Structural Racism and Maternal Health Among Black Women

Jamila K. Taylor

Introduction

The United States has the highest maternal mortality rate among comparable countries in the developed world.[1] While the overall rate of 17.4 per 100,000 live births is cause for alarm among all American women, Black women are dying more than any other racial or ethnic group.[2] The widest disparity is seen when compared with white women, where Black women are two to three times more likely to die of pregnancy-related causes.[3] They are also more likely than white women to experience severe maternal morbidity, also known as "near misses." Based on qualitative research designed to highlight the personal stories of women and their experiences during the birthing process and up to a year after giving birth, poor maternal health outcomes among Black women cannot solely be attributed to social determinants like poverty and educational attainment, or access to health care.[4] I assert that structural racism is a powerful social determinant of maternal health that has roots in a historical system of oppression and devaluing of women of color, and persists today in more subtle health care policies and practices.

The Aspen Institute defines structural racism as a system where public policies, institutional practices and cultural representations work to reinforce and perpetuate racial inequity.[5] Under this definition, dimensions of American history and culture, which have allowed privileges associated with "whiteness" and disadvantages associated with "color," are connected in ways that have adapted and endured over time. The Aspen Institute affirms that structural racism has been a mainstay of the social, economic and political systems in which we all take part, and this article considers how this has shaped maternal health in U.S. health care.

This article first provides an historical overview of reproductive oppression in America. It discusses how racism has been integrated into the structures of society, including public policies, institutional practices, and cultural representations that reinforce racial

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inequality, particularly as it pertains to maternal health. Important historical examples rooted in reproductive oppression include the advent of the study of obstetrics and gynecology with the use of enslaved Black women's bodies; forced sterilization and promotion of birth control among low-income Black women as a condition of social welfare programs; and ignoring Black women's pain.

Next, this article analyzes how that oppression has perpetuated racial inequalities in health care and contributed to poor maternal health among Black women. The vast racial disparities in maternal mortality among Black women and white women are discussed, and the harmful institutional practices by health care providers which are rooted in negative cultural representations of Black women are presented. Finally, solutions are offered for improving important public policies and health practices to ensure the continuum of quality health care that is equitable and respectful of Black women, including reforms that address bias and racism within the health care system.

This article analyzes how that oppression has perpetuated racial inequalities in health care and contributed to poor maternal health among Black women. The vast racial disparities in maternal mortality among Black women and white women are discussed, and the harmful institutional practices by health care providers which are rooted in negative cultural representations of Black women are presented. Finally, solutions are offered for improving important public policies and health practices to ensure the continuum of quality health care that is equitable and respectful of Black women, including reforms that address bias and racism within the health care system.

Historical Foundations of Racism and Suppression of Reproductive Freedom

The experience of the female slave was one of peculiarity and much different from the experience of the male slave. In a time when Black people had no rights that were recognized under U.S. law, Black enslaved women found themselves struggling to control their own bodies. Slaveholders held significant interest in the reproduction of black women in the decades before the Civil War.[6] Black enslaved women held an important role in the plantation south as their capacity to bear children was exploited, while they were also expected to tend to their daily workloads oftentimes enduring extreme physical labor — pregnant or not pregnant.[7] According to Dorothy Roberts in *Killing the Black Body*, whites' domination over Black women's wombs to sustain a system of slavery provided an early model for reproductive control.[8]

In 1662, the law made the children of enslaved women the property of the slave owner.[9] Hence, plantation owners could increase their wealth by controlling their slaves' ability to reproduce. Plantation owners expected to increase profits anywhere from five to six percent through the reproduction and increased fertility of enslaved women.[10] In 1808, a ban on the importation of slaves made the reproduction of slaves even more valuable.[11] Thomas Jefferson expressed the importance of childbearing enslaved women in *Thomas Jefferson's Farm Book* by the statement, "...a woman who brings a woman every two years is more profitable than the best man on the farm."[12] The reproduction of slaves has been used to explain the growth of the slave population to 1.75 million by the year 1825.[13]

The keen interest of plantation owners in the reproduction of enslaved women encouraged the owners to take extreme measures to ensure that these women could not only conceive, but also bring a fetus to full term. Techniques were used to enhance fertility, including rewarding pregnancy with relief from work in the fields and the provision of food and clothing. Enslaved women who did not bear children were often punished by being forced to breed or through manipulated marital practices.[14] Others were threatened that they would be sold off to other plantations, leading to separation from family and loved ones. Infertile enslaved women were treated like damaged goods; slave owners wreaked havoc on these women with physical abuse and torment in times where they perceived the failure to bear children as a loss to profit. Some enslaved women who did deliver numerous children, and in short periods of time, were rewarded

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freedom. However, for many of these women "freedom" never came: One woman was offered manumission for bearing twelve children. She died one month before the birth of her last child.[15]

"Forced-mating" was also an important aspect of reproductive control during the antebellum period. A practice known to be widely perpetuated by slave owners, enslaved people that were considered "prime stock" were forced to mate in order to produce children of the same stature and ideal for purchase in the labor market.[16] Systematic breeding was two-pronged: it involved interference in the sexual relations of slaves for the purpose of increasing female fertility and also the raising of enslaved people for the primary purpose of sale — all in the same vein as cattle or livestock.[17] Enslaved women could expect to be pregnant every eighteen months to two years.[18]

The sexual exploitation of enslaved women also played a major role in their subjugation. Even on slave ships, Black women were raped as a method of torture after being made to strip completely naked.[19] For it was then that the threat of sexual abuse and other physical harm pervaded the minds of African women en route to the Americas. Surely, they knew that this was a preview of the torment they would experience while living in captivity. There were no laws in place to protect enslaved women from the crimes imposed on them by slave owners.[20]

Mothers were not permitted time off from work to return to infants if they needed to care for them. Becoming a mother did not preclude the lengthy physical labor that women endured daily. Infants were either brought into the fields with their mothers or left at home unattended for hours at a time.[21] In fact, infant mortality was very prevalent on plantations due to lack of attention to the infant because of their mother's seemingly endless work schedules, as well as the short intervals for which female slaves were expected to bear children.[22] The infant mortality rate among enslaved people in 1850 was twice that of whites, and less than two out of three Black children lived to see the age of ten.[23]

Medical Legacy, Experimentation, and Mistrust

In the plantation south, slave owners sought the assistance of physicians in the management of Black women's fertility.[24] According to Marie Jenkins Schwartz in *Birthing A Slave,* the owners had become familiar with new training practices and the sophistication of surgical procedures to reproductive organs by medical doctors by the mid-nineteenth century.[25] The new surgical procedures in the area of women's health served to enhance plantation productivity as the United States ceased the importation of slaves in 1808.[26] The use of a "scientific approach" to plantation management ushered in a new era of slave breeding, coercion, medical experimentation, and the neglect for reproductive freedom.

Treatment of infertility among black female slaves often proved to be injurious and painful. In the 1800s, much of it was experimental. Some doctors relied heavily on experience and observation in the study of gynecologic medicine, yet the support of scientific method was precluded. Black enslaved women were picked and prodded with all types of surgical instruments. Anesthesia was not used in most cases. Morphine was over-used as a way to drug Black enslaved women as well as to assist in reducing the screams that resulted from undergoing invasive vaginal surgeries. A physician named Nathan Bozeman came to be a popular gynecologic surgeon who operated on enslaved women in Alabama.[27] He tested a surgical technique in the repair of vesicovaginal fistula, a condition that developed in women after enduring prolonged labor.[28] Kitty, the eighteen year-old enslaved girl on whom Bozeman conducted the experimental surgery, was bedridden for two months following the procedure.[29] Due to her condition, Kitty could no longer have children nor could she return to work. Much of Kitty's recovery was spent confined to a stool with a hole in the seat — designed to collect the urine that would trickle from her vagina.[30] Needless to say, Kitty's owner ended up losing more than he had gained with the loss of productivity and revenues due to Kitty's debilitating condition as the result of Bozeman's experimental surgery. Despite this outcome, physicians in the antebellum South had specific orders to ensure that reproductive conditions did not negatively impact an enslaved woman's ability to bear children on the plantation.

Harriet Washington in *Medical Apartheid* highlights the image of an enslaved woman who was subject to experimental gynecologic surgeries. The image was painted by Robert Thom in *J. Marion Sims: Gynecologic Surgeon*. The enslaved woman portrayed in the painting, named Betsey, is kneeled calmly at a small table before three white physicians with her hand at her breast.[31] Two other enslaved women are also portrayed in the painting with looks of curiosity on their faces. Washington describes the painting as an "innocuous tableau" that differs greatly from the real surgical scene that plagued enslaved women as they struggled to protect their bodies from physicians.[32] The Black enslaved woman was often forced and restrained by physicians only to experience intense pain and suffering as their genitals were sutured without anesthesia.[33] At times, other enslaved people were ordered to help restrain the women undergoing the surgical

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procedures.[34] Sims, like Bozeman and other physicians of their time, contributed to enslaved women's addiction to morphine as the powerful drug was used as they underwent the experimental surgeries without consent for many years. This proved to help advance the study of gynecology and subsequently heal white women of their reproductive injuries and illnesses.[35] The aforementioned examples add to the decades-long history of mistreatment, experimentation, and exploitation of Black people by the medical establishment. These practices have continued on, leading to inferior treatment practices and poor medical care, even in maternal health today, which will be articulated later in this article. As the nineteenth century approached, the reproductive injustice of Black women changed into that which was further institutionalized through sterilization and eugenic control.

Compulsory sterilization epitomized the two-sided character of eugenics as a means of social-sexual control. Its focus was on attacking populations thought to be expendable or threats to American society.[36] Low-income women and women of color were demonized as their sex and reproduction were symbolic of all that was wrong in society. Eugenics was used to label Black women as "sexually indiscriminate" and as bad mothers who would give birth to defective offspring.[37] This demonization of Black mothers as behaviorally and medically unfit has had a long history. A medical doctor named Harry J. Haiselden prayed on Black mothers and gained fame by openly admitting to news media and medical journals that he allowed Black babies to die based on eugenic beliefs.[38] Scientific racism helped to further perpetuate the biological foundation for these ideals. The eugenics movement and the scrutiny that accompanied it forced Black women and other women of color into sterility.[39] This can also be seen in the institutionalization of eugenics and forced sterilization that occurred across the United States in the early 1900s.

A small number of eugenicists had successfully pushed for legislation that authorized states to sterilize women in the interest of social wellness.[40] For example, Indiana passed the first eugenics law in 1907.[41] The passage of this law ushered in a trend for the institutionalization of eugenic control and sterilization — between 1905 and 1922, eighteen states passed a total of thirty bills authorizing involuntary sterilization. Several states even had two or three sterilization statutes on the books at one time. In 1923, new compulsory sterilization laws were put into place. In some states, including Montana, Delaware, and Oregon, compulsory sterilization statutes were compiled with court rulings. These new laws included procedural mandates that included hearings, jury trials, and appeals processes used to comply with opponents' due process claims. Opponents challenged the constitutionality of the laws time and again, yet in 1927 the Supreme Court upheld Virginia's sterilization law in the *Buck v. Bell* decision.[42] Following that decision, thirty more states adopted similar statutes by 1942. Sterilization rates also increased greatly to over 38,000 in the United States by 1941, with between 2,000 and 3,000 sterilizations performed annually.[43]

The South became the first region to perform forced sterilizations, although sterilization abuse was not confined to the southern region. In 1972, the *Boston Globe* reported that Boston City Hospital was conducting hysterectomies on Black patients at high rates.[44] Other incidents were reported at New York municipal hospital where low-income Black, Puerto Rican, and Native American women were targeted and given unauthorized hysterectomies.[45] At the time, hospitals had no policies requiring informed consent. Physicians, social workers, and members of state eugenics boards worked together in the sterilization of low-income Black women with the intention of reducing the number of Black women eligible for public assistance.[46]

Black Women and the Reproductive Health, Rights and Justice Movement

The resistance of Black women is also a notable component of the historical foundations of reproductive oppression. Liberation in the form of reproductive freedom was essential to their movement work on other issues plaguing the Black community, and that work continues on today. After abortion became legal under *Roe v. Wade* in 1973, women of color organizations began to use the term "reproductive justice" in recognition of the control, regulation, and stigmatization of female fertility, bodies, and sexuality which were all connected with the white control of communities.[47] This control was based on race, class, gender, sexuality and nationality.[48] If Black women and other women of color were to address the assault on their reproductive freedom, they also had to emphasize the interconnectivity of reproductive rights, human rights, and economic justice. According to Loretta Ross — a founding mother of reproductive justice, "Our ability to control what happens to our bodies is constantly challenged by poverty, racism, environmental degradation, sexism, homophobia, and injustice in the United States."[49] The ability to have a child and not have a child, and to do so with dignity, respect, and all of the available resources and supports needed to live well and thrive, are key pillars of reproductive justice.

Black women's organizations played a key role in ensuring that the needs of Black women were not forgotten as white women focused on advocating for the

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legalization of abortion. In 1973, the National Council of Negro Women responded to the narrow focus of reproductive rights as abortion rights. A response to an editorial in support for *Roe v. Wade* was submitted by the organization stating that:

> The key words are "if she chooses." Bitter experience has taught the Black woman that the Administration of justice in this country is not color blind. Black women on welfare have been forced to accept sterilization in exchange for continuation of relief benefits and others have been sterilized without their knowledge or consent. A young pregnant woman recently arrested for civil rights activities in North Carolina was convicted and told that her punishment would be to have a forced abortion. We must be ever vigilant that what appears to be on the surface to be a step forward, does not in fact become yet another fetter or method of enslavement.[50]

The narrow focus on abortion effectively neglected the intersecting oppressions of race, class, and gender. Touting this focus as "choice" implied that all women had the right to make determinations about their bodies, hence deeming their bodies legally protected. "Choice" in these terms ignored the fact that economic and institutional barriers restricted the "choices" of Black women.

Other Black women's groups followed the lead of the National Council of Negro Women and began to weigh in on reproductive freedom. The Women's Political Association of Harlem was the first Black women's club to schedule lectures on birth control.[51] The group demanded that the American Birth Control League open birth control clinics in Black neighborhoods as the ability of Black women to control their fertility would help to improve their economic and social well-being. Black churches also organized public meetings about family planning, and leading organization like the National Association for the Advancement of Colored People (NAACP) and the Urban League promoted birth control as part of their agendas.[52] Approximately 2.5 million Black women were taking part in social and political clubs by 1949.[53] Most of these organizations supported Black women's access to birth control and legal abortion. They also publicly decried the use of eugenics and sterilization that espoused earlier efforts to deny low-income women of color reproductive freedom. In the years to come, Black women would continue to organize around reproductive justice — taking into account the economic disadvantage and sexual discrimination that many of them experienced in their daily lives.

During the 1960s and 1970s, Black women activists made reproductive freedom a key component in the struggle for civil rights. Francis Beal, head of the Black Women's Liberation Committee of the Student Non-Violent Coordinating Committee (SNCC), expressed the right of women to decide whether or not to have children in 1970.[54] Other Black women leaders like Shirley Chisolm and Toni Cade Bambara insisted that in order for Black women to be free from poverty and welfare, they had to begin taking control over their bodies. The National Council of Negro Women broadened its agenda in 1970 to also take a supportive stance on birth control and reproductive freedom. Under the leadership of Dorothy Height, the Council also worked to ensure that other civil rights organizations understood the implications of reproductive freedom for Black women.

The examples laid out in this section aim to present the historical context and foundations of racism, in both explicit manifestations and covertly through America's structures and institutions. These historical foundations serve as a grounding in understanding the racialized norms and practices seen in public policy and health care today. The norms and practices of discounting the pain of Black patients, institutionalizing reproductive control through public policy, and the stereotyping of women of color and low-income women. According to the seminal text *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare,* racial and ethnic disparities in health care occur in the broader historic context and contemporary social and economic inequality.[55] The forthcoming examples in this article are reminiscent of the history outlined in this section, yet they have taken different forms and manifestations in the lives of Black women in the present. I argue that they are contributing factors to high rates of maternal mortality among Black women in America, as well as the vast maternal health disparities when comparing pregnancy-related outcomes for Black women and white women. Both are evidence of persistent racial discrimination.

Structural Racism & Maternal Mortality and Morbidity in America Today

The World Health Organization defines maternal health as the health of women during pregnancy, childbirth, and in the postpartum period.[56] High rates of maternal mortality and morbidity present major public health concerns for the United States. According to the Centers for Disease Control and Prevention, approximately 700 women die each year in this country due to pregnancy-related complications.[57] Most of these deaths are preventable. Severe maternal morbidity occurs when pregnancy-related complications

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result in significant health consequences in both the short and long term for women.[58] Both maternal mortality and morbidity disproportionately impact Black women.

Multiple factors impact a woman's ability to have healthy pregnancies and positive birth outcomes. This can include health status — before conception, during pregnancy, and after birth. It can also include social and environmental factors like socioeconomic status, education, income level, and exposure to environmental toxins. For Black women, the answer to adequately addressing this issue is not clear cut. The social determinants of health, defined as health care conditions that affect the health and quality of life of people in a given environment, including where a person works, lives, or plays, are not protective factors for Black women.[59] Black women, regardless of social or economic status, are more likely to die of pregnancy-related causes. This is even true when compared with white women who never finished high school. The maternal health crisis cannot adequately be addressed without taking account of how racism and bias manifest in the health care system, and in turn contribute to the high rates of maternal mortality and morbidity among Black women.

The ways in which a pregnant and postpartum woman interacts with the health care system has implications for her maternal health outcomes. Access to quality care and supports are part of this, but so is how she is treated by health care providers and other health personnel. When a woman is treated poorly, poor health outcomes may follow, including lasting physical and mental traumas that could extend to her infant and family.

Research has consistently showed that racism compromises health.[60] Unfortunately, racism is an inescapable force that pervades the lives of people of color in America, with Black Americans experiencing some of the harshest and longstanding byproducts of racism and discrimination in this country. Racism can manifest in both explicit and implicit forms. For the purposes of this article, I focus on the more implicit and less overt manifestation that is structural racism. When racism in the health care system is examined, harmful institutional practices and negative cultural representations of Black women intermingle in a way that makes them invisible and devalues their pain. This in turn has led to trauma-inducing pregnancy and birthing experiences, and even death for some women.

Health Care Delivery and Structural Racism

The ways in which a pregnant and postpartum woman interacts with the health care system has implications for her maternal health outcomes. Access to quality care and supports are part of this, but so is how she is treated by health care providers and other health personnel. When a woman is treated poorly, poor health outcomes may follow, including lasting physical and mental traumas that could extend to her infant and family.

In a research survey titled *Listening to Mothers*, conducted and published by the National Partnership for Women and Families in 2018, women were asked questions about their maternity care and birthing experiences in California hospitals.[61] Across race and ethnicity, including Asian and Pacific Islander mothers, Latina mothers, Black mothers, and white mothers, women reported experiencing discrimination during childbirth. Respondents to the survey were asked whether or not they had experienced unfair treatment during their hospital stay for childbirth because of their race or ethnicity, the language they spoke, type of health insurance coverage, or lack of health insurance coverage. The findings showed better treatment among white women, English speakers, and those with private health insurance.[62] About one in ten women reported being spoken to disrespectfully by hospital personnel. The same women also reported "rough handling" by hospital personnel and being ignored after expressing fears and/or concerns. These women were also more likely to be enrollees of Medi-Cal, California's Medicaid program. Black women were more likely to report unfair treatment and discrimination within the health care system than white women and Latina women.[63]

The *Listening to Mothers* survey also examined differences in treatment practices among women, and along racial and ethnic lines. Black women were most likely to be given cesarean sections, at a rate of over forty percent, while white women were given them at a rate of twenty-nine percent. These rates are somewhat consistent with national cesarean section rates — Black women receive them at the highest rate when compared to white women and other women of

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color groups. That rate is thirty-six percent (even for low-risk pregnancies).[64] The national rate for white women is thirty-one percent. The over-use of cesarean sections in the United States has been a cause for concern by the medical and public health communities for decades. The rates for maternal mortality and morbidity are about three times higher for women who had cesarean sections versus vaginal deliveries.[65] Black women in the *Listening to Mothers* survey also reported high rates of depression and lack of practical and emotional support.

Underlining the differences in treatment practices and respect for bodily autonomy for white women and Black women are institutional practices that perpetuate racial inequity as a form of structural racism. Long-standing research has showed that negative cultural representations of people of color, namely Black Americans, invoke bias and stereotyping.[66] In the book *Reproducing Race: An Ethnography of Pregnancy as a Site of Racialization*, Khiara Bridges offers the notably persistent view of what she calls "obstetrical and gynecological hardiness" of Black women, which is a false belief that has been passed down over decades and conditioned how pregnant Black women are treated in health care.[67] This false belief, which also implicates racist views by the physicians who hold them, has led to Black women becoming invisible to the health care system and by health care providers. This invisibility then leads to ignoring expressions of pain and discomfort (similar to the workings of J. Marion Sims and other physicians while using Black women's bodies in the study of gynecologic surgical procedures mentioned previously), discounting treatment considerations and preferences offered by the patient, and maternal deaths and injuries. These concepts can be seen in two real-world, present day examples of mistreatment and maternal death through the experiences of Shalon Irving and Kira Johnson.

Shalon Irving was an epidemiologist for the Centers for Disease Control and Prevention. She had dedicated her career to structural inequality and the need to address health disparities. Then, after years of building a successful career in public health, including earning a bachelor's degree, two master's degrees, and a Ph.D., Shalon decided it was time to become a mom. Although she had waited until her mid-thirties, she was determined and excited about parenthood. Unfortunately, Shalon would not be able to fully experience motherhood — she died of preventable, pregnancy-related causes days after giving birth to her daughter.

Shalon delivered her daughter via cesarean section. She experiences a lump on her incision just days after giving birth, which was examined and drained by her doctor. Her blood pressure was also high. She continued to experience fluctuations in blood pressure, headaches, and swelling in her limbs in the following days. Her doctors continued to pass these conditions off as not serious enough for admittance into the hospital. Shalon kept insisting to her nurses and doctors that something was seriously wrong. They insisted she wait it out. Shalon died days later. An independent autopsy, concluded that Shalon died of complications associated with high blood pressure.[68]

Kira Johnson was also at her prime when she died of preventable pregnancy-related causes. She spoke five languages, worked as a pilot, and loved to travel. By all accounts, she lived a full and active life. Kira made it to all of her prenatal appointments and was excited about becoming mom to another little boy. She and her husband were already raising a nineteen-month-old son.

Kira gave birth on April 12, 2016 at Cedars-Sinai Medical Center, a top medical facility in the United States.[69] Given that fact alone, the assumption was that Kira would undoubtedly receive the best health care. Kira's husband noticed blood in her catheter soon after recovery from her cesarean section. When he alerted Kira's medical team, his calls for help fell on deaf ears. It would be seven hours before Kira would receive the medical attention she desperately needed. Kira was finally taken to another exam room. There, her abdomen was cut open by doctors to find three liters of blood. Kira's cause of death was postpartum hemorrhage.

Shalon and Kira were highly educated Black women. They had a network of family and friends supporting them in their journey to motherhood. They had well-paying jobs and lived in safe neighborhoods. They had access to nutritious foods and clean drinking water. They had health insurance coverage and access to care. None of those factors could protect them from maternal death. Social determinants are not protective factors for Black women — not when they are deemed invisible to the health care system and their cries for help or expressions of pain are ignored. The invisibility of Black women that occurs at the hands of health care providers and the health care system is rooted in bias, discrimination, and racism. It is a driver of maternal mortality and morbidity. Public policies can also be a vehicle for how structural racism manifests in the lives of people of color to instigate poor health outcomes.

Medicaid and Structural Racism

Public policies can also perpetuate racial inequity as a form of structural racism and lead to health disparities. In fact, *Unequal Treatment* asserted that disparities in health not only emerge from how health care systems operate, but also from the legal, regulatory, and policy

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climate within which health care is delivered.[70] Policies and programmatic changes that make it harder for Medicaid enrollees to access needed health care is just one example. Medicaid is an important source of health insurance for women of reproductive age. It is a joint federal and state program that covers health care for low-income Americans. Approximately twenty-five million women are enrolled in the Medicaid program.[71] Almost half of all births in the country are covered by Medicaid.[72] Medicaid is also the largest payer of family planning and maternal health care services including prenatal care, labor and delivery, contraception, screenings for reproductive cancers, and testing and treatment of sexually transmitted infections, including HIV.[73] Women who enroll in Medicaid under the pregnancy pathway are covered for prenatal and postnatal care, delivery, and limited postpartum care. Health care coverage under the Medicaid pregnancy pathway ends at sixty days postpartum if women do not meet the income specifications for the state in which they live. For state Medicaid programs in non-expansion states, the income threshold is 40% of poverty the federal poverty level or $8,532 for a family of three.[74] In states that have adopted Medicaid expansion under the Affordable Care Act, the income threshold is adjusted up to 138% the federal poverty level or $17,236 for individuals and families.[75] Most states expand coverage for pregnant women beyond this minimum income threshold to about 200% of the federal poverty level.[76] It should be noted that income thresholds vary by state and eligibility pathway.

The Affordable Care Act helped to greatly expand health care coverage. Medicaid expansion, a key feature of the health care law, has been significant in helping more Americans get the health care coverage and access to health services they need. Expansion was designed to do just that. However, in states that have not expanded Medicaid, many American families still face challenges in gaining coverage — especially if they make too much to meet the traditional Medicaid income threshold, lack affordable coverage options through an employer, do not qualify for premium subsidies through marketplace plans, or lack sufficient income to pay for coverage out of pocket. These burdens fall hardest on low-income families of color. Most of the states that failed to expand Medicaid are concentrated in the South, where approximately fifty percent of African Americans live.[77] Furthermore, ninety-two percent of the 2.3 million Americans that fall within the coverage gap live in the South.[78]

Failure to expand Medicaid perpetuates racial inequity, as consistent with the Aspen Institute's definition of structural racism. As stated above, most of the states that have failed to expand Medicaid are concentrated in the south and have large concentrations of people of color. The decision not to expand Medicaid has a disproportionately harmful impact on the health and wellbeing of African Americans. The uninsured rate among African Americans in non-expansion states is 14 percent.[79] In expansion states, it is 8 percent.[80] For white children and adults, the overall uninsured rate is much lower at 10% for non-expansion states and 6% for expansion states.[81] Black-white health disparities across chronic conditions persist in the South, including for maternal mortality and morbidity and infant mortality.[82] Income inequality is also pronounced in the region.[83] The Kaiser Family Foundation asserts that if all states expanded Medicaid, more than 4.8 million people in non-expansion states would become eligible for Medicaid — helping to significantly close the coverage gap.[84]

Medicaid has been subject to other policy decisions in recent years that only serve to further harm enrollees and limit coverage under the program. Medicaid has experienced drastic funding cuts; been used as an example of government waste and fraud; and has experienced renewed efforts to block grant the program.[85] All of this is cause for major concern for the future of Medicaid. Reproductive health care, in particular, has been a target for funding restrictions, having a particularly severe impact on women of color. For example, the Hyde Amendment prohibits federal Medicaid funding from being used to pay for abortion services in many instances.[86] In addition, persistent attempts to deny federal family planning funds, through the Title X program, as well as state defunding attempts targeting Planned Parenthood and other family planning clinics have impeded poor women's access to trusted reproductive health providers.[87] All of these decisions, including the lack of Medicaid expansion in some states, have gone forward despite the success of Medicaid in ensuring health care coverage for low-income Americans and addressing health disparities — especially those that exist in maternal and infant mortality.

Medicaid expansion has been found to help lower rates of maternal and infant mortality. According to Adam Searing and Donna Cohen Ross of the Georgetown University Policy Institute Center for Children and Families, states that expand Medicaid improve the health of childbearing aged women.[88] This is largely due to increased access to preventive care and the continuum of comprehensive health care and support during preconception and through the postpartum period, in turn reducing adverse health outcomes. Better health outcomes for mothers also led to better health outcomes for infants. States that expanded Medicaid saw infant mortality rates drop

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by 50 percent, much greater than in non-expansion states.[89] Maternal deaths in those states dropped at a rate of 1.6 per 100,000.[90] Medicaid expansion has also helped reduce disruptions in health coverage for pregnant women and new mothers, which can also contribute to lack of access to care and poorer mental and physical health. Fifty-five percent of new mothers on Medicaid lose coverage within six months after giving birth.[91] These findings show how critical it is to ensure Medicaid coverage for all women who qualify, as well as extending postpartum coverage beyond sixty days, to ensure the continuum of comprehensive health care for pregnant women and new mothers. The findings also show how essential Medicaid coverage is in helping to reduce maternal mortality and morbidity, especially among Black women.

For the purposes of this article, I focused on the historical foundations of racism and reproductive oppression as a way to set the stage for manifestations of structural racism seen in the present against the backdrop of ongoing patterns of perpetual and persistent racial inequity in health care. All of which have led to vast racial disparities in maternal health and poor pregnancy-related outcomes among Black women. Provider bias and racism within the health care system are important contributors, as well as policy restrictions that undermine health care access and impose barriers to comprehensive health coverage for women on Medicaid.

Addressing Structural Racism Through Policy Change and Institutional Practices in Health Care

In order to adequately address structural racism and its role as a contributing factor in the maternal deaths of Black women, policy and programmatic solutions must be developed in a way that targets racism and bias within health care. Barriers to health care access must be removed and concrete measures must be in place in order to ensure quality of care. Medicaid is a policy lever in which to address health coverage and access issues, while programmatic efforts must entail eliminating health provider bias and racism which manifests in a lack of compassion and support for Black woman patients interacting with the health care system. And while these efforts may not completely eliminate racial disparities in maternal health, they do serve to influence the quality of health care for Black women and help to hold institutions and individual actors accountable for discriminatory policies and practices.

Health care providers must be adequately trained in order to ensure an antiracist health care system — one that is free from bias and unequal treatment of people of color. This will require providers to be affirming of and sensitive to cultural differences. Power imbalances between patient and health care provider must be addressed. In the context of maternal health care, power imbalances may be seen in a patient's interaction with her health care provider when she is ignored after asking for help to address a health issue. This has been documented in the stories of Shalon and Kira as highlighted earlier in this article, as well as in the *Listening to Mothers* survey responses. The standard should be health care providers working in partnership and collaboration with patients and families to devise treatment plans, consider personal histories, and adhere to health care preferences.[92] This approach treats the patient and provider as equals. The trainings should also be substantive, process-oriented and ongoing, as opposed to a "check-the-box" training that is fulfilled once in the continuum of a person's career in health care. The antiracism and bias trainings should also be integrated with additional professional trainings, including those that ensure safety protocols in maternity care.

Ensuring a more diverse, culturally competent health care workforce would also help to promote a health care system that acknowledges the unique needs of Black women and other women of color at risk for poor maternal health outcomes, as well as help to address bias and racism. According to the American College of Obstetricians and Gynecologists, only 11 percent of OB-GYNs were African American in 2016.[93] Research shows that when health care pro-

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viders of color serve patients with the same cultural backgrounds, those patients have better health care experiences and outcomes.[94] For Black women, this is understandable given the long history of reproductive oppression and mistreatment they have endured at the hands of the medical establishment. Even if patient-physician racial concordance is not present, it is extremely important that trust between patient and physician is built and cultivated.

Medicaid has already been highlighted as an important source of health insurance for pregnant women and new mothers. Unfortunately, the program has been subject to funding cuts and restrictive policy guidelines in recent years. Because the majority of Medicaid enrollees are women of color, policy prescriptions that undermine the integrity of the program disproportionately impact those women, and in turn perpetuate racial inequity.

All states must fully expand Medicaid, which has been proven to help drive down maternal and infant mortality rates. The postpartum coverage limit of 60 days must also be extended to at least one year. The Centers for Disease Control and Prevention estimates that about a third of maternal deaths occur within a week up to one year postpartum.[95] In order for the low-income women that are part of the Medicaid population to fully take advantage of the benefits of comprehensive coverage, and during the very sensitive period after the birth of a child, the coverage extension is vital to addressing maternal mortality among Black women. In a study conducted by Jamie R. Daw, Katy Backes Kozhimannil, and Lindsay K. Admon, it was found that the time-limited coverage during the postpartum period for women on Medicaid caused disruptions in health care coverage.[96] Women that fall outside of the income specifications for subsidized private coverage or living in states without expansion find themselves without the health insurance coverage they need. The uninsured rate tripled for postpartum women living in non-expansion states who had been dropped off of the Medicaid program.[97] Medicaid must also be fully funded and void of draconian policy restrictions that lead to less comprehensive coverage and barriers to health care for enrollees.

As seen throughout history, activism continues to be essential in sparking policy change and holding our systems and institutions accountable. Black women-led organizations continue to lead movement work in ensuring that the health and social concerns of women of color are centered in social justice movements. This centering is pronounced in reproductive justice — a framework and movement that asserts the bodily autonomy of all people to determine their own reproductive and birthing experiences.[98] Addressing maternal mortality among Black women through activism and policy change is a top priority for reproductive justice movement leaders, allies, and organizations.

Conclusion

Black women should be treated with dignity and respect when seeking health care. Health equity, a concept where every person has a fair and just opportunity to be healthy, is essential if the United States is to adequately address the maternal mortality crisis. Interventions to combat bias and racism within the health care system can be effective, but it will take commitment and concerted effort at both the institutional and individual levels. Policymakers, health care systems, and health care providers all have a role to play. For the purposes of this article, I focused on the historical foundations of racism and reproductive oppression as a way to set the stage for manifestations of structural racism seen in the present against the backdrop of ongoing patterns of perpetual and persistent racial inequity in health care. All of which have led to vast racial disparities in maternal health and poor pregnancy-related outcomes among Black women. Provider bias and racism within the health care system are important contributors, as well as policy restrictions that undermine health care access and impose barriers to comprehensive health coverage for women on Medicaid.

Note

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