Maternal Mortality Rates in African-American Women in the United States: A Narrative Review

An Honors Thesis (HONR 499)

By

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ABSTRACT

In the United States, black mothers are dying four times as often as white mothers. To understand this phenomenon, a model was created using deductive reasoning and the Social Ecological Model to develop the many factors that attribute to the drastic death of black mothers. There are five areas of analysis for black maternal mortality: social determinants, adversely affected health, institutional biases, compounding national issues, and culture identity, and they are all divided into subsections that analyze these factors in greater detail. While this is an incredibly complex and deeply rooted problem within the United States, solutions are presented that serve as a spring board to make a difference, so that black mothers can stop fearing that death can come as soon as she gives life.
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# TABLE OF CONTENTS

I. Abstract ................................................................. 2
II. Acknowledgments ......................................................... 3
III. Process Analysis .......................................................... 5
IV. Introduction ................................................................. 7
V. The Model ................................................................. 7
VI. Social Determinants ....................................................... 9
   A. Geography ......................................................... 9
   B. Income ............................................................ 10
   C. Education ............................................................ 11
   D. Home Environment .................................................. 11
VII. Adversely Affected Health ............................................... 12
   A. Stress Levels ......................................................... 12
   B. Incidental Health Issues ............................................. 13
   C. Chronic Health Issues .............................................. 14
VIII. Institutional Biases ...................................................... 15
   A. Racially and Gender Insensitive Medical Practices ............. 15
   B. Lack of Diversity in US Healthcare Force ...................... 16
IX. State and Federal Policies and Practices ............................ 17
   A. Rising Maternal Mortality .......................................... 17
   B. Healthcare Debates ................................................. 18
   C. Physician Shortages .................................................. 19
   D. Reproductive Rights .................................................. 20
X. Cultural Identity .......................................................... 21
   A. Views Health ......................................................... 21
   B. Collectivism ........................................................ 21
XI. Solutions ................................................................. 22
   A. Legislative Measures ................................................ 22
   B. Institutional Measures .............................................. 23
   C. Personal Measures .................................................. 23
XII. Conclusion ............................................................... 24
XIII. References .............................................................. 25
PROCESS ANALYSIS

As a Biochemistry and Pre-Medicine double major who aspires to be an obstetrician and gynecologist for underprivileged women in urban areas of the United States—and of course, as an African-American woman who would like to be a mother one day—this has always been a topic with which I have personally identified. The research for this topic began as a part of a persuasive speech for the Ball State Speech Team. With this speech, I saw the semifinal round at the American Forensics Association National Individual Events Tournament in April of 2017 at Bradley University and placed third nationally at the National Forensics Association National Tournament in April of 2017 at the University of Wisconsin Eau-Claire. Persuasive Speaking, as an event, requires speaking on a topic you are very knowledgeable about, from memory, in eight to ten minutes. The research began by using academic journals as well as recent media coverage since this topic was being covered by major news outlets around August of 2016 and I also had access to quality literature. Once I had gathered enough information to create a basic outline of problems, causes, and solutions, the speech was then used as a guide to expand upon the many factors that can be equated to the high maternal mortality rate for African-American (AA) women. From these outlined factors, using the Social Ecological model, I created my own predictive model to explain the many connections between various factors and how they are causally linked to high rates of maternal mortality in AA women.

The greatest challenge for this topic was the complex interplay and interrelationships between factors that have been responsible for higher maternal mortality rates in AA women. The data about this topic is certainly there, but the amount of data there that has no connection or no conclusions is disorienting. That was the beauty of creating a model; it organized the information and allows the connections to be made to show meaningful conclusions. However, I
did learn that if there is anything that needs to be improved in the United States is how we collect data and measure health outcomes, particularly for racial and ethnic minority individuals.

For me, this thesis is the product of a topic I was incredibly passionate when I took it on, and am even more passionate about it now. This has genuinely led me to believe that this is what I want to study, what I want to do with my live, and how I want to leave my imprint on the world. This is an issue that, while complicated and deeply rooted in the overarching issue of racism, can start being improved. Black lives do matter, mothers' lives matter, and I hope that this thesis can begin to convince those who read it that black mothers’ lives matter.
INTRODUCTION

Inamarie Stith-Rouse, a 33-year old AA female, was 41 weeks pregnant when she was admitted into Brigham and Women’s hospital in Boston, Massachusetts. She was given medication to induce labor, was sent in for an emergency cesarean section, and gave birth to a healthy baby girl named Trinity. Unfortunately, shortly after delivery, Inamarie developed symptoms of hemorrhage, was admitted for surgery, but tragically suffered brain damage and died after a four day coma. Her husband, Andre Rose, told Amnesty International in their report “Deadly Delivery,” that his wife’s pleas for help went unheeded and her last words were “Andre, I’m afraid” (Deadly Delivery, 2010)

Unfortunately, stories like Mrs. Stith-Rose’s are not unique or unusual in the United States. A recent study published in the journal Obstetrics & Gynecology reported that nationally, AA women die four times as often as White women, with states like DC and Mississippi losing AA mothers at rates proportional to sub-Saharan African countries (American Congress of Obstetrics and Gynecology, 2015; Newman, 2016). This is disconcerting, considering that the United States spends more per capita on healthcare than any other developed nation and has one of the most sophisticated health care technologies in the modern world (Perry, 2016), and should serve as a model for the rest of the world to address racial disparities in healthcare practice and maternal and child health arena. Such prevailing racial/ethnic disparities are making motherhood a potentially life threatening endeavor, and it is an issue that must be resolved.

THE MODEL

To understand why maternal mortality is highest for African-American women in the United States, it is important to acknowledge the numerous factors that attribute to the problem.
To do so, a conceptual model was created to link the very specific causes to their overarching themes, which ultimately connect them to maternal mortality in AA women.

![Diagram of Maternal Mortality for African American Women in the US, based from the Social Ecological Model](image)

**Figure 1: Model for Maternal Mortality for African American Women in the US, based from the Social Ecological Model**

This model is derived from the Social Ecological Model. Social Ecological Models are often used to explain the relationships between social and structural factors, as well as individual practices and the physical environment, and how these factors are all connected in influencing the health of any specific demographic group (McLeroy et al, 1988). For example, in 2005, the Center for Disease Control and Prevention adapted the Social Ecological Model to represent the Colorectal Cancer Control Program’s multi-level approach to colorectal cancer prevention, revealing the multiple ranges of influence, from individuals factors like family relationships and personal ideals, to organizational factors such as Medicaid access and health departments, to policy factors like clinic programs and state/federal legislation (Centers for Disease Control and
Prevention, 2015). By utilizing this model and deductive reasoning, the compounding factors that attribute to maternal mortality for African American women can be understood.

There are five areas of analysis that necessitate a thorough understanding to better evaluate maternal mortality for African American women in the United States: social determinants of health, adversely affected health, state and federal health care policies and practices, current institutional/systematic biases, and AA women's cultural identity. Each factor has more specific areas of discussion that are given further detail and explained below.

SOCIAL DETERMINANTS

The social determinants of health, or the conditions in which people are born into, live, work, and age, play massive factors in the overall health of communities and individuals (World Health Organization, 2015). Thus, to fully understand the health of AA mothers and why they are dying at such rates, it is important to understand each determinant, and how these determinants translate into AA maternal health, mortality, and morbidity.

Geography

In the United States, 14% of people identify themselves as African-American, either alone or as a mixture of another race. The majority (60%) of African-Americans live in 10 states (i.e. Texas, Georgia, and Virginia) with Washington DC holding the highest percentage of AA people amongst states (52%) (US Census, 2010). In these states with high African American populations, majority of them live in urban areas and tend to be lower to middle class in social/economic status. Urban areas can serve as either havens of incredible healthcare opportunities, or they can serve as abysmal places for healthcare (World Health Organization, 2010). For African Americans, it tends to be the latter AA mothers who live in these areas tend to be working class individuals with limited economic resources into which they were most
likely born, and don’t have appropriate means to travel, pay, or care for themselves during pregnancies, placing them at a greater risk for mortality.

**Income**

Perhaps the most noteworthy determinant that affects the health of AA mothers is employment and household income. As of 2010, the mean earning for full time employed AA women is about $39,377. For one individual, with no dependent family members, this amount is well above the federal poverty level. However, for African American women with no spouse present with a family, their median income is $25,417, which, depending on the number of children this woman has, could place her near the federal poverty level, and even in poverty depending on the state of her residence. Additionally, nearly half (46%) of AA female households with no spouse and children 18 years or younger are living in poverty (US Census, 2010). The difference is the women who make $39,377 are generally gainfully employed, have no dependents, and do not have a spousal income upon which they are dependent. The African American women who make $25,417 are mothers, have absent spouses, and are not necessarily considered gainfully employed. Income is a considerable determinant for AA women who are pregnant and seeking maternal care, as these mothers must find the means to pay for pre-natal care, which unfortunately, most AA mothers do not receive. Additional burden is imposed by the limited ability to travel and find those that provide reproductive healthcare, medications, and childcare.

In studying the AA women’s income, employment is to be taken into consideration as well. As of 2010, majority (62.7%) of AA women over the age of 16 are in the civil labor force, and almost a tenth (9.9%) of them were considered unemployed and were actively looking for work (US Census, 2010). However, AA mothers are often more likely to be unemployed because
of their pregnancy, or denied scheduling modifications, and they are more likely to be denied maternity leave and cannot take the appropriate time to recover from (National Partnership for Women and Families, 2016). For black women without a means of income, these scenarios worsen, putting them at risk of maternal death.

**Education**

Education also plays a role in the overall health of African American women due to the direct and indirect influence of educational attainments. As of 2010, the vast majority (83.2%) of AA women have a high school diploma or equivalent or higher, while only a fifth (19.85)% had a baccalaureate degree or higher. Additionally, less than two thirds (60.5%) of AA children were enrolled in a school kindergarten through 12th grade (US Census, 2010). Generally speaking, these are good signs as education is becoming more and more prevalent in the United States, not only for young children, but for adults pursuing higher education. However, because of where many African Americans are populated—urban areas that prey on lower class people—educational systems tend to be corrupt and damaged or expensive if the public school system were to be avoided. This leads to poorer educations for African Americans in these areas, which then leads to poor incomes and shorter, less healthy lives (Johnson, 2013). This also attributes to the lack of education amongst African American women about what the appropriate health and wellness related steps are during childbirth and pregnancy.

**Home Environment**

When speaking about home environments, the marital statuses of African American women and whether or not they were previously mothers or have children needs to be considered for pregnancy related outcomes. As of 2010, 33% of African American women were married and not separated and 46.7% of African American women were never married, with 18.4% being
divorced or separated (US Census, 2010). Women that are married and are assumed to be in healthy marriages tend to have the benefit of financial stability, insurance coverage, and other marital benefits. However, for women that are single, their resources are more limited for finding help during cases of unintended pregnancies or when pregnancy complications arise.

The issue becomes more complex when children and families are present. Majority (63.6%) of African American households are familial households with 32.6% of them with children. However, more of these households are matriarchal with no father present than married couple households: 29.8% and 27.8% respectively. For mothers that are the sole breadwinner in their household, especially the 17.6% of these female only households with children (Census 2010), black mothers face very limited resources. Additionally, their health tends to be poorer, and they must front childcare on their own, which is on average one-fifth of a median household income (Zarya 2016), leaving them without many options of take time off of work after delivery, exacerbating any complications persisting postpartum.

ADVERSELY AFFECTED HEALTH

Generally, racial and ethnic minorities have poorer health than White Americans. This is the result of several compounding factors, including economic disparities, education, geography, lack of access, and blatantly lower-quality care. This is a major factor that contributes to AA mothers dying at greater rates than White women, as AA women experience higher stress levels and increased risks for both incidental, or non-chronic, illness, and chronic illness.

Stress Levels

One hypothesis for this increase in deaths amongst African American women is that AA women experience drastically higher exposure to acute and chronic stressors, with many of these stressors related to racism and discrimination (Associated Press, 2012).
In a normal, well-monitored pregnancy, maternal cortisol, or stress levels, can increase two- to four-fold over the course of a full term pregnancy. These stress levels are required for any full human gestation, as they prepare the fetus for birth and are crucial for certain developmental processes, such as the development of fetal lungs, neural system development, and regulation of emotional and cognitive function. However, when the fetus is overexposed to maternal cortisol, it can result in low birth weight, disruptions in cognitive fetal development, and premature delivery (Davis and Sandman, 2010). This abnormal process also directly affects the health of the mother, increasing risks of heart disease, high blood pressure, preeclampsia, and other illnesses that contribute to early maternal death (Hogue and Bremner, 2005).

AA women, while also faced with the increased stressors of pregnancy, face the constant stress associated with, for lack of a better term, being “Black”. It is not surprising that those of a low socioeconomic status experience additional work, family, and community stress than those that aren’t compounded with the stress of poverty and racism; however, African American women of the same socioeconomic status as White women still face increased risks of unemployment, illness and death, family instability, and criminalization (Guerra, 2013). Because of the ever existing presence of this kind of stress in life of AA mothers, it places AA women at a greater risk for complications during and after pregnancy.

Incidental Health Issues

Incidental or non-chronic health issues used to be the leading cause of death among mothers in the United States (Frostenson, 2016). This includes infections from surgery like cesarean sections, pregnancy-induced hypertension, placental abruption, and postpartum hemorrhaging. In a recent study published in the American Journal of Public Health, the authors reported while comparing the pregnancies of African American and White women, the prevalence of these
illnesses, were no higher in AA women than in White women (Tucker et al, 2007). On average, White and Black women have the same risk of suffering from these illnesses during pregnancy. However, when reviewing the case-fatality of these illnesses within Black and White women, Black women died on average two to three times more often than White women. While this may be attributed to the access to hospitalization, any preexisting health issues, or the debate of race being a social construct rather than a biological construct, it cannot be ignored that White women face the same prevalence of incidental health issues as Black women, but Black women are dying at disproportionally higher rates from these illness.

**Chronic Health Issues**

As of 2006, chronic health issues such as cardiovascular conditions, high blood pressure, and obesity are now the leading causes of maternal mortality in the United States. Cardiovascular diseases, between 2011 and 2013, made up 15.5% of pregnancy-related deaths, which was a significant increase from the 3% of pregnancy related deaths between 1987 and 1990 (Frostenson, 2016). These illnesses also place AA women at an increased risk to die during or after childbirth. For example, a study conducted by the National Institute of Health found that AA women have a prevalence of hypertension that is two times greater than White women, which also leads to an increased risk for preeclampsia and eclampsia (Geronimus et. al, 1991). Black women are also twice as likely to suffer from cardiac arrest during pregnancies, which is attributed to their increased risk of heart disease (Mhyre et. al, 2014).

Obesity is also a chronic health risk factor that leads to the increased deaths of AA mothers, as AA women are one and a half times more likely to be obese than White women, with 20.5% of African American girls being obese in 2011 (State of Obesity, 2014). Because obesity
has a direct correlation to increased rates of hypertension, heart disease, and diabetes, these are all compounding factors that cause AA mothers to die more than white mothers.

INSTITUTIONAL BIASES

The Oxford University Press defines institutional bias as “A tendency for the procedures and practices of particular institutions to operate in ways which result in certain social groups being advantaged or favored and others being disadvantaged or devalued.” While these biases may not be of any conscious prejudice or discriminatory beliefs, they are the result of passed down practices that the majority of the institution blindly follow that were never broken from a previously discriminatory system (Oxford Reference, 2017). Maternal care, or rather healthcare in general, is an institution riddled with these biases, placing AA women at an increased risk of death in child delivery.

Racially and Gender Insensitive Medical Practices

Whether or not it is conscious or unconscious racial or gendered discrimination, some practices in the United States maternal care system are biased against African American women. For example, a study at the University of Virginia found that medical students and professionals still hold deeply racist beliefs about the biological differences between AA and White Americans, with stereotypes such as “Black people feel less pain” and “Black people’s blood coagulates faster.” This undoubtedly leads to the under prescription of pain medications for African American patients (coupled with the over prescription for white Americans), and the under treatment of pain symptoms for black patients (Trawater et. al., 2012). There is also a systematic bias against women for treatment, as women’s pain often goes undertreated by medical professionals (National Pain Report, 2014). For AA mothers, this means their cries of pain in maternity wards or during delivery can go ignored by hospital staff, warranted as
exaggerated and leaving black mothers with untreated infections, pains, and potentially deadly diseases and conditions.

These racial and gender disparities also manifest in the cesarean rate for A mothers. Currently, the United States is well above the World Health Organization’s ideal cesarean section rate of 10 to 15% for a developed and high functioning nation, with one third of all deliveries resulting in a C-section (World Health Organization, 2015). For AA women, more than a third (35.8%) of all deliveries result in C-sections. Often, these are not the choices of AA women, as two thirds of first time C-sections are of the doctor’s decision. Minority women, particularly AA women, are subjected to C-sections by physicians because women of low socioeconomic status have less power when dealing with physicians and C-sections earn physicians more money on average than natural deliveries. This places AA women at higher risk of infection as a result of cesarean sections, leaving AA women ten times more likely to die from these complications (Grant, 2016).

Lack of Diversity in US Healthcare Workforce

The racial divide in physician practice, health outcomes, and maternal healthcare is arguably due to a lack of diversity amongst medical and health professionals. Specifically, the United States doesn’t have enough AA female physicians or gynecologists. Initially, AA students are more reluctant to become physicians because of financial constraints, lack of role models in the medical profession amongst their communities or on TV, and the racial disparities that unintentionally discourage AA youth from entering the medical field. In fact, there are fewer AA students applying to medical school now than there were in 1978 (Rao and Flores, 2007). Additionally, women are also not encouraged to become doctors over becoming physician’s aids or nurses, as female doctors across the board make 64 cents to a male doctor’s dollar in pay, and
only make up 5% of major medical boards. Together, this results in only two percent of practicing physicians in the United States being AA women, making them an overwhelming minority in the medical profession (Emery, 2017).

This is extremely pertinent to the care of AA mothers during and after child birth. It is not to say that only AA female physicians can treat Black female patients, but having more doctors that at least fall amongst one of these marginalized groups have better empathy and understanding to treat patients of the same marginalization. Ultimately, without doctors that are empathetic toward AA women; their bodies; and their children; Black women will continue to receive poor treatment from doctors with unconscious biases, risking their lives in the process.

STATE AND FEDERAL POLICIES AND PRACTICIES

Many of the causes presented for the astoundingly high Black maternal mortality rate are directly related to Black women, from their health to the racial insensitivity of the maternal healthcare system. However, there are also compounding national issues that, while they do not only affect African American women, these are factors that affect their maternal mortality rate.

*Rising National Maternal Mortality*

While AA women’s maternal mortality rate has always been higher than White women in the United States, the United States has also been experiencing a rise in maternal mortality. The United States has experienced a 26.6% increase in maternal mortality—18.8 deaths for every 100,000 live births in 2000 to 23.8 deaths for every 100,000 live births in 2014. While California has decreased its maternal mortality over the last several years—from 21.5 deaths per 100,000 live births in 2003 to 15.1 deaths per 100,000 live births in 2014—Texas’s maternal mortality rate doubled in a span of only five years—18.6 deaths in 2010 to 35.8 deaths in 2014 (MacDorman, 2016).
This is a surprising development, considering global trends regarding maternal mortality. After the United Nations initiated its eight Millennium Development Goals in 1990, including a decrease of the maternal mortality rate by 75%, the global maternal mortality rate decreased approximately 44%—385 deaths in 1990 to 216 deaths in 2015 (UNICEF, 2017). It is important to note that the United States, in comparison to low-income countries, still has a tremendously low maternal mortality rate; the United States has the 48th lowest maternal mortality rate globally, while South Sudan, the country with the highest maternal mortality rate—2,054 deaths per 100,000 live births—is almost 86 times higher than the maternal mortality rate in the United States (Central Intelligence Agency, 2016). However, maternal mortality has a direct correlation to the state of healthcare in the region, indicating that the state of healthcare in the United States is on a downturn. Because Black women are most at risk of death during and after pregnancy, this directly affects their maternal health; if the maternal mortality rate in general is increasing, it is definitely increasing for Black women.

Healthcare Debates

Because Black women's maternal mortality can be attributed to a lack of health care access, insurance and beyond, it is important to discuss the debate of healthcare in the United States. The United States' healthcare system is principally in the private sector, with most Americans benefiting from private health insurance coverage either from work or from a private company. Those in the public sector benefit from federally funded insurance programs, such as Medicaid and Medicare. However, in 2016, 30 million Americans were still uninsured, with 12.2% of those people being African American under the age of 65 (Collins et al, 2016). To alleviate this, 32 states have adopted a Medicaid Expansion to cover people within 133% of the poverty line; the Medicaid expansion was a part of the provisions from the Affordable Care Act,
enacted during the Obama administration in 2010 (Kaiser Family Foundation, 2017). However, the 19 states that didn’t, including Alabama and Texas, have sizeable African American populations, which attributes to the racial disparities in insurance coverages. By failing to institute a viable reform to establish appropriate healthcare coverage for all Americans, especially for African American women, the disparities present in maternal care will not been corrected; this will continue to contribute to the high death rate of AA mothers.

Physician Shortages

Unbeknownst to many in the American population, the United States is in the midst of an obstetrician/gynecologist (OB/GYN) shortage, leaving many women without a regular physician or one to care for them during pregnancy. According to the American College of Nurse-Midwives, nearly half of all counties in the United States lack a practicing OB/GYN, and this will only worsen over the next few years. The national demand for women’s health professionals is predicted to grow 6% by 2020, meaning the United States will need a clinical equivalent of 2,090 full-time OB/GYNs (Dall et. al., 2013). The shortage, however, is expected to intensify, with the American Congress of Obstetricians and Gynecologists estimating 6,000 to 8,800 fewer OB/GYNs than necessary by 2020, and 22,000 by 2050 (Ollove, 2016).

Because of this shortage, there are approximately 29 physicians per 100,000 women that are unevenly disturbed across the country, leaving one gynecologist responsible for 3,448 women on average. Thus, when pregnant mothers need on average 10 to 15 prenatal visits, and one or two postpartum visits, travel is very difficult and expensive; this is especially true for women in lower socioeconomic classes, primarily African American women (Levy, 2016). While midwives are rising in popularity, they still lack the certification and clout in the medical
field to provide these services like OB/GYNs, only exacerbating the issues faced by mothers, especially AA mothers.

Reproductive Rights

The debate surrounding reproductive rights in the United States has never been an easy one for any women, and it has been especially problematic for Black women. In much of the advocacy encompassing women’s reproductive rights have distinctively left out Black women, with the rise of White feminism in the third wave feminist movement. In the Winter/Spring 2001 Issue of Political Environments, a publication of the committee on women, population, and the environment at University of California at Berkeley Law, executive director of the Chicago Abortion Fund Toni Bond puts it best:

“The charge of the reproductive rights community must stop merely giving lip-service to the notion of organizing around a broader spectrum of reproductive health. That means remaining steadfast and committed to devoting time and energy to issues beyond abortion. It means...listening and hearing women of color... It also means confronting the racist assumption of “ownership” of this movement. The reproductive health of women of color is in serious jeopardy.” (Bond, 2001)

Even conversations about abortion leave out Black women, considering Black women still die approximately two to three times as often as White women from abortion-related complications do and AA women make up 37% of abortions (Zane et al, 2015). What should also be considered is the issue of access to abortions and contraception for AA women, especially because 98 out of every 1,000 pregnancies for Black women of reproductive age are unintended (Guttmacher, 2016). There is an inherently unjust and unfair stereotype that Black women, more often than White women, are child bearers, and the Reproductive Rights
Movement should not only acknowledge these disparities, but help fight these disparities in abortion and contraception access for black women as well as White women.

CULTURAL IDENTITY

There are some portions of healthcare for African Americans that are dictated by personal beliefs. This does not in any way blame African Americans for their health; however, it is important to understand the cultural norms that may lead to a poor relationship with the healthcare system, ultimately attributing to the maternal mortality rate for black women.

Views of Health

African Americans on average are more distrustful of the healthcare system and of health providers. This is not surprising, as this is rooted in the current and historical racial inequalities that are credited for inequitable treatment of African Americans by the healthcare system, almost certainly fueled by the legacy of the Tuskegee study. This also deals with the interpersonal communication between Black patients and their physicians, between Black patients and their insurance providers, and the general characteristics of their physician (John Hopkins Press, 2008). Ultimately, this leads to African Americans delaying certain health treatments: for Black mothers, this may attribute to prolonging pre-natal and post-partum visits, or waiting to schedule deliveries with maternity wards. While guesses have been made about how the more religious sectors of American Africans view health from a religious standpoint, but other than anecdotal evidence very little research has been done.

Collectivism

Another portion of the African American identity that may affect their health deals with reliance in their own community, and health decisions tend to be made using a collective sense of being rather than an individualistic cultural identity. Ultimately, African American culture
harbors a sense of a "your decisions affect the community" type of narrative (Kline, 2007). Thus, Black women may be more reliant on family or friends to make decisions regarding their health, especially from elder women in their families—mothers, grandmothers, aunts, etc. However, when AA mothers lack this support, or are discouraged by their family for certain types of care, this can play a role in lacking appropriate healthcare knowledge or increased complications during pregnancy and delivery.

SOLUTIONS

A problem to this scale is not one that can be resolved immediately. Realistically, it would take drastic reform on both legislative and institutional levels to even begin making a dent in this drastic disparity. However, as the United States begins to move toward resolving the inequities of maternal care, some short term solutions have been presented to begin a future of healing and of righting this wrong.

Legislative Measures

Some would argue that in our current political climate, advocating for legislative reform toward national healthcare isn’t an issue that can gain bipartisan support. However, the House of Representatives introduced H.R. 1318 to the 115th congress on March 2nd, 2017. This bill, known in its text as the Preventing Maternal Deaths Act of 2017, was introduced in a bipartisan effort by United States Representatives Jaime Herrera Beutler, a republican from Washington state; Diana DeGette, a democrat from Colorado; John Conyers, a democrat from Michigan; and Ryan Costello, a republican from Pennsylvania. The bill aims to do the following:

"To support States in their work to save and sustain the health of mothers during pregnancy, childbirth, and in the postpartum period, to eliminate disparities in maternal health outcomes for pregnancy-related and pregnancy-associated deaths, to identify
solutions to improve health care quality and health outcomes for mothers, and for other purposes.” (H.R 1318)

Thus, it addresses not only the maternal mortality rate in the United States being on the rise, but it aims to improve data collection and correct the racial disparities between White and Black mothers. It has most recently been referred to the subcommittee on Health on March 17th, 2017 so the best course of action is to contact representatives in these subcommittees and express the desire of the American people to pass this bill, in the hopes that it becomes law.

**Institutional Measures**

On an institutional level, the best way to improve the treatment of AA mothers by doctors is to make physicians aware of the institutional biases they may be perpetuating. To combat this, the Association of American Medical Colleges is beginning “Unconscious Bias Training for Health Professionals,” otherwise known as the Everyday Bias Workshop. This workshop caters to current and future physicians to explore how the “assumptions [of race and sex] impact choices around communication, innovation, hiring, engagement, management, promotion, marketing, and building organizational culture” (AAMC). Workshops are available through certain universities, like Vanderbilt and New York, but those interested can take the “Train the Trainer” Workshop to host workshops in areas where the workshop is needed. Hopefully, this will provide a springboard for health professional programs to start training their physicians to take these biases into consideration and be more cognizant when treat women of color (Association of American Medical Colleges, 2017).

**Personal Measures**

There are personal solutions that individuals can take to advocate for AA mothers’ lives. AA mothers are often left out of the conversation of advocacy for women’s and mother’s rights,
and in an era where advocacy is so easily accessible and can be spread to literal worldwide audiences, there are several resources available for those interested in advocacy. One organization leading the charge is Black Mamas Matter, a partnered initiative created by the Center for Reproductive Rights and Sistersong Women of Color Reproductive Justice Collective. As a woman-led, cross-sectional alliance, they aim to change policy, cultivate research, advance care for black mothers, and shift the conversation on black maternal health to amplify their voices. They’ve also created a tool kit to help distill outcomes on conversations about race, reproduction, parenting, and rights into concrete steps to improve black maternal care (Black Mamas Matter, 2017).

They are one of several organizations to fight this fight, including the Maternal Health Task Force, the Black Women’s Initiative, Sistersong, and Black Mother Birthing Justice. One could donate or advocate for any of these organizations, as well as garner support through their own form of advocacy. One of the greatest ways to fight an issue to make the world aware it exists and to educate the masses on why they should care and why they should be fighting. These mothers deserve justice, whether or not they are alive or dead, and these personal measures, as well as the other proposed solutions, can make a difference, even if it’s a small one.

CONCLUSION

Trinity Rose is 12 years old now, and she never knew her mother. Inamarie’s story is tragic, but it’s certainly a story that deserves to be told. Hopefully, by delving deeper into the disparities that Black mothers face in maternal care, one can have a better understanding to help more women like Inamarie, Black mothers across the United States, so that death is the last thought these women have when they bring about new life.
REFERENCES


