ISSUE BRIEF

BLACK MATERNAL HEALTH

The United States (U.S.) has some of the worst rates of maternal and infant health outcomes among high-income nations, despite spending an estimated $111 billion per year on maternal, prenatal, and newborn care.[1] Nationally, Black women are three to four times more likely to die from pregnancy-related causes than white women.[1] Maternal and infant health disparities are a public health priority with many social and economic implications, such as poor health outcomes and increased direct and indirect healthcare costs. Health inequities lead to $1.24 trillion in indirect medical costs, and 30% of direct medical care expenditures for racial and ethnic minorities.[2]

This brief highlights the disparities in reproductive and perinatal health that impact Black women due to structural and systemic inequities that impact their health outcomes. The purpose is to highlight issues that are driving Black maternal health disparities in the U.S. Additionally, this brief emphasizes the need for more research to understand and improve perinatal healthcare that Black women and birthing people want and receive. By highlighting these issues, BMMA aims to offer more literature, further guidance, and amplify community-driven innovations that addresses negative health outcomes and advances maternal health equity.

HEALTH INEQUITIES IN BLACK WOMEN

Disparities in maternal and infant mortality are rooted in racism. Due to the structural racism embedded in healthcare, Black women often receive indigent quality care.[3] In a report by the Institute of Medicine (IOM), it highlighted substantial disparities in the quality of care for minority communities even when accounting for healthcare insurance coverage and income.[4] The long-term psychological effects of racism puts Black women at higher risk for a range of medical conditions that threaten their lives and their infants' lives, including preeclampsia, eclampsia, embolisms, and mental health conditions.[5] Black women experience higher rates of many preventable diseases and chronic health conditions including higher rates of diabetes, hypertension, and cardiovascular disease.[6] Black women are also more likely to experience reproductive health disorders such as fibroids, and are three times more likely to have endometriosis. Due to Black women's increased risk for pregnancy-related complications such as preterm labor, preeclampsia and hypertensive disorders, the loss of wages due to pregnancy discrimination is challenging.[7] Discrimination can increase cortisol levels with adverse effects on maternal and infant health.[8] The experience of discrimination, chronic stress of poverty, and racism has been shown to have a deleterious effect on Black women's health outcomes and is linked to persistent maternal health disparities.[9]

SOCIO-ECONOMIC IMPACT

Black women are typically paid 62 cents for every dollar paid to non-Hispanic white men.[10] Median wages for Black women in the U.S. are $36,227 per year, which is $21,698 less than the median wages for non-Hispanic white men.[10] Black women must work an extra 233 days to simply catch up in pay. In Georgia, Black women earn 63 cents for every dollar earned by their white male counterparts.[11] Currently, Louisiana has the most significant gap in earnings between Black women and white men in the country, with Black women earning 46.3% less than half of white men's earnings.[12] Gaps in pay further challenges Black women's ability to support themselves and their families.[7]

Black women with low socio-economic status are more likely to experience poor nutrition, inadequate housing, and greater exposure to environmental hazards—all of which contribute to overall health.[13,14] More than one in four Black workers report that there was a time in the last two years that they needed or wanted to take time away from work for parental, family, or medical reasons but were unable to request leave.[15] Compared to non-Hispanic white women, Black women are more likely to quit, be fired, or return to work before they are healthy after giving birth due to inadequate leave policies.[16] Furthermore, nearly three in ten charges of pregnancy discrimination were filed by Black women from 2011-2015.[17] The lack of economic security and discrimination has shown to have a detrimental impact on Black women's health outcomes.

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ACCESS TO CARE

Research indicates that 22% of Black women receive lower quality of care than white women and are subject to discrimination in the healthcare field.[18] In 2008, only 6.4% of obstetrician gynecologists practiced in rural settings.[19] By 2010, 49% of the 3,143 U.S. counties (home to 10.1 million women or 8.2% of all women), lacked an obstetrician–gynecologist.[20] Expansion of prenatal and postpartum care models can reduce the overall cost of care due to fewer emergency visits, reduced cesarean births, and fewer postpartum hospitalizations.[8] Perinatal community-based models of care offer enhanced care and support throughout the pre-pregnancy to postpartum period, including doula and midwifery childbirth services to pregnant women who face barriers to care.[3] Community-based perinatal models of care help to increase access to care, assist people in connecting with social services, and bridge cultural gaps between providers and clients.[21]

BREASTFEEDING

The American Academy of Pediatrics asserts that breastfeeding is the optimal source of nutrition for newborns and infants less than six months of age.[22,23] Breastfed infants are less likely to experience ear infections, asthma, respiratory infections, diabetes, and obesity.[22,23] While there are several causes for the current breastfeeding outcomes among Black women, myths suggest that Black women have not been exposed nor know how to breastfeed, creating false narratives that feed into negative stereotypes about Black motherhood.[24] Black maternal health advocate, Sunshine Muse, highlights Black women's experiences in American colonial history. Sunshine Muse states, "Black women helped build the immune system of almost 12 generations of Americans with our breast milk and traditionally nursed our children long before slavery and colonialism."[24]

Current statistics still indicate that Black women have the lowest prevalence of breastfeeding, lowest rates of breastfeeding initiation and continuation at six months and twelve months, when compared to all other racial/ethnic groups in the U.S.[23] Other studies argue that the low breastfeeding rates among Black mothers at six months is a missed opportunity to improve health disparities among this population.[25] Typically, breastfeeding support is conducted in-person through lactation consultants. With the evolution of technology and its impact on the way people communicate, limited research exists that examines the use of social media to disseminate breastfeeding support. A study by Dr. Ayanna Robinson et al. has shown that Black mothers value the convenience of breastfeeding information and support on social media platforms such as Facebook and access to online breastfeeding support communities.[25] Future research should continue to explore how Black women use breastfeeding information provided through online platforms.[23,25] This information may assist birth workers and educators in advancing tools that promote an increase in breastfeeding initiation rates, support provided to new mothers, breastfeeding exclusivity, and duration in this population. [23,25]

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REPRODUCTIVE HEALTHCARE AND FAMILY PLANNING

The work of BMMA is informed by the reproductive justice framework, which supports personal bodily autonomy, the right to have children, not have children, parent in safe and sustainable communities, and access to unbiased reproductive health information and care.[26] Reproductive health disparities impacting Black women include but are not limited to lack of access to unbiased family planning information, contraception, abortion, and accurate and timely diagnosis of reproductive disorders.[26,27] In recent years, there has been increased acceptance and support for long-acting reversible contraceptive (LARC) methods among U.S. reproductive health care providers.[27] Health care providers have supported this method because of its potential to decrease the rate of unintended pregnancy.[27,29] Historically, LARC methods such as intrauterine devices (IUDs) and implants have not been options that women could easily choose because of barriers such as lack of knowledge, providers' low familiarity, and cost.[28] However, given the recent popularity of LARC methods, it is important to highlight that LARC advertisement and promotional efforts can undermine reproductive autonomy and increase barriers women face in accessing contraceptives.[27]

In a national study of Black women, 67% of participants who had seen a health care provider for family planning services reported experiencing race-based discrimination when obtaining these services.

Despite the increase in LARC promotional efforts, disparities in levels of unintended pregnancy in the U.S. persist.[30] Rates of unintended pregnancy are disproportionately high among Black women despite increased interventions aimed at reducing barriers to LARC methods.[28,31] In addition to facing barriers to contraceptive access, Black birthing people face challenges to their bodily and reproductive autonomy. The history of such reproductive oppression is well-documented; for example, between 2006 and 2010; women, primarily Black and Latina, in California prisons experienced coerced sterilizations.[32] Furthermore, women continue to experience racial discrimination in family planning settings.[33-37] In a national study of Black women, 67% of participants who had seen a health care provider for family planning services reported experiencing race-based discrimination when obtaining these services.[37] Other studies have found that Black women may feel pressured to use contraceptives, and Black women are more likely to be advised to restrict their childbearing.[36] These studies showcase consistent evidence that providers consider race and socioeconomic status (SES) in making recommendations.[27]

Ultimately, the confluence of barriers to contraceptives, lack of access to family planning, and lack of reproductive autonomy is tantamount to reproductive coercion for Black women and birthing people. To address disparities in Black maternal morbidity and mortality, it is vital to support reproductive equity and justice.[38] Philanthropists and funders must use Black feminism and reproductive justice as ethical standards if they truly seek to drive equitable transformation; philanthropists must practice "cultural rigor."[38]

REPRODUCTIVE DISORDERS

Black women are also more likely to experience reproductive health disorders such as fibroids and endometriosis. Endometriosis is a condition in which tissue similar to the uterine lining grows outside of the uterus.[39] It is estimated that 176 million women are currently affected by endometriosis.[40,41] Black women are three times more likely to have endometriosis.[40] Since endometriosis can only be definitively diagnosed through laparoscopy (a surgical procedure used to view a woman's reproductive organs), the general prevalence increases in women of older reproductive age due to delayed diagnosis.[40,41] The delayed diagnosis of endometriosis has been suggested to increase the likelihood of infertility.[41]

Uterine fibroids are benign tumors that grow in the uterine wall.[43] Research suggests that fibroids may occur at younger ages and grow more quickly for Black women.[43] This may hinder Black women's abilities to conceive, and put them at an increased risk for complications at delivery, such as hemorrhaging.[43] Only 42% of fibroids in pregnancy are detected clinically, usually when they are large; which leaves room for under detection if they are smaller during the first trimester.[43,44] Given that Black women are three times more likely to have fibroids, it is important to understand its impact on overall maternal health outcomes, including fertility.[43,44]

INFERTILITY AND ASSISTED REPRODUCTIVE TECHNOLOGY

Studies indicate that Black women are disproportionately affected by infertility in terms of prevalence, utilization of treatment, and access to care.[45,46,47] Even after adjusting for socioeconomic status, risk factors, and pregnancy intentions, a U.S. population-based study highlights that Black women between the ages of 33 and 44 are almost twice as likely to experience infertility than white women. However, less than 50% of them will seek medical care.[46] Several studies have confirmed that there is a racial disparity regarding infertility, which prevails through access, pursuit, utilization, and success rates of treatment.[47] Researchers at the University of Michigan have suggested that infertility is a silent issue.[49] A University of Michigan study focusing solely on Black women and infertility found that nearly all women dealt with their infertility in silence. Thirty-two percent of women that participated in the study said they felt incomplete as 'a woman' because they didn't have biological children.[49] Additionally, infertility may impact Black women's sense of self and gender identity.[49]

In regards to Black women's interactions with medical professionals, 26% of participants believed that their encounters might have been influenced by gender, race, and class discrimination.[49] Black women expressed their experiences with doctors who made assumptions about their sexual behaviors, ability to pay for services, or support a child. Another factor that influences Black women seeking care for infertility is the cost of care.[47,49] Presently, a cycle of in vitro fertilization can cost at least $12,000.[49] This estimate does not include the time a woman has to request off work or childcare.[49] Lastly, regarding the pursuit of infertility care and success rates of Assisted Reproductive Technology (ART), research indicates that Black women usually have a longer duration of infertility before seeking care and pursue medical care for infertility significantly less often than women of other racial/ethnic groups in the U.S.[48] Considerations of culturally relevant marketing for fertility treatment and better understanding of Black women's fertility needs are important research approaches to combating infertility disparities.

MISTREATMENT AND RESPECTFUL MATERNITY CARE

One in six women experience mistreatment by healthcare providers during the process of giving birth.[50] Some of the most reported mistreatment experiences include verbal abuse, stigma, discrimination, threatening to withhold treatment or forcing them to accept treatment that they do not want, and delay and refusal of care.[50] Perinatal health experiences across the U.S. have indicated that how individuals are treated during childbirth can impact the health and well-being of the mother, baby, and family.[50,51] Specifically in Black communities, delays and refusals of care are especially significant given that Black birthing people have the highest rates of death from pregnancy-related complications.[50,51] Communities of color experience high rates of mistreatment by healthcare providers during birth, and their experience is supported in a community-led study that examines the birth experiences of people of color in the U.S.[50] In the Giving Voices to Mothers (GVTM) study, Indigenous women were more likely to report experiencing at least one form of mistreatment by healthcare providers, closely followed by Hispanic and Black women.[50]

Rates of mistreatment for women of color are consistently higher even when accounting for other maternal characteristics like socioeconomic status and partner race.

Additionally, this study has highlighted that the place in which one gives birth may impact and influence the rate of mistreatment; roughly 28% of mothers who participated in the GVTM study indicated a higher mistreatment rate in hospital settings than in community birth settings.[50]

Additionally, approximately 13% of participants who gave birth in a hospital setting reported being ignored by health care providers, or providers refused to help after women indicated unusual discomfort; moreover, 7% of participants who gave birth in a hospital setting indicated being threatened by health care providers, or being forced to accept treatment.[50]

Rates of mistreatment for women of color are consistently higher even when accounting for other maternal characteristics like SES and partner race. For example, 27% of women of color with low SES reported experiencing any mistreatment versus 19% of white women with low SES.[50] Lastly, when accounting for partner race, having a partner who was Black also increased reported mistreatment.[50] The experience of mistreatment violates one's human rights. The GVTM study was the first community-led study that highlights women of color experiences with mistreatment.[51] **However, mistreatment experienced by Black women deserves specific investigation.** A study led by Dr. Karen Scott et al. entitled *The SACRED Birth Study: Advancing a Culture of Dignity, Racial Justice, and Equity in Hospital Based Perinatal Care and Experiences for California Health Care Foundation* aims to develop a participatory patient-reported experience measure (PREM) of obstetric racism.[51] It seeks to shift the power of knowledge construction, in the evaluation and transformation of hospital based perinatal care, from Quality Improvement (QI) experts to a community of Black mothers and birthing people.[51] The Sacred Birth Study partners with Black women scholars, about labor, birth, and immediate postpartum care in hospital settings in California. More research is needed to understand the experiences of Black women seeking maternity care. Black birthing and maternal experiences are critical to informing respectful maternal care.

MATERNAL MENTAL HEALTH

Mental health conditions are a leading cause of maternal mortality.[52] Perinatal mood disorders are the number one complication of pregnancy and childbirth affecting up to 1 in 7 pregnant and postpartum women in the U.S.[53] Maternal mental health problems are considered a major global public health challenge.[54] Worldwide, about 10% of pregnant women and 13% of women who have just given birth experience a mental health disorder, primarily depression.[54] Data indicate that at least 600,000 women will develop perinatal depression each year related to a live birth, and the total numbers are likely far higher when other mental health disorders are included.[55] These disorders also have a demonstrated impact on the entire family including the father's mental health and on infant and child development.[55] Black women not only face a higher chance of developing perinatal mood disorders than white women, but they are also less likely to receive treatment due to factors such as fear of stigma, involvement of child welfare services and financial barriers.[56] A report from nine maternal mortality review committees in the U.S. found that mental health problems, ranging from depression to substance use and trauma, went unidentified in many cases and were a contributing factor in pregnancy-related deaths.[57]

Not only are Black women more likely to develop perinatal mood disorders than white women, they are also less likely to receive treatment due to factors such as fear of stigma, involvement of child welfare services, and financial barriers.

Lack of social support, perceived stress, prior history of depression, a history of sexual or physical violence, low SES, age, and poor access to education and healthcare have been most frequently identified as potential risk factors for perinatal depression and other mood disorders among Black women in the U.S.[58] Additionally, Black women experience stress and health disadvantages because of the interaction and multiplicative effects of racism, gender, class, and age.[59] Due to the unique lived experiences of Black women, the Jackson, Hogue, Phillips (JHP) contextualized stress measure was developed to measure race and gender-specific stress for Black women.[60] The JHP contextualized stress measure elaborates the social determinants for the unique stressors and mediators specific to Black women.[60] Black women and Black-led organizations should be uplifted and remain at the forefront in research, development, implementation, and evaluation of mental health solutions that integrate cultural and evidence-based methods to support Black maternal mental health.

CONCLUSION

Black women need the resources, opportunities, and support that will enable them to protect their human right to health and life and to make the best decisions for themselves and their families. Maternal health disparities have many causes, but disparate social conditions, lack of access to quality prenatal care, and substandard maternal and reproductive health care are often key factors. To address the tragedy of the rising Black maternal mortality rates and health disparities, we have to make reproductive justice a priority and ensure Black women have a voice in policies that impact their health care. We must center Black women and birthing people when addressing systemic change and shift culture to improve Black maternal health outcomes. We must center Black women and birthing people's voices, experiences, and traditions when creating solutions to address health inequities in maternal healthcare. Black women and birthing people are deserving of our efforts to change policy, cultivate meaningful research, advance holistic care, and shift culture to improve Black maternal and reproductive health outcomes.

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THE BLACK MAMAS MATTER ALLIANCE (BMMA) is a national network of Black women-led organizations and multi-disciplinary professionals that work to ensure all Black Mamas have the rights, respect, and resources to thrive before, during, and after pregnancy.