

Disparities in Black Maternal Health in the United States: A Literature Review

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INTRODUCTION

Health Problem

Despite innovative advances in medical technology and increased healthcare access, maternal morbidity and mortality remain critical public health issues in the United States, reflecting ongoing gaps in healthcare quality and equity. Among high-income nations, the U.S. continues to exhibit one of the highest maternal mortality rates globally. According to the Centers for Disease Control and Prevention (CDC, 2023), the maternal mortality rate in the United States was approximately 22 deaths per 100,000 live births in 2022, which is nearly three times the rates observed in comparable countries such as Canada (8.6 per 100,000 births) and the UK (6.5 per 100,000 births). This significant contrast highlights how having advanced healthcare infrastructure and technology does not necessarily guarantee improvement in maternal outcomes, emphasizing the need to reevaluate gaps in care delivery and accessibility. The term severe maternal morbidity (SMM) describes unexpected complications during labor and/or delivery that can create serious long-term physical or psychological health issues for the mother (CDC, 2024). Maternal mortality, in contrast, refers to the death of a woman during pregnancy or within 42 days of terminating the pregnancy due to direct or indirect obstetric complications (WHO, 2025). Distinguishing between these terms is critical, as both serve as indicators for the quality and effectiveness of maternal health systems.

Hemorrhage, hypertension, and cardiovascular complications remain among the most common causes of maternal mortality in the United States (Petersen et al., 2022). These documented cases reveal that maternal mortality is not a randomized occurrence, but often seen in cases that were preventable. Approximately one third of all pregnancy-related deaths are caused by cardiovascular disease, whereas mental health conditions (including depression,

suicide, and substance-use related deaths) have emerged as rapidly increasing contributors as well (CDC, 2023). A 2022 CDC-based study analyzing nationwide pregnancy data found that across 2005-2022, approximately 11% of maternal deaths were due to homicide and suicide (Azad et al., 2022). This statistic highlights that the issues behind maternal death often extend past the context of clinical issues into social and behavioral determinants of health. More specifically, 61% of the deaths in this study were the result of homicide and 39% were the result of death by suicide (Azad et al., 2022). Serious consequences of severe maternal morbidity vary, ranging from psychological distress to chronic health conditions. Further, the long-term outcomes of SMM, ranging from trauma to chronic illness, show that changing the future of maternal health is not solely about reducing deaths. These outcomes not only impact the quality of life of women but also their families, communities, and the U.S. healthcare system as a whole.

It is critical to recognize that maternal morbidity and mortality are not issues that impact all populations equally. Non-Hispanic Black women continually face maternal mortality rates nearly three times higher compared to non-Hispanic White women (70 vs. 27 deaths per 100,000 live births) (CDC, 2023). Additionally, in a recent study conducted by Howell et al. (2020), researchers examined the relationship between SMM and insurance type by assessing hospital discharge data and insurance coverage by women of diverse racial and ethnic backgrounds. Researchers found that non-Hispanic Black women experience 2.3 times the rate of severe maternal mortality compared to non-Hispanic White women (Howell et al., 2022). These disparities continue to exist regardless of controlled socioeconomic, education, and insurance coverage variables (Taylor et al., 2023), indicating that this issue is one dictated by equity, structural racism, and clinical bias. Therefore, understanding the roots of maternal mortality requires more than solely exploring statistics; it requires the determination of why specific

populations are disproportionately affected and the impact of current healthcare systems on this issue.

Social determinants play a huge role in shaping maternal outcomes, from geography, to transportation, housing, provider access, and continuity of care. Over half of counties in the United States lack access to maternity care providers and birthing facilities, forging healthcare deserts that delay necessary treatment (Medicus Healthcare Solutions, 2025). Over half of maternal deaths occur postpartum, suggesting a lack of follow-up visits rather than inevitable risks or complications (Petersen et al., 2019). These patterns suggest that solutions to maternal mortality must extend past labor and delivery visits to include long-term community support and health monitoring. In this context, maternal mortality becomes a reflection of not only medical care, but of public health policy and priorities.

Together, maternal morbidity and mortality serve as powerful indicators of public health status and national healthcare equity. Research consistently demonstrates systemic disparities and patterns of preventability. There is an immediate need for comprehensive, issue-driven intervention in our current system of healthcare.

METHODS

A literature search was conducted across two different databases, PubMed (maintained by the National Library of Medicine, U.S. National Institutes of Health) and CINAHL (Cumulative Index to Nursing and Allied Health Literature, hosted by EBSCO). PubMed covers a broad spectrum of biomedical and life-science literature journals, providing a range of health-science topics and articles. CINAHL focuses more on allied health sciences and nursing, often covering allied health research, nursing practices, and delivery of care. These two databases were chosen

with intent to identify recent peer-reviewed studies assessing maternal mortality and morbidity among Black women in the United States. The inclusion criteria for both databases were identical: articles published within the last five years, peer-reviewed journal articles with full-text access, studies conducted in the United States, and research addressing maternal morbidity and mortality among Black or African-American women that included risk factors, determinants, or disparities in maternal outcomes.

Inclusion and Exclusion Criteria

Studies were included in the potential research pool if they were published between the years of 2015-2025, conducted in the United States, available in full-text with a written English version, and published in peer-reviewed journals. Additionally, the articles needed to address Black maternal mortality and/or morbidity among African-American women, focusing on health determinants, risk factors, or contributors. Exclusion criteria included all studies that were conducted outside of the United States, non-peer-reviewed sources (including commentaries, reports, and editorials), and articles that did not explicitly cover data related to Black or African-American women. Additionally, studies that focused more on neonatal, postnatal, or infantile outcomes rather than maternal outcomes were excluded. Lastly, articles that lacked empirical data or those that addressed unrelated concepts, such as contraception or fertility without connecting to maternal morbidity or mortality, were excluded from the search.

The screening process for the articles included in this literature review consisted of two phases. During the first phase, all potential articles were reviewed based on title and abstract to assess relevance to the research question, and the second phase included a full-text review to assess methodology and eligibility. Specifically, these articles needed to present relevant

information regarding maternal morbidity and mortality among Black women. Studies that focused on structural determinants or racial comparisons of maternal outcomes and identified critical social or clinical risk factors were prioritized.

Search Progression

The PubMed search used the following terms: (((("maternal mortality"[All Fields]) AND ("united states"[All Fields])) AND ("black women"[All Fields])) AND (disparities). The initial search returned 120 results. Next, filters were applied that limited the publication date to the last 10 years (2015-2025), English-language, available version of the full text, and studies conducted in the United States. After applying these filters, 112 results remained. All titles and abstracts were reviewed to assess relevance to the literature review, and 10 articles were further reviewed in full text. After reviewing these articles in detail, 7 were included in the final synthesis.

The CINAHL search utilized a similar combination of terms but returned a larger initial pool of potential articles. The search terms included were (maternal mortality or morbidity) AND (united states or america or usa or u.s) AND (black women or african american women) AND (disparities or disparity or inequities or inequality or bias or disproportionality). The initial search returned 276 results. Next, filters were applied that limited the publication date to the last 10 years (2015-2025), peer reviewed articles, English-language, available version of the full text, and studies conducted in the United States. After these filters were applied, 99 results remained. Due to a large number of studies, a primary title review was conducted to narrow the potentially relevant sources. 27 of these articles were reviewed in full text, and 13 studies were ultimately selected for their relevance to the research question. The variation in search results observed between PubMed and CINAHL highlights the differences in each database's research scope and

availability. PubMed focuses more on biomedical and clinical literature, whereas CINAHL provides a more nursing and community health research-centered representation of literature.

RESULTS

Structural Barriers of the Healthcare System

A significant amount of research indicates that structural barriers in the healthcare system play a critical role in the disproportionately higher rates of maternal morbidity and mortality among Black women. A Georgia study published in 2024 reviewed approximately 130 pregnancy-related deaths and conducted a retrospective state review comparing outcomes by race, age, education, and geography. Nearly half of all deaths (48%) occurred within 60 days postpartum, indicating that risk does not resolve at delivery, but rather continues into the period where clinical monitoring begins to decline (Kondracki et al., 2024). Researchers also found that cardiomyopathy, hemorrhage, and cardiovascular disease were the leading causes among these deaths, with Black women accounting for a disproportionately elevated amount of these outcomes, despite representing a smaller percentage of overall deliveries. This disparity emphasizes systemic gaps in continuity of care, including insufficient follow-up care and barriers to care access after discharge. These findings reinforce the importance of extending postpartum monitoring and addressing racial disparities in maternal healthcare outcomes. In another study conducted in 2023, researchers employed multilevel logistic regression to analyze national hospitalization datasets and found that Black women who gave birth in counties with higher racialized economic segregation had significantly greater odds of experiencing severe maternal morbidity (SMM) (Jeffers et al., 2023). This correlation reflects the healthcare consequences of segregation: areas with more economic division often have fewer OBGYN providers and lesser

availability of specialty obstetric care. Therefore, this research displays that structural racism shapes the healthcare environment on its own, dictating where people can seek care and how their care is managed. These findings link economic segregation to preventable maternal health complications, representing how systemic inequities can reinforce disparities in health outcomes among Black women in the United States. A 2024 study analyzing 528 patient safety incident reports from a large academic hospital found that non-Hispanic Black patients accounted for 43.2% of reported adverse maternal care outcomes, even though they represent only 36.5% of the overall birthing population, highlighting a disproportionate burden (Alfred et al., 2024). Among the reported incidents, Black patients disproportionately experienced complications of care, infrastructure or technology failures, and medical record identification errors, which suggests systemic failures in hospital practices and quality of care rather than random variation. These patterns sound alarms about institutional-level inequities within maternal care outcomes, including patient safety procedures and monitoring.

Healthcare access and insurance coverage also impact maternal outcomes in the United States. A study conducted in New York City in 2020 reviewed nearly 600,000 deliveries to examine racial and ethnic disparities in severe maternal morbidity (SMM) and to assess whether outcomes differed by insurance coverage (Howell et al., 2020). Researchers found that Black women experienced SMM nearly three times more often compared to White women (4.2% vs. 1.5%), even when they were covered through the same insurance and treated in the same hospital departments. Researchers noted that equal insurance access did not eliminate disparities, suggesting that differences were driven by provider biases and the quality of healthcare. Therefore, Black women are receiving care under the same conditions but continue to face worse outcomes, demonstrating failures in clinical procedures and practices and overall treatment

quality.

Several studies conducted nationwide reinforce these racial disparities in maternal outcomes, linking them directly to factors within the healthcare system. Admon et al. (2018) reviewed delivery hospitalizations in the United States from 2012-2015 and found that across all racial minority groups, severe maternal morbidity (SMM) incidence was highest among non-Hispanic Black women compared to non-Hispanic White women (231.1 vs. 139.2 per 10,000 deliveries). Disparities were especially prominent among Black women with several chronic conditions, suggesting that preexisting conditions exacerbate risk for SMM. This study highlights the idea that interventions targeting high-risk women, such as increased monitoring and attention to complications, could reduce these inconsistencies. These findings reinforce the position that structural factors contribute substantially to racial disparities in maternal outcomes. Similarly, Minehart et al. (2021) reviewed national data and found that Black women faced a three to four times higher rate of maternal mortality and twice the risk of severe maternal morbidity compared to White women (37-40 vs. 10-12 per 100,000 live births), with provider bias and systemic racism simultaneously fueling these disparities in care (Minehart et al., 2021). These studies represent how uneven access to quality obstetric treatment and structural inequities in healthcare practices lead to elevated morbidity and mortality outcomes in Black birthing women in the United States.

Cultural and Psychological Contributors

Cultural and psychological factors also contribute to elevated maternal health risks. A 2024 study examined 38 Black women experiencing high cardiometabolic risk and found that the “Superwoman Schema,” was found to increase stress and risk for cardiovascular conditions

(Kyalwazi et al., 2024). The “Superwoman Schema” is a term that describes the pressure put on African-American women to exhibit strength and hide weakness, and this research concluded that increased stress caused by this concept can lead to hypertension and other cardiovascular risks during and after pregnancy. In a 2024 cohort of 6,501 pregnant American women (1,155 non-Hispanic Black, 5,346 non-Hispanic White), researchers found that 32% of Black women developed hypertensive disorders of pregnancy compared to 23% of White women (Keith and Martin, 2024). This statistic highlights a clear racial disparity in maternal health outcomes. Additionally, researchers used structural modelling to study how specific social determinants, such as household income and marital status, impact psychological stress markers. These markers were found to increase risk for the development of hypertensive disorders, which are much more pronounced in Black women. These findings support the concept that systemic social and environmental factors play a role in maternal health risk. In another study conducted in 2023, researchers used a community-based participatory research structure to explore the perinatal and postpartum experiences of 31 Black women who had given birth up to three years prior. Researchers conducted structured interviews that revealed consistent patterns of negative maternal healthcare experiences which included insufficient provider communication, dismissal of signs and symptoms, and delayed treatment processes. Several participants described discriminatory experiences with healthcare providers and low levels of accessibility for mental health care services, which may have contributed to overall poorer recovery outcomes. While this study does not quantify morbidity and mortality rates, the qualitative findings signify the impact of negative provider interactions and how they directly influence maternal health outcomes.

Additional studies following a qualitative structure provide additional context regarding the true experiences of Black women in the United States. A study conducted by one researcher consisted of interviewing nine Black women who reported experiences of severe maternal morbidity, in which she discovered that limited health education, implicit bias by healthcare professionals, and negative provider interactions caused negative psychological stress and impacted postpartum recovery (Canty, 2021). In a 2021 qualitative study of women who experienced SMM, Black participants reported consistent problems in peripartum care including feelings of emotional distress and gaps in communication (Wang et al., 2021). These reported accounts emphasize that disparities in maternal health outcomes may stem from systemic failures in care delivery, especially for women of color and ethnic minorities.

Social Determinants and Disparities

Social determinants play a critical role in racial disparities in maternal health outcomes. In a 2024 study conducted in Georgia, researchers assessed hospital discharge data to estimate that around 26% of the Black-White disparity in severe maternal morbidity outcomes was attributable to hypertensive disorders (Labgold et al., 2024). In addition, another study that analyzed over 1 million deliveries in the United States between 2016 and 2020 found that hypertensive disorders greatly increase the risk for severe maternal morbidity for all racial groups, but Black women experienced disproportionately higher rates regardless (Albright et al., 2024). Similarly, another 2024 study found that non-obstetric maternal mortality increased over time, highlighting the role of chronic illness as a critical complication (Huang et al., 2024). In this study, Black women faced the highest risk as well, even though the risks studied were not related to obstetrics

Social and structural stressors are further compounded by culturally-specific pressures, such as the Superwoman Schema, which explains the expectation for Black women to exhibit strength and hide weakness (Kyalwazi et al., 2024). Chronic psychological stress linked to this expectation contributes to elevated blood pressure and increases the risk of developing hypertensive disorders during pregnancy. This could explain the heightened prevalence of SMM among Black women before, during, and after pregnancy (Keith & Martin, 2024).

In another research study conducted in 2024, Azad et al. found that violent deaths, including suicide and homicide, served as major contributors to maternal mortality among Black women, accounting for 11% of pregnancy-related deaths between 2005-2022 (Azad et al., 2024). Although violence occurs outside of the clinical setting, these deaths highlight critical deficiencies in the healthcare systems, particularly in mental health screenings, postpartum follow-up care, and recommendation of safety programs. Because providers fail to identify warning signs of mental distress, intimate partner violence, and illness, preventable deaths occur. This study reevaluates maternal mortality as a responsibility of the healthcare system to assess and implement behavioral health programming and safety planning to protect high-risk mothers. Furthermore, Moaddab et al. (2018) found that Black women were disproportionately affected by maternal mortality, particularly Black women who were unmarried, had low utilization of prenatal care, or delivered through Cesarean delivery procedures. Limited prenatal care and lower utilization of healthcare services were associated with higher complications, whereas history of Cesarean delivery increased the likelihood of developing post-surgical infections and hemorrhages. These findings reinforce the idea that demographic factors interrelate with gaps in healthcare access to heighten the risk of negative maternal outcomes among Black women (Moaddab et al., 2018).

Further studies highlight how social determinants contribute to these racial disparities. Garland et al. (2024) followed 666 women with severe maternal morbidity and found that non-Hispanic Black women had a significantly higher likelihood of experiencing adverse delivery outcomes, even after researchers assessed medical preventability. Because the disparities persisted following the preventability review, the researchers concluded that clinical error could not solely account for the discrepancies. Instead, different key contributors, such as hospital quality, specialty obstetric service accessibility, and social stressors emerged. This strengthens the assertion that maternal risk among Black women is elevated because social and structural conditions within the healthcare system increase their likelihood of experiencing preventable complications (Garland et al., 2024). Another study conducted in Maryland in 2023 found that Black women had the highest odds of severe maternal morbidity, regardless of rural or urban residence (Cudjoe et al., 2023). The persistence of this disparity regardless of geographic location suggests that residence alone does not dictate maternal health outcomes. Instead, social determinants, such as access to quality hospitals, provider biases, transportation barriers, and socioeconomic stressors likely contribute to the elevated risk. This study supports the argument that racial disparities are produced by systemic factors, not necessarily due to where an individual resides. Therefore, the healthcare environment partially drives the disproportionate amount of SMM experienced by Black women. This research emphasizes that sole location does not define or explain racial disparities. Additionally, a 2021 study that analyzed enhanced vital records found that Black women had over a 3.5 times higher risk of maternal mortality than White women (MacDorman et al., 2021). The majority of this disparity was attributed to eclampsia/preeclampsia, postpartum cardiomyopathy, embolism, and hemorrhage.

DISCUSSION

This literature review sought to address the research question: What risk factors and disparities contribute to Black maternal morbidity and mortality in the United States? The evidence consistently demonstrates that Black women experience significantly higher rates of severe maternal morbidity and mortality compared to other racial groups, and the origins of these inequities are structural in nature. Across the research, three dominant themes emerged: structural challenges within the healthcare system, cultural and psychological stressors, and social determinants. First, Black women repeatedly experience higher rates of SMM, maternal mortality, and adverse complications even when controlling for extraneous variables like clinical setting or insurance type. Segregation, provider biases, and inadequate postpartum care reveal systemic roots in this issue. Second, chronic illness, housing instability and financial strain can worsen obstetric risk. Violent deaths, mental health decline, and preventable pregnancy-related health complications further represent how environmental and social stressors contribute to maternal outcomes. Third, hypertensive complications and cardiometabolic conditions are aggravated by stressors, often reinforced through social expectations of strength and resilience. Analyzing qualitative experiences of neglect and dismissal confirm the belief that psychological trauma and inflicted distress are not side effects of poor hospital care, but are mechanisms of intentional harm.

Collectively, these studies demonstrate the disproportionate maternal risk that Black women face across various settings and clinical conditions. These conditions cannot be associated with sole individual behaviors, but are rather caused by inequitable healthcare systems. Segregated hospital access, provider biases, and insufficient follow-up appointments are all indicators of consistent inequities seen among healthcare systems. Effective intervention must

integrate social, environmental, and emotional determinants that shape maternal safety altogether.

Limitations

Several limitations must be evaluated when interpreting findings from this literature review. For instance, many of the studies relied on geographically-confined data, which may not be representative of national trends as a whole. While localized research offers valuable contextual insight for confined geographic areas, regions that are different population densities may differ from that context. Additionally, many of the sample sizes within the studies were small, which also plays a role in the limited generalizability of the data. This limits causal inference and may underrepresent nuanced patient experiences.

Data quality also raises some concerns for the validity of certain findings. Utilizing data sources, such as death certificates, aren't always credible due to the misreporting of race and ethnicity, while large-scale databases often lack detailed variables like stress or psychosocial factors to fully explain patterns in disparity. Additionally, some of the studies measured self-reported data, such as stress and discrimination, which could be vulnerable to self-reporting bias. Despite these potential limitations, the consistency of findings across all the different study methodologies increases reliability that Black maternal health disparities are due to systemic issues.

Implications of Research

The literature clearly indicates that reducing maternal morbidity and mortality among Black women requires intervention from several target areas (structural, clinical, social). At the

clinical level, increasing the window for follow-up care beyond the traditional six-week mark may prevent a significant percentage of late maternal deaths. In addition, screening these postpartum women for cardiovascular complications and mental health conditions may also improve future outcomes for those at heightened risk. Providing culturally competent care, through structured anti-bias clinician training in the healthcare system, could drastically reduce psychosocial barriers. For example, the Awareness to Action initiative through March of Dimes was developed to teach healthcare professionals about providing equitable care for women before, during, and after pregnancy (March of Dimes, 2023). The training was primarily developed to improve treatment practices for racial and ethnic minority women by addressing implicit biases in healthcare settings and strengthening clinician awareness of systemic inequities. This training also emphasizes the importance of patient-centered communication and trust between providers and patients, pushing a much-needed culture shift towards achieving equity for all mothers and babies.

Additionally, expanding community-based support from Black midwives, doulas, and other healthcare workers could improve outcomes and mitigate systemic and social stressors. Bohren et al. (2017) found that doulas and other continuous-support models were very effective in preventing emergency Cesarean rates, shortening labor duration, improving maternal satisfaction, and decreasing negative birth experiences. These outcomes particularly benefit socially disadvantaged women and could potentially bridge racial gaps in maternal health outcomes. Policy reforms addressing racial and socioeconomic disparities are also needed to reduce systemic barriers to maternal health disparities. Addressing risk factors from various sectors can help healthcare systems significantly reduce maternal morbidity and mortality for Black women.

CONCLUSION

In the United States, Black women face disproportionately higher rates of maternal morbidity and mortality as a consequence of systemic inequities. This is due to a combination of systemic, clinical, cultural, and psychological factors. The literature and research highlights the urgent need for expanding multi-level interventions, which include structured postpartum follow-up care; practicing culturally competent healthcare and anti-bias procedures; introducing community-based support programming; and implementing policy reforms to address systemic inequities in the United States. By targeting risk factors from various regions, healthcare systems can substantially reduce the risk of preventable maternal morbidity and mortality and improve outcomes for the most vulnerable birthing populations. Approaching Black maternal health from a systemic rather than patient-centered perspective will allow healthcare systems to reduce preventable complications and ensure safer maternal outcomes.

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