



Evidence-Informed and Community-Based Recommendations for Improving Black Maternal Health

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April 2021

The United States is experiencing a maternal mortality crisis that disproportionately affects Black women.* The nation's capital has emerged as having the highest average maternal mortality rate in the country, and Black women suffered nearly 75 percent of all pregnancy-related deaths in Washington, DC, from 2014 to 2016.¹ The Urban Institute collaborated with the National Birth Equity Collaborative, a national nonprofit organization that creates solutions that optimize Black maternal and infant health, to produce a research brief that centers Black expertise, experiences, and voices in the Black maternal health crisis. In this brief, we share findings from informant interviews and established research recommendations to provide policy and programmatic strategies for addressing maternal health disparities both in DC and nationally. These recommendations can guide health care workers, policymakers, providers, and educators in the District and across the country in advancing birth equity.

* Throughout this brief, we use the terms “women” and “mothers” as shorthand for all people who get pregnant, give birth, or use maternity care services. However, we recognize not all such people identify with the terms we use, and we remain committed to using respectful, inclusive language.

Background: The Black Maternal Health Crisis

The adverse maternal health outcomes Black women experience in the United States are tied to systemic racism. Racism is woven throughout our society, and structural forces perpetuated by racist policies, including redlining, Jim Crow laws, and mass incarceration, have created inequities in housing, food stability, education, access to care, and safety. Black women are more likely than white women to experience poverty and food insecurity and to work in low-wage jobs that do not provide fringe benefits, like paid leave and health insurance. Black women are also more likely to live in maternity care deserts and to have difficulty accessing comprehensive reproductive health care services that include affordable contraception and abortion care (March of Dimes 2020). In addition, Black women experience race-based discrimination from health care providers, including excessive questioning, condescending tones, and disrespect from their providers (Dehlendorf et al. 2014; Hamel et al. 2020; NPWF 2018; Taylor 2020). These factors, and more, determine health outcomes and are associated with the poor maternal health outcomes Black women experience.

Compared with white women, Black women are nearly three times more likely to experience preventable maternal deaths and severe health consequences and twice as likely to die from pregnancy-related complications or experience near misses.² The differences in maternal health outcomes between Black and white women do not owe to chance, nor are they solely attributable to socioeconomic status or education level; disparities in health outcomes, including for maternal health, are manifestations of racism. Racism affects people, and thereby maternal health, through weathering, a process by which the constant stress of racism affects the body by triggering harmful biological responses (box 1; Geronimus et al. 2006). Understanding Black women’s lived experiences and the toll racism takes on their mental and physical health is central to addressing the Black maternal health crisis.

BOX 1

Important Definitions

Birth equity is “the assurance of the conditions of optimal births for all people with a willingness to address racial and social inequities as a sustained effort.”^a

Federally qualified health centers are community-based health care providers that receive funds from the federal government to provide primary care services in underserved areas. To qualify, a facility must meet stringent requirements, including providing care on a sliding scale (i.e., based on ability to pay) and operating under a governing board that includes patients.

Health disparities adversely affect groups of people who have systematically experienced greater social or economic obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.^b

Health equity is achieved when every person can attain their full health potential and no one is prohibited from this potential by socially determined circumstances.^b

Racism is the merging of systems of power with discrimination against people perceived as inferior to inflict harm upon those people. Race is a social construct used to justify racism, not a biological fact (Brown et al. 2019).

Respectful maternity care constitutes “respect for women’s basic human rights, including respect for women’s autonomy, dignity, feelings, choices, and preferences” during maternity care.^c

Structural racism, or systemic racism, constitutes the policies, court decisions, programs, and institutional practices that facilitate the economic and social upward mobility of white people while creating barriers to the economic and social upward mobility of people of color (Brown et al. 2019).

Weathering is a proven phenomenon by which the health of African American women may begin to deteriorate in early adulthood as a physical consequence of cumulative socioeconomic disadvantage (Geronimus et al. 2006).

White supremacy is a “historically based, institutionally perpetuated system of exploitation and oppression of continents, nations, and people of color by white peoples and nations of the European continent to maintain and defend their wealth, power, and privilege” (Lawrence and Keleher 2004).

^a Joia Crear-Perry, “Root Causes of Black Maternal Health Inequities,” National Birth Equity Collaborative, accessed April 5, 2021, <http://www.nationalperinatal.org/resources/Documents/2019%20conference%20presentations/NPA%20April%202019%20-%20Perry.pdf>.

^b “Disparities,” Healthy People 2020, accessed April 6, 2021, <https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities>.

^c “Respectful Maternity Care: The Universal Rights of Childbearing Women,” White Ribbon Alliance, accessed April 6, 2021, https://www.who.int/woman_child_accountability/ierg/reports/2012_015_Respectful_Maternity_Care_Charter_The_Universal_Rights_of_Childbearing_Women.pdf.

Case Study: Black Maternal Health in Washington, DC

In a study of maternal mortality rates in 38 states from 2007 to 2015, Black women in Washington, DC, fared the worst; DC had the highest average maternal mortality rate at 33.3 per 100,000 live births (Hawkins et al. 2020). The location and quality of the prenatal services offered in DC’s majority-Black communities suggest structural biases may affect the maternal health outcomes of Black DC residents. Further, not enough women in DC have access to ongoing health insurance coverage in the postpartum period. Currently, DC Medicaid offers postpartum coverage for up to 60 days after delivery. However, several research studies have indicated extending postpartum coverage to one year after birth significantly reduces maternal deaths.³

In Washington, DC, racial and income disparities lie along political boundaries known as wards. DC has eight wards, with Wards 7 and 8 comprising communities east of the Anacostia River. Wards 7 and 8 residents have lower incomes, are majority Black, and have higher rates of food insecurity and unemployment than residents of other wards. In line with the structural insufficiencies that often plague majority-Black communities, Wards 7 and 8 also lack an adequate maternal health care system. Ward 2, composed mostly of white residents with high incomes, has 12 prenatal care facilities; in

comparison, both Wards 7 and 8 have 4 facilities.⁴ This is especially problematic because Ward 8 has the highest birth rate in DC.

Currently, 39 health care facilities provide prenatal care services in DC. Notably, 41 percent of them are federally qualified health centers.⁵ Maternal health care facilities have a troubled history in Wards 7 and 8. The number of obstetric facilities serving these wards has dwindled. Most notably, the obstetrics ward in the United Medical Center in Ward 7 closed in 2017, in part because of low-quality care and preventable morbidity and mortality, including a newborn contracting HIV and a pregnant woman dying of acute respiratory distress.⁶ A District-wide investigation found United Medical Center's maternity ward did not conduct a test for the presence of HIV in the newborn or treat the infant with the antiretroviral HIV-preventive drug, though the mother was known to be HIV positive. The hospital also failed to monitor the pregnant woman who died in their care, even with her history of pre-eclampsia, or high blood pressure during pregnancy. These scenarios underscore the structural implications of *who* receives care in Washington, DC. Mothers in Wards 7 and 8 often travel to neighboring Prince George's County, Maryland, to receive care, whereas residents residing in wealthier and whiter parts of the District can receive care closer to home.

In response to high maternal mortality rates and its racial implications, the Washington, DC, Office of the Chief Medical Examiner formed a maternal mortality review committee in 2018 to “determine the causes associated with maternal mortalities of District residents and those that occur in the District, to describe and record any trends, data, or patterns that are observed surrounding maternal mortalities, [and] to create a strategic framework for improving maternal health outcomes for racial and ethnic minorities in the District.”⁷ The maternal mortality review committee's establishment act included a clause to create publicly available annual reports based on the committee's findings, recommendations, and progress on the previous year's recommendations. Per the Mayor's Office requirements, the committee constitutes 12 members with the following qualifications:⁸

- an obstetrics registered nurse
- an obstetrics and gynecology representative from each of the District's birthing centers (maximum of 7 representatives)
- an obstetrics and gynecology representative with maternal fetal medicine as a subspecialty
- a certified midwife from a DC birthing center
- a doula who serves DC residents
- a representative from a pediatric hospital
- three representatives from community organizations specializing in women's health, teen pregnancy, or public health
- a DC resident
- a representative from the American College of Obstetricians and Gynecologists

Research Methodology

This research sought to center the voices of Black people, primarily Black women, in the Black maternal health discourse. We drew on the expertise of Black-led community advocacy groups, Black providers, and Black researchers to build recommendations for effective policies to address the Black maternal health crisis. The research questions covered

- the causes of the disparities in Black maternal health outcomes in DC and nationally,
- the ways in which previous interventions have come up short,
- the systems-level interventions that might improve maternal health outcomes in DC and nationally,
- and local and national policy-level interventions that might improve maternal health outcomes.

In the winter of 2020, the Urban Institute conducted a literature review and key informant interviews with local community health organizers, researchers, and clinicians to develop recommendations for addressing maternal health disparities in Washington, DC. The National Birth Equity Collaborative assisted with recruiting participants. We conducted five interviews with six participants, two of whom were community health leaders, two of whom were researchers, and two of whom were clinicians working in the Black maternal health space. We conducted the semistructured interviews virtually on Zoom between November 19 and December 15, 2020, and later had the interviews professionally transcribed. We manually coded the interviews by identifying common themes and respondents' convergent and divergent perspectives. Though the findings are exploratory, consistent themes emerged across all of the interviews that can help spur further research and action to improve Black maternal health.

Findings from the Field

During interviews, the Urban Institute explored how systems-level programmatic and policy interventions can help address the Black maternal health crisis. Four main themes emerged:

1. Acknowledging the role of white supremacy in the health care system
2. Understanding how racism affects provider-patient interactions and maternal health outcomes
3. Expanding health equity in maternity care
4. Building a respectful maternity care framework

Acknowledging the Role of White Supremacy in the Health Care System

Higher Black maternal mortality in DC is linked to white supremacy and systemic racism (box 1). All interviewees discussed how white supremacy has negatively affected efforts to achieve and maintain

health equity for Black mothers. One interviewee described how structural racism and white supremacy within the health care system—historically composed of predominantly white institutions—are intrinsically tied to health inequities. Another noted the need “to help, correct, and meet, or fix and reform” the health care system to advance optimal maternal health outcomes.

The first assumption is that white supremacy is working. It exists, and it has caused hell for a lot of us...And if we're not equitable in a way—to help, correct, and meet, or fix and reform some of the crap that we've had to endure as a result of inequitable PWIs [predominantly white institutions] in the health care system—then we're not really doing what we're supposed to do when seriously addressing Black health inequity.

—Dorian Wingard, MPA, Chief Operating Officer and Partner, Restoring Our Own Through Transformation

The same interviewee also discussed racism’s role in the Black maternal health crisis in the context of resource allocation, which includes financial support for essential services, such as transportation infrastructure, access to health care, and food availability:

“We can always speak about how resources are allocated. We can also talk about who they’re allocated to and the conditions around their allocation. Most importantly, we must talk about who and what is considered evidence based in the allocation and what value is being placed on Black competent, skilled, and professional organizations within this paradigm of white supremacy.”

—Dorian Wingard, Restoring Our Own Through Transformation

Similarly, one Black maternal health researcher summarized the connection between access to resources, racism in public policy, and poor maternal health outcomes:

“[In research], you control for access to care, you still see the same likelihood for adverse outcomes, so what’s the bigger picture? It’s the history that is internalized and somatized and that plays out in the outcomes that we’re still continuing to see. If I could boil it down to one thing, it’s structural racism. And that bleeds through everything from housing, to access, to educational opportunity. We could go on, but it’s simple racism.”

—Deliya Wesley, PhD, MPH, Scientific Director for Health Equity Research in the Healthcare Delivery Research Network, MedStar Health Research Institute

Understanding How Racism Affects Provider-Patient Interactions and Maternal Health Outcomes

Interviewees noted racism is woven throughout the traditional medical field. As one interviewee said, current curriculum and training standards require additional analysis to understand how white supremacy affects provider training:

“[It’s important to] acknowledge that white supremacy and racism is built into provider training. We’ve got to have that conversation...again about, Why have the numbers? Why do we see such lower numbers of BIPOC [Black, Indigenous, and people of color] providers? What we really need to have the conversation about is racism, oppression.”

—Ebony Marcelle, CNM, Director of Midwifery, Community of Hope

Conversations about disparities within DC described the lack of maternity units in Wards 7 and 8 as a byproduct of racism and a barrier to meeting basic needs. The lack of access to high-quality care dovetails with local policy that has resulted in inequitable access to basic necessities, like affordable and nutritious food, reliable transportation, and maternal health care.

Without a structural overhaul, health disparities and inequities among Black communities will persist. Prioritizing providing resources to Black-led health care and health services organizations is necessary to advance health and birth equity. This recommendation will create more pathways for birth workers of color to enter the field while bolstering community buy-in and incentivizing high-quality maternity care. Promoting health and well-being in a more socially just and equitable manner starts by acknowledging racism’s role in policies, ideas, and structures.

Expanding Health Equity in Maternity Care

Expanding health equity in maternity care relies on expanding birth equity (box 1).⁹ Optimizing health equity, birth equity, and maternal health outcomes requires a systems-level approach. The informants emphasized access to education, safe communities, transportation, and better health care infrastructure as issues associated with health equity. Interviewees also discussed increasing postpartum insurance coverage to one year after birth as integral to achieving health equity.

To me, it's just leveling the playing field...so that everybody has the same opportunity to achieve health, to have health. [For] historically marginalized communities, there are a number of factors that contribute to why we see the disparities that we see, the differences that we see. And to eliminate them, we have to level the playing field of opportunities, access, experiences of racism and discrimination, stressors, social supports, education, you name it.

—Angela Thomas, DrPH, MPH, MBA, Vice President of Healthcare Delivery Research, MedStar Health Research Institute

Interviewees also expressed that the principles of health equity, when applied to maternal health, should address structural and social forces associated with maternal health outcomes. The interviewees broadly reflected on how Black maternal health equity must go beyond implicit bias training. One informant noted how clinicians can intervene on a patient-provider level to transform an inequitable system:

“[It is important to] align health equity or to really have health equity baked into every single policy in areas outside of health, because health is just one piece of it, and health is how we see the outcomes...To think that transportation policies are linked to health equity, pretty much anything out there, because it's that 60+ percent of factors that drive health outcomes which are not clinical. So to me, you have to look at what the policies are better driving all of those 60 percent of things—so all of your economic policies, pretty much everything that impacts the life of a woman outside of the clinical environment.”

—Deliya Wesley, MedStar Health Research Institute

Applying a racial equity lens to public health practice is critical to identifying the root causes of disparities, understanding the context of inequities, and applying policies and practices that dismantle racism and seek to improve health outcomes for the most marginalized communities; as noted, racism—not race—is the true driver of health inequities and poor health outcomes.

Building a Respectful Maternity Care Framework

Equally critical to the prevention of maternal mortality and morbidity is ensuring pregnant people have “the right to the highest attainable standard of health, including the right to dignified, respectful care during pregnancy and childbirth.”¹⁰ Respectful maternity care is a key component of care quality and includes addressing effective communication between clinicians and patients.

Informants also agreed maternity care should be predicated on choice, autonomy, and decision-making that centers the birthing person’s needs and concerns. Such care means listening to patients, respecting them, and dismantling inequitable historical structures that concentrate power among providers.

Respectful maternal care is a holistic approach to the whole family, equity, and centered care that involves informed decisionmaking. Health care providers, you don't always have to agree with what the family decides, but you must ensure that the care is centered.

—Jessica Roach, MPH, Chief Executive Officer and Partner, Restoring Our Own Through Transformation

Emerging Policy Recommendations to Address Disparities in Black Maternal Health Outcomes

As noted, Washington, DC, continues to have the highest Black maternal mortality rate in the United States.¹¹ The ongoing Black maternal health crisis can be addressed with the right tools and policies, as 60 percent of maternal deaths are preventable and a third of those deaths occur between one week and one year postpartum.¹² We developed the following policy recommendations from informants' suggestions and conceptual ideas. Though no single policy solution will solve this public health crisis, we suggest the following as ways to begin addressing the Black maternal health crisis.

Address racism within the health care system. Black women's chronic exposure to racism, gendered discrimination, disrespect, and abuse—within the health care system and beyond—directly affects their abilities to exercise bodily autonomy and make decisions about their health. Effective maternal health policies require more expansive solutions to address racism across varying levels of power and thereby reduce maternal health disparities. Racism in the health care system can be addressed by acknowledging racism as a public health threat, addressing provider bias and discrimination through racial equity training and medical school curriculum, expanding access to birth work for Black people by creating more direct training pathways, improving the quality of care at hospitals serving Black communities, and promoting respectful maternity care models.

Increase access to Black-led community-based providers. Community-based birth workers, such as doulas, midwives, lactation consultants, and community health workers, are known to improve maternal and infant health (BMMA 2018). Community-based providers fill gaps in the health care system by offering emotional, physical, and educational support throughout the perinatal period to childbearing people who face barriers to care. Improving access to Black-led community-based providers is an essential step toward improving maternal health outcomes for Black women. Further, access to community-based providers can be improved by expanding innovative care delivery models, promoting alternative payment models that link reimbursement to quality of care, and ensuring equitable Medicaid reimbursement for doulas and community health workers. These solutions will harness community power, create more pathways for birth workers of color to enter the field, bolster community buy-in, and incentivize high-quality maternity care.

Increase access to high-quality, affordable health insurance. Women need health insurance to access postpartum health care and achieve financial stability. The postpartum period is particularly critical for infants' and mothers' well-being, as 18 percent of maternal deaths occur between 43 days and 1 year after birth (BMMA 2018). Many women with low incomes qualify for health coverage through Medicaid when they become pregnant, but their eligibility typically ends 60 days after giving birth. Clinical guidelines recommend mothers receive ongoing postpartum care that is patient centered and comprehensive. However, many women cannot access postpartum health care because they cannot access health insurance. Black women, in particular, are chronically underinsured, often because they work in low-wage jobs that do not provide fringe benefits like health insurance. To increase access to health insurance, policymakers could extend Medicaid postpartum coverage to at least one year.

Doing so will improve maternal outcomes and reduce mothers' financial instability immediately following birth.

Create accountability mechanisms to better understand why Black mothers die at a higher rate than white mothers. Black women in the United States are dying from pregnancy-related complications at an alarming rate. Accountability measures are needed to create a system where high-quality health care is the standard. Such accountability could also allow providers within the system to maintain integrity of their profession, abiding fully to the ethical and moral codes to which they have agreed (BMMA 2018). Creating accountability requires standardizing assessment and quality improvement measures; requiring data collection and disaggregation by race and ethnicity, sex, pregnancy and postpartum status (experienced pregnancy within the past year, including miscarriage and stillbirth); increasing monitoring of and research on key maternal and child health priorities, including birth defects, preterm birth, health disparities, maternal depression, and infant and maternal mortality; and improving maternal mortality review committees.

Center Black women's leadership in efforts to address the Black maternal health crisis. For generations, Black women and Black women-led organizations have had the solutions to address the maternal health crisis. In 2019, Congresswomen Alma Adams and Lauren Underwood launched the Black Maternal Health Caucus, which seeks to elevate the Black maternal health crisis within Congress and advance policy solutions to improve maternal health outcomes and end disparities. Created by and for Black women, the caucus cosponsored the Black Maternal Health Omnibus Act in 2020. On February 8, 2021, the bill was reintroduced as a package of 12 bills designed to address systemic racism and the social risk factors that have led to the maternal mortality crisis. These bills would invest in and formalize mechanisms to uphold respectful maternity care models, for example, by changing payment models to link reimbursement to quality of care and changing data collection requirements to better monitor Black maternal and infant health outcomes. Equal respect for Black women's voices will center efforts to address the Black maternal health crisis on policy leaders and policies with the power to advance birth and health equity for Black women.

Listen to patients, listen to Black women. [It] starts and ends there.

—Deliya Wesley, MedStar Health Research Institute

Notes

- ¹ Sasha Ann Simons, “‘Save Black Women’: DC Gets to Work Addressing Pregnancy-Related Deaths,” WAMU, April 12, 2019, <https://wamu.org/story/19/04/12/save-black-women-new-committee-will-address-maternal-deaths-in-d-c/>.
- ² Centers for Disease Control and Prevention, “Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths,” news release, September 5, 2019, <https://www.cdc.gov/media/releases/2019/p0905-racial-ethnic-disparities-pregnancy-deaths.html>.
- ³ Laurie Zephyrin, Akeiisa Coleman, Rachel Nuzum, Yaphet Getachew, “Increasing Postpartum Medicaid Coverage Could Reduce Maternal Deaths and Improve Outcomes,” Commonwealth Fund blog, November 21, 2019, <https://www.commonwealthfund.org/blog/2019/increasing-postpartum-medicaid-coverage>.
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- ⁵ “Health Care Facilities Providing Prenatal Care in the District of Columbia,” Government of the District of Columbia, DC Health, accessed March 31, 2021, https://dchealth.dc.gov/sites/default/files/dc/sites/doh/page_content/attachments/Prenatal%20Facility.v2.pdf.
- ⁶ Peter Jamison and Fenit Nirappil, “Dangerous Mistakes Led to Shutdown of United Medical Center Obstetrics Ward,” *Washington Post*, August 14, 2017, https://www.washingtonpost.com/local/dc-politics/dangerous-mistakes-led-to-shutdown-of-united-medical-center-obstetrics-ward/2017/08/14/5639006a-8114-11e7-b359-15a3617c767b_story.html.
- ⁷ More information about the Maternal Mortality Review Committee Establishment Act of 2018, D.C. Law 22-111, is available at <https://code.dccouncil.us/dc/council/laws/22-111.html>.
- ⁸ More information about the qualifications for serving on DC’s Maternal Mortality Review Committee is available at <https://motaboard.applytojob.com/apply/Cd1cPgO2Ax/Maternal-Mortality-Review-Committee>.
- ⁹ Joia Crear-Perry, “Root Causes of Black Maternal Health Inequities,” National Birth Equity Collaborative, accessed April 5, 2021, <http://www.nationalperinatal.org/resources/Documents/2019%20conference%20presentations/NPA%20April%202019%20-%20Perry.pdf>.
- ¹⁰ “The Prevention and Elimination of Disrespect and Abuse during Facility-Based Childbirth,” World Health Organization, accessed March 31, 2021, https://apps.who.int/iris/bitstream/handle/10665/134588/WHO_RHR_14.23_eng.pdf;jsessionid=BA60A275BB9E36A3A8C6ADD31B550953?sequence=1.
- ¹¹ “Pregnancy-Related Deaths,” Centers for Disease Control and Prevention, May 7, 2019, <https://www.cdc.gov/vitalsigns/maternal-deaths/index.html>.
- ¹² Centers for Disease Control and Prevention, “Pregnancy-Related Deaths Happen before, during, and up to a Year after Delivery,” news release, May 7, 2019, <https://www.cdc.gov/media/releases/2019/p0507-pregnancy-related-deaths.html>.

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Dawn Godbolt, PhD, is the policy director at the National Birth Equity Collaborative, where she works to improve maternal health disparities by creating a more equitable health care system through federal policy levers. Her previous research examines race differences in mothers' fears of allowing children outside, disparities in neighborhood factors, and the connection between stereotypes, religion, and obesity. Godbolt completed her doctorate in sociology from Florida State University.

Alise Powell is the federal policy analyst at the National Birth Equity Collaborative. In her current role, she is responsible for conducting federal legislative analysis and developing policy recommendations centered in a reproductive justice and health equity framework. Powell is a tireless champion for change, striving to help guide the American healthcare system toward the high mark of equity. She received her bachelor's degree in political science and health and society from Wellesley College.

Joia Crear-Perry, MD, FACOG, is a physician, policy expert, thought leader, and advocate for transformational justice. As the founder and president of the National Birth Equity Collaborative, she identifies and challenges racism as a root cause of health inequities. She is a proud recipient of both the Congressional Black Caucus Healthcare Heroes award and the Maternal Health Task Force at Harvard University Global Visionary Award for Commitment to Advancing Women's Health. She has also been recognized as a fellow of the American College of Obstetricians and Gynecologists. Crear-Perry's most notable efforts include the removal of race as a risk factor for illnesses including premature birth. After completing undergraduate studies at Princeton University and Xavier University, she received her doctor of medicine from Louisiana State University and completed her residency in obstetrics and gynecology at Tulane University's School of Medicine.

Acknowledgments

This brief was funded by the Urban Institute. The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders. Funders do not determine research findings or the insights and recommendations of Urban experts. Further information on the Urban Institute's funding principles is available at urban.org/fundingprinciples.



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