positive effect on trust in provider and on prenatal care satisfaction (Dahlem et al. (2015), as cited in Lister et al., pp. 4-5).

The second study,

a qualitative study of 22 African American Women, [identified] the qualities important to effective communication were (a) demonstrating quality patient-provider communication, (b) providing continuity of care, (c) treating the women with respect, and (d) delivering compassionate care (Lori et al. (2011), as cited in Lister et al., p. 5).

Not only do these studies show that effective communication can build a positive healthcare experience, where patients will feel more trusted and inclined to seek care, but they mention qualities that make communication between healthcare providers and patients successful.

The Association of Black Cardiologists (ABC) published a position paper stating more than half of Black maternal death cases were from preventable causes with cardiovascular disease being the leading one (Bond et al., 2021). The ABC addressed many topics, including pre-conception counseling to provide health education, risk assessment, and intervention before pregnancy. Their goal is to help reduce adverse outcomes by expanding community outreach programs, using media to expose the issue of Black maternal mortality to the public, building a faith-based partnership between professionals and patients, acknowledging Black mother's concerns, and improving overall quality care during the antepartum⁸ and postpartum periods. In 2020, *SELF*, a popular media/magazine company,

published an eleven-part editorial to provide Black mothers-to-be information about their pregnancy journey (Bond et al.). We have also seen Black public figures who have given birth like Serena Williams, Beyonce, and Michelle Obama to name a few, share their experiences on their pregnancy journey to the public. This can raise awareness to other Black women who look up to them. The use of media is an excellent way to implement change by informing women of color on a global scale and diversifying what is being put out on media.

Another idea Bond et al. reported is to have insurance companies hold hospitals accountable for collecting and reviewing patients' morbidity and death outcomes, including the physicians' race/ethnicity. If hospitals reported the physician's race/ethnicity, they could then provide a list of physicians the patient may want to seek care from. Bond et al. argue this is important as,

Research has shown that patient-physician racial concordance has led to improved quality of care with greater interpersonal trust, satisfaction with

⁸ Antepartum is referred to a time period right before childbirth.

care, loyalty and satisfaction with the physician, self-reported health improvement, and willingness to give the physician control in the relationship (p.5).

Having a patient-physician racial concordance can also help reduce implicit bias because implicit bias only occurs when two or more people of different backgrounds come together. When a patient and physician share the same racial/ethnic background, the physician may exhibit less bias toward the patient because of the shared bond. Healthcare systems need to hire more people of color so that patients have a team of providers they might identify with.

Bond et al. cite that the U.S. spends about \$111 billion on maternal, prenatal, and newborn care per year, but I think the budget should be greater. According to USAspending.gov, the military received an annual budget of almost two trillion dollars in 2023. Allocating just five percent of that budget, about \$100 billion, would increase the annual

maternal healthcare budget to about \$200 billion per year. This can allow more community-based outpatient clinics to be built, hire more Black doulas⁹ and healthcare professionals, and advocate for WIC program¹⁰ funding to research more on prevention of postpartum cardiovascular events and more.

Conclusion

This essay examines the racial disparities seen in maternal mortality, why we are seeing those racial disparities, the history of Black women's childbearing, and the experiences of pregnant Black women/mothers and how that impacts their families. The essay also examines possible solutions to decrease the rate of Black maternal mortality such as increasing funding and hiring more people of color. In doing so, I have argued that Black maternal mortality is a racial issue rather than a socioeconomic status issue, as articulated by Kendall's chapter on "Reproductive Justice, Eugenics, and Maternal Mortality" in her book, *Hood Feminism*.

⁹ Doulas are trained professionals that help support/guide mothers-to-be through childbirth, they do not provide medical assistance.

¹⁰ WIC program stands for Women, Infants, and Children program, government assisted program to help with nutrition needs.

As an ally to Black women, I want to spread knowledge to others and have open discussions on Black maternal mortality issues, especially to those who are not Black. I also want to increase awareness that maternal death is one of the many societal issues Black women face every day. We must make it a priority to acknowledge the pain these women have felt and find solutions together. You and I need to fight back against systemic racism. You and I need to fight back against implicit bias. You and I need to fight for more resources. You and I must listen to the cries of Black women. You and I need to protect Black women.

Imagine we are 200 years in the future where people live harmoniously across all intersections with unlimited access to resources needed to survive, and policies like the Affordable Care Act, and Women, Infants, and Children (WIC). Programs do not exist because everything is free of cost. Black women can come seek care without the fear of dying because systemic racism was addressed and corrected with new policies. Medical debt is nonexistent because society cares for a human's wellbeing rather than money. Funerals for grieving partners is long past because the gap between maternal mortality is gone. Imagine.

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