

The Impact of Racism on Maternal Health Outcomes for Black Women

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The Impact Of Racism On Maternal Health Outcomes For Black Women

Gabrielle T. Wynn*

I. INTRODUCTION	86
II. THE ROLE OF RACISM ON MATERNAL HEALTH DISPARITIES	88
A. <i>Serena, Shalon, and Kira</i>	90
B. <i>Racial Disparities in Quality of Care</i>	91
III. THIS ISN'T NEW: A HISTORY OF MISTREATMENT IN ACCESSING MEDICAL CARE.....	95
A. <i>Stereotypes Affect Social Ideas of Black Women</i>	97
IV. ADOPTING A HUMAN RIGHTS FRAMEWORK TO COMBAT MATERNAL MORTALITY.....	99
A. <i>International Human Rights Standards that Focus on the Right to Health, Life, and to be free from Discrimination</i>	100
B. <i>Addressing Maternal Mortality in the United States and Abroad</i>	102
C. <i>Effective Solutions Must Include the Community Most Impacted – Black Women</i>	106
V. CONCLUSION AND FINAL THOUGHTS.....	108

* Juris Doctor candidate, 2020, University of Miami School of Law. As a young Black woman, I am eternally grateful for the opportunity to write a Note on an issue that directly impacts my community in a multitude of ways. I dedicate this Note to my mother, my grandmothers, and to Black women around the world who have sacrificed everything—even their own lives—to bring a new life into the world. I hope that my work will contribute to the conversation on eliminating racial disparities in maternal health outcomes for Black women. I would also like to thank Professor Zanita E. Fenton, my faculty advisor, for her guidance and support throughout this endeavor. Finally, I would like to thank the editors of the University of Miami Race and Social Justice Law Review for selecting this Note for publication.

I. INTRODUCTION

Bringing a child into the world should be one of the happiest moments in a woman's life. However, many Black women will never leave the hospital holding their new bundle of joy. According to the Centers for Disease Control and Prevention (CDC), roughly 700 women in the United States die each year due to pregnancy or delivery-related complications.¹ Alarming, maternal mortality rates for women living in the United States are the highest in the developed world with stark racial disparities. Specifically, Black women have the highest maternal mortality rate in the U.S. and are nearly four times more likely to die from pregnancy-related causes compared to White women.² Even more shockingly, research shows that roughly 63.2% of maternal deaths are preventable.³ This begs the question – with all the successes of modern medicine, why is it that Black women are dying, still, even with all the successes of modern medicine?

In 2018, President Trump signed a bill entitled the *Preventing Maternal Deaths Act*, which allocated millions of dollars to help states determine why women are dying at such a fast rate; unfortunately, this law does not require states to investigate whether flawed medical care played a role in any particular maternal death.⁴ “Studies have found that at least half of the childbirth-related deaths could have been prevented if healthcare providers had followed best medical practices to ensure that any complications were diagnosed and treated quickly and effectively”.⁵ In a report by *USA Today*, it was found that many physicians and nurses across the country skip safety procedures known to head off tragedy.⁶ Specifically, after obtaining more than 500,000 pages of internal hospital quality records, the report found that hospitals were not taking steps such

¹ Centers for Disease Control and Prevention (CDC), *Maternal Mortality* (Sept. 4, 2019), <https://www.cdc.gov/reproductivehealth/maternal-mortality/index.html>.

² Merck for Mothers, *Safer Childbirth Cities Initiative* (Sept. 2019), <https://www.merckformothers.com/docs/report-safer-childbirth-cities-initiative.pdf> [hereinafter Merck for Mothers].

³ Review to Action: Working Together to Prevent Maternal Mortality, *Report from Nine Maternal Mortality Review Committees* 22 (2018), https://reviewtoaction.org/sites/default/files/national-portal-material/Report%20from%20Nine%20MMRCs%20final_0.pdf.

⁴ Alison Young, *Mothers are dying. Will this bill help?* USA TODAY (Dec. 19, 2018, 4:44PM), <https://www.usatoday.com/story/news/investigations/deadlydeliveries/2018/12/19/maternal-mortality-rate-bill-targets-childbirth-deaths/2339750002/>.

⁵ *Id.*

⁶ Alison Young, *Hospitals Know How to Protect Mothers. They just aren't doing it*, USA TODAY (Last updated Mar. 6, 2019, 4:54PM) <https://www.usatoday.com/in-depth/news/investigations/deadly-deliveries/2018/07/26/maternal-mortality-rates-preeclampsia-postpartum-hemorrhage-safety/546889002/>.

as quantifying women's blood loss or tracking whether those with high blood pressure got the right medication on time – with grave consequences.⁷ This serious lack of attention towards safety practices in labor wards has contributed to making the United States the most dangerous country to give birth. But this danger does not apply equally to all women; that is, a disproportionate number of the victims of maternal mortality in the United States are Black women.⁸

Researchers have begun to identify several factors that contribute to these stark disparities in pregnancy-related deaths, for Black women specifically. On a broad scale, social inequities involving differential access to healthy food and clean drinking water, safe neighborhoods, quality schools, good jobs, and reliable transportation influence various aspects of a Black woman's overall life and health, which extends to their health during pregnancy, and immediately after birth as well.⁹ However, racial bias and stereotypes play a major role in how pregnant Black women are treated in comparison to their White counterparts. Conscious and unconscious biases are prevalent throughout the medical system, and they significantly impact how medical professionals perceive and respond to Black patients' pain.¹⁰ Further, limited diversity in the medical profession leads to culturally inappropriate treatment and contributes to feelings of isolation among Black women during medical treatment.¹¹ Although the issue of maternal mortality is rooted in the medical field, there is inarguably a legal component when the U.S. government systemically fails to provide adequate care for Black women and fail to properly investigate and prevent maternal mortalities.

This Note argues that states should adopt a human rights-based approach in developing progressive policies to address maternal health disparities in the United States. Furthermore, the federal government can support this initiative through the passage of bills that promote and

⁷ *Id.*

⁸ Merck for Mothers, *supra* note 3.

⁹ Nina Martin and Renee Montagne, *Nothing Protects Black Women From Dying in Pregnancy and Childbirth*, PROPUBLICA (Dec. 7, 2017, 8:00AM), <https://www.propublica.org/article/nothing-protects-black-women-from-dying-in-pregnancy-and-childbirth> [hereinafter *Nothing Protects Black Women From Dying*].

¹⁰ Hoffman, M. K et al., *Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between Blacks and Whites*, PROCEEDINGS OF THE NATIONAL ACADEMY OF SCIENCES (PNAS) 4296 (Mar. 1, 2016),

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4843483/pdf/pnas.201516047.pdf>.

¹¹ AAMC Facts & Figures, *Diversity in Medical Education* (2016), <http://www.aamcdiversityfactsandfigures2016.org/report-section/section-3/#figure-20> (figure 17 showing that in 2015 African-American and Latinos represented only 5.7% and 4.6% of recent U.S. medical school graduates, respectively).

mandate access to health care for expectant mothers for up to a year postpartum. While this section has introduced the issue of maternal health disparity, and its impact on Black women in the United States, Part II discusses the ever-rising rates of maternal mortality among Black women and its causes. Part III then delves into the history of America's control of Black female reproduction through the creation of racialized stereotypes, while Part IV introduces key international human rights standards which have been ratified by the United States and examines how these standards can be used together with local policy provisions to prevent the deaths of Black women on the birthing bed. Finally, Part V will conclude by offering potential solutions to these issues, which so gravely impact Black women throughout the United States, and the world.

II. THE ROLE OF RACISM ON MATERNAL HEALTH DISPARITIES

The United States is in a maternal health crisis – and, like many other crises, this one is disproportionately impacting women of color. Black women are four times more likely to die from pregnancy-related complications than White women.¹² While this phenomenon has been attributed to poverty, lack of access to quality healthcare, location, the true cause is racism. While race and racism are implied in all of the aforementioned causes of maternal mortality, it is racist attitudes towards Black women that are the dispositive factor in whether these mothers live or die.

Globally, more women are surviving pregnancy and childbirth each year, yet there is still work to be done.¹³ “To measure the extent of these risks, researchers commonly discuss maternal deaths in terms of ratios, with the maternal mortality ratio (MMR) representing the number of women who die from pregnancy-related causes for every 100,000 live births.”¹⁴ Pregnancy-related deaths are those that occur during pregnancy or within the following year due to pregnancy complications, either initiated by the pregnancy or because of an unrelated condition that was

¹² World Health Organization (WHO), *More women and children survive today than ever before – UN report* (Sept. 19, 2019), <https://www.who.int/news-room/detail/19-09-2019-more-women-and-children-survive-today-than-ever-before-un-report>.

¹³ *Id.*

¹⁴ Black Mamas Matter Alliance and Center for Reproductive Rights, *Black Mamas Matter: Advancing the Human Right to Safe and Respectful Maternal Health Care*, 19 (2016), https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/USP_A_BMMA_Toolkit_Booklet-Final-Update_Web-Pages.pdf [hereinafter Black Mamas Matter Alliance].

aggravated by pregnancy.¹⁵ A directly related event called severe maternal morbidity (SMM) refers to instances where women *almost* die from a life-threatening complication during pregnancy or childbirth.¹⁶ Maternal morbidity operates on a spectrum, with a healthy pregnancy on one end, and maternal death on the other, and severe maternal morbidity (as well as many other classifications) being somewhere in between.¹⁷ Since 1990, 169 different countries have successfully managed to reduce their MMR.¹⁸ With an MMR of 29.6 deaths for every 100,000 live births, the United States is the only industrialized nation with a rising rate.¹⁹ “This not only puts the United States behind wealthy countries like the United Kingdom, Japan, and Sweden, but also behind less wealthy countries such as Libya and Kazakhstan.”²⁰ The rising rates of MMR in the United States represents a real decline in maternal health outcomes.²¹ Moreover, cases of SMM are affecting more than 60,000 women in the U.S. every year, and that number is steadily increasing.²² For every woman who dies in childbirth, approximately 100 women receive a life-threatening diagnosis or undergo a life-saving procedure during their delivery hospitalization.²³ The rate of hospitalizations due to severe delivery complications has more than doubled between 1998 and 2011.²⁴ These increases in SMM are driven by many factors, including higher maternal age, obesity, rising cesarean delivery rates, and a growing number of pregnant women with pre-existing chronic medical conditions.”²⁵ As these statistics illustrate, the United States is falling behind its global counterparts in improving maternal health outcomes for women, and Black women are paying the ultimate price.²⁶

¹⁵ *Id.* (citing CDC, *Reproductive Health: Pregnancy-Related Deaths* (Mar. 29, 2016), <http://www.cdc.gov/reproductivehealth/MaternalInfantHealth/PregnancyrelatedMortality.html>).

¹⁶ Black Mamas Matter Alliance, *supra* note 14 (citing CDC, *Reproductive Health: Severe Maternal Morbidity in the United States* (Apr. 1, 2016), <http://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html>).

¹⁷ *Id.*

¹⁸ WHO, *Trends in Maternal Mortality: 1990 to 2015 70-77* (2015), <https://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2015/en/> [hereinafter *Trends in Maternal Mortality*].

¹⁹ America’s Health Ranking, *Public Health Impact: Maternal Mortality*, UNITED HEALTH FOUND (2019), https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/maternal_mortality_a/state/ALL.

²⁰ Black Mamas Matter Alliance, *supra* note 15; *see also Trends in Maternal Mortality, supra* note 19.

²¹ *Id.*

²² *Id.* at 20.

²³ *Id.*

²⁴ *Id.*

²⁵ *Id.*

²⁶ *Id.*

Poor maternal health outcomes reap a heavy toll on Black women of all education levels and socio-economic statuses. Low-income Black women are prime victims of negative maternal health outcomes due to unemployment and underemployment, low and stagnant wages, lack of health insurance, and reductions or complete erasure of programs that help low income families with health and economic security.²⁷ While higher poverty rates directly coincide with rates of maternal mortality,²⁸ the prevalence and severity of maternal mortality cannot solely be blamed on poverty. Indeed, a 2016 study by the New York City Health Department publishing five years of data found that Black, college-educated mothers who gave birth in local hospitals were more likely to suffer severe complications of pregnancy or childbirth than White women who never graduated from high school.²⁹ This data – which points to the true cause of the disproportionate impact of maternal mortality on Black women being racial, not socioeconomic, in nature – is also backed up by first-person stories of Black women – some of whom are certainly considered affluent – who have been ignored by the medical community while pregnant.

A. *Serena, Shalon, and Kira*

Maternal mortality and morbidity impact Black women of all socio-economic backgrounds. Specifically, last year, Serena Williams shared her own near-death experience after giving birth to her daughter.³⁰ In a cover story for *Vogue*, Williams detailed how both a doctor and nurse dismissed her concerns over potentially life-threatening blood clots—conditions that were eventually confirmed with a CT scan.³¹ If Serena Williams, a legendary tennis star with access to the best medical care money has to offer, has her health concerns ignored by medical professionals then this issue goes beyond socio-economic status – instead, it clearly points to racial prejudice. The story of Shalon Irving is similar. Irving was an epidemiologist at the CDC who, only three weeks after giving birth to a little girl, died.³² Again, Irving’s case did not fit the typical

²⁷ *Id.* at 22.

²⁸ WHO, *Maternal Mortality Fact Sheet* (Sept. 19, 2019), <https://www.who.int/news-room/fact-sheets/detail/maternal-mortality>.

²⁹ New York City Department of Health and Mental Hygiene, *Severe Maternal Morbidity in New York City, 2008-2012*, 15 (2016), <https://www1.nyc.gov/assets/doh/downloads/pdf/data/maternal-morbidity-report-08-12.pdf>.

³⁰ Allyson Chui, *Beyoncé, Serena Williams open up about potentially fatal childbirths, a problem especially for Black mothers*, WASHINGTON POST (Aug. 7, 2018), <https://www.washingtonpost.com/news/morning-mix/wp/2018/08/07/beyonce-serena-williams-open-up-about-potentially-fatal-childbirths-a-problem-especially-for-Black-mothers/>.

³¹ *Id.*

³² *Nothing Protects Black Women From Dying*, *supra* note 10.

story of poverty – she had a B.A. in sociology, two masters degrees and dual-subject PhD, great insurance, and a rock solid support system, yet it made no difference in the end, because Irving was a Black woman.³³ Raegan McDonald-Mosley, the chief medical officer for Planned Parenthood Federation of America, who met Irving in graduate school and was one of her closest friends said, “It tells you that you can’t educate your way out of this problem. You can’t health-care-access your way out of this problem. There’s something inherently wrong with the system that’s not valuing the lives of Black women equally to White women.”³⁴ Kira Johnson’s story serves as yet another illustration of the wrongs of the American healthcare system.³⁵ Johnson spoke five languages, raced cars, and was the daughter-in-law of famed judge Glenda Hatchett.³⁶ Already a mother of one young son, Kira was excited to have another baby boy with her husband, Charles.³⁷ Yet, what was supposed to be one of the happiest days of her life ended in tragedy.³⁸ The nightmare began when shortly after the birth of her second son, her husband noticed blood in her catheter.³⁹ After bringing it to the attention to doctors and nurses at Cedar-Sinai Medical Center in Los Angeles, they laxly ordered a CT scan.⁴⁰ One would think that the medical staff would move with more urgency in such a situation. However, Kira and Charles waited for over seven hours for the doctors to do the scan while Kira got progressively worse. The ordered CT scan was never completed, and Johnson eventually died from a hemorrhage, in the hospital.⁴¹ Her death was avoidable; she was in great health, at a world-renowned hospital, and had no pre-existing condition that would make her susceptible to complications.⁴² Her problem was that of many women who die or nearly die in childbirth in the United States – she was a Black woman.

B. *Racial Disparities in Quality of Care*

To this point, there is a huge disparity in the quality of healthcare that Black women receive in comparison to White women. According to

³³ *Id.*

³⁴ *Id.*

³⁵ Angela Helm, *Kira Johnson Spoke 5 Languages, Raced Cars, Was the Daughter-in-Law of Judge Glenda Hatchett. She Still Died in Childbirth*, THE ROOT (Oct. 19, 2018, 10:03AM), <https://www.theroot.com/kira-johnson-spoke-5-languages-raced-cars-was-daughter-1829862323>.

³⁶ *Id.*

³⁷ *Id.*

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ *Id.*

⁴² *Id.*

the 2017 National Healthcare Disparities Report, Black patients received worse care than White patients on 40% of quality measures and experienced worse access to care compared with White patients for 52% of the measures.⁴³ The quality of care that a woman receives in childbirth can depend heavily on the healthcare setting where a pregnant woman delivers.⁴⁴ While there are standards of care and best practices for handling obstetric emergencies, the success or failure of these practices depends largely on the clinical performance, which varies based on the healthcare setting.⁴⁵ Interestingly, and perhaps unsurprisingly, disproportionate numbers of Black people receive health care in a concentrated number of U.S. hospitals; and, these sites have been shown to provide lower quality of care in obstetrics.⁴⁶ Specifically, “. . . three-quarters of Black women in the United States deliver their babies in only one-quarter of U.S. hospitals.”⁴⁷ In these hospitals, the risk of SMM increased for women of all backgrounds.⁴⁸ This evidence illustrates the need to target improvements in quality of care at hospitals serving Black and minority communities.⁴⁹ Without access to quality health care, Black women are at an even greater risk of complications from pregnancy; but, it is important to note that quality of care encompasses more than just the knowledge of the doctors or cleanliness of the facilities. Rather, it includes how medical professionals treat their patients – regardless (or perhaps because of) their race.

The quality of care for pregnant Black women decreases when healthcare providers ignore or minimize their concerns. Despite attempts by the Affordable Care Act (ACA), many Black women are still uninsured as many states with large health disparities refuse to expand Medicaid, placing many poor Black adults in a coverage gap, where they make too much to be eligible for Medicaid and too little to pay for private health

⁴³ Agency for Healthcare Research and Quality (AHRQ), *2017 National Healthcare Disparities Report* 1, 14 (Sept. 2018), <https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqdr/2017nhqdr.pdf>.

⁴⁴ Black Mamas Matter Alliance, *supra* note 15 at 25.

⁴⁵ *Id.*

⁴⁶ Black Mamas Matter Alliance *supra* note 15 at 25 (citing Andreea A. Creanga, *Performance of Racial and Ethnic Minority Serving Hospitals on Delivery-Related Indicators*, 211 AM. J. OBSTET. GYNECOL. 647.e1, 647.e5-e7 (2014) (showing that Black-serving hospitals performed worse than White- or Hispanic-serving hospitals on 12 of 15 delivery-related indicators).

⁴⁷ *Id.* (citing Elizabeth A. Howell et al., *Black-White Differences in Severe Maternal Morbidity and Site of Care*, 214 AM. J. OBSTET. GYNECOL. 122.e1, 122.e1 (2016)) [hereinafter Howell].

⁴⁸ Howell, *supra* note 48 at 122.e5.

⁴⁹ Black Mamas Matter Alliance, *supra* note 15 at 25.

insurance.⁵⁰ Moreover, women who are thought to be uninsured or on public health assistance report being treated horribly by medical staff at hospitals.⁵¹ They are subject to unreasonably long delays, and are often ignored or treated with indifference by staff.⁵² Additionally, since Black women are less likely than other women to be insured, they are also less likely to receive their recommended care for disease prevention and management.⁵³ While early identification of these types of co-morbidities and pregnancy complications through preconception and prenatal care can help ensure appropriate treatment and better outcomes, Black women receive alarmingly low rates of prenatal care during the first trimester of pregnancy compared to women from most other racial and ethnic groups.⁵⁴ Postnatal care is also limited because most U.S. health plans restrict such care to a single appointment six weeks after childbirth, unless a complication has been recognized.⁵⁵ “Combined, these disparities in access expose a pattern in which Black women have more limited access to adequate health care at every point along the reproductive life course, raising the likelihood of a higher risk pregnancy, maternal morbidity, and maternal mortality.”⁵⁶

Black women are discriminated against in the healthcare system and experience higher rates of disrespect and abuse.⁵⁷ In a report by Amnesty International, a woman spoke on her experience of being forced to undergo a Cesarean section:

[T]here was no explanation as to why I could not have a vaginal birth. It was cesarean and that’s it. All other options were taken off the table.” One doctor reportedly took her aside after the delivery and told her, “We don’t

⁵⁰ Kaiser Family Foundation (KFF), *Who is Impacted by the Coverage Gap in States that Have Not Adopted the Medicaid Expansion?*, (Jan. 2016), <https://www.kff.org/slideshow/who-is-impacted-by-the-coverage-gap-in-states-that-have-not-adopted-the-medicaid-expansion/> (Slideshow using data from 2016 Medicaid eligibility levels and 2016 Current Population data, noting that 31% of Black adults fall into the coverage gap).

⁵¹ U.S. Dep’t. of Health & Human Servs. (HHS), Agency for Healthcare Research and Quality, *2012 National Healthcare Disparities Report Chapter 9* (2013), <http://archive.ahrq.gov/research/findings/nhqrdr/nhdr12/chap9.html>

⁵² Amnesty International, *Deadly Delivery: The Maternal Health Care Crisis In the USA*, 23 (2009), <https://www.amnestyusa.org/files/pdfs/deadlydelivery.pdf> [hereinafter *Deadly Delivery*].

⁵³ U.S. Dep’t. of Health & Human Servs., *supra* note 52.

⁵⁴ *Id.*

⁵⁵ Black Mamas Matter Alliance, *supra* note 15 at 24.

⁵⁶ *Id.*

⁵⁷ Maternal Health Task Force at the Harvard Chan School Center of Excellence in Maternal and Child Health, *Maternal Health in the United States*, (2016), <https://www.mhtf.org/topics/maternal-health-in-the-united-states/#Resources>.

get many Black patients. They're just not used to your personality, asking the questions that you're asking, saying what you're saying. Challenging and holding them to their diagnoses." She noted, "I was quite aware of their perceptions of me. There's that assumption – I'm a young Black girl so obviously I'm poor and uneducated . . . [but] I was asking questions every step of the way. And the more I asked, the more animosity the doctors built up towards me."⁵⁸

This is just one example of how Black women's voices are not valued by medical professionals. It should be the doctor's goal to work with the mother to determine the childbirth plan that is best for mother and baby. Due to racial prejudice, many Black mothers to be are forced to take a passive role while doctors exert their will which can have disastrous consequences. According to the World Health Organization (WHO), caesarean sections should only be performed when medically necessary and that caesarean sections done unnecessarily can put mothers and their babies at risk for short- and long-term health problems.⁵⁹ Moreover, WHO underscored the importance of doctors focusing on the individual needs of the patient, on a case by case basis, and "discourages the practice of aiming for target rates."⁶⁰ When doctors coerce Black women into undergoing a medically unnecessary caesarean section, it can result in death or disability.⁶¹

Racial prejudice against Black women can impact the level of care that they receive from medical providers. Many doctors and nurses unfortunately see race before they determine how they will treat and help their patients. In their view, Black patients are poor, uninsured, uneducated, "ghetto," and therefore unworthy of proper care and treatment. A Black woman from Memphis who later became pregnant described how the attitude of staff inhibited the quality of her care: "It was really frustrating. [I] was talked down to, things were not explained. [I] was stunned by the way [I] was treated . . . It was a real eye opener. [I] had to struggle to get the information [I] needed."⁶² The woman eventually lost her baby.⁶³ The issue is not only that Black women do not have equal

⁵⁸ *Deadly Delivery*, *supra* note 53 at 23.

⁵⁹ World Health Organization (WHO), *Caesarean sections should only be performed when medically necessary* (Apr. 10, 2015), <https://www.who.int/mediacentre/news/releases/2015/caesarean-sections/en/>.

⁶⁰ *Id.*

⁶¹ *Id.*

⁶² *Deadly Delivery*, *supra* note 53 at 24.

⁶³ *Id.*

access these services, it is that when they are able to access resources, they are treated as second class citizens and made to feel less than human. Physicians' perceptions of their patients vary by race and ethnicity, which can lead to Black patients often feeling disconnected from their overwhelmingly White doctors.⁶⁴ These perceptions are often informed by historical stereotypes of Black women, which are still pervasive to this day and extremely dangerous, especially because they impact the way that medical professionals assess and treat their patients.

III. THIS ISN'T NEW: A HISTORY OF MISTREATMENT IN ACCESSING MEDICAL CARE

Unfortunately, the abusive and inhumane treatment of Black women in the birthing bed is not a new phenomenon. Indeed, in order to fully comprehend the disproportionate impact that maternal mortality has on Black women in the United States today, it is necessary to first understand the history of the mistreatment of Black women dating back to slavery. From the moment that Black men and women were first enslaved, the Black female body was an object which, it was understood, could be manipulated and defiled without consequence. Black women were never part of the American ideal of motherhood which warranted protection and care. African slaves were viewed as Other, not human, but sub-human. And, as these beliefs evolved, African slaves soon became the victims of a racialized science which used Black bodies to support ideas of White supremacy and scientific exploration.⁶⁵

Out of this racialized science birthed a human classification system which used phenotypical traits to justify slavery and the abuses of people of African descent.⁶⁶ Under this system, African slaves were thought to have thicker skin and skulls, which according to White scientists, made them less sensitive to physical pain and less able to think abstractly (characteristics which, it was argued, naturally suited them to slavery).⁶⁷ For female slaves, this meant that they experienced relatively

⁶⁴ Brian D. Smedley et al., *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, INST. OF MEDICINE OF THE NAT'L ACADEMIES 165 (2003), <http://www.nap.edu/catalog/10260/unequal-treatment-confronting-racialand-ethnic-disparities-in-health-care> (providing an overview of the "limited but growing" body of research about the ways that biased or prejudicial attitudes among health care providers can manifest in interactions with patients.) [hereinafter Smedley].

⁶⁵ *Id.*

⁶⁶ *Id.*

⁶⁷ S. Plous and Tyrone Williams, *Racial Stereotypes From the Days of American Slavery: A Continuing Legacy*, J. OF APPLIED PSYCHOL. 795, 796 (1995).

little pain in child birth in comparison to their White counterparts.⁶⁸ A 1817 report in the *London Medical and Chirurgical Review* stated that “Negresses . . . will bear cutting with nearly, if not quite, as much impunity as dogs and rabbits.”⁶⁹ It was this stereotype of Black women’s inability to feel pain that spawned the work of J. Marion Sims, a doctor who rose to fame through his experiments on enslaved women.⁷⁰ Female slaves were the unfortunate guinea pigs for many of the gynecological breakthroughs that we have today, many of which were first pioneered by Sims.⁷¹ At the time, the sole purpose of Black female reproduction was to sustain slavery. Moreover, due to the lack of adequate medical care, many women suffered debilitating complications after childbirth including constant pain and incontinence.⁷² To remedy this, slaveowners would send their slaves to Sims, where he would perform experimental operations on them as a method of testing these procedures before they were performed on White women.⁷³

Sims is most known for pioneering a surgical technique to repair vesicovaginal fistula, a common complication back then in which a tear between the uterus and bladder caused constant pain and incontinence.⁷⁴ One of Sims’ first attempts to repair a vesicovaginal fistula was performed on a slave named Lucy, who was eighteen years old, had given birth a few months prior and had not been able to control her bladder since.⁷⁵ Lucy endured an hour-long surgery, naked, screaming and crying out in pain, as nearly a dozen other doctors watched.⁷⁶ As Sims later wrote, “Lucy’s agony was extreme.”⁷⁷ She became extremely ill due to his controversial use of a sponge to drain the urine away from the bladder, which led her to contract blood poisoning.⁷⁸ “I thought she was going to die . . . it took Lucy two or three months to recover entirely from the effects of the operation,” he wrote.⁷⁹ Only after perfecting the procedure, did Sims

⁶⁸ *Id.*

⁶⁹ *Id.*

⁷⁰ Brynn Holland, *The ‘Father of Modern Gynecology’ Performed Shocking Experiments on Slaves*, HISTORY (Aug. 9, 2017), <https://www.history.com/news/the-father-of-modern-gynecology-performed-shocking-experiments-on-slaves> [hereinafter Holland].

⁷¹ *Id.*

⁷² *Id.*

⁷³ *Id.*

⁷⁴ *Id.*

⁷⁵ Dorothy Roberts, *KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY* 23 (1st ed. 1997).

⁷⁶ *Id.*

⁷⁷ *Id.*

⁷⁸ *Id.*

⁷⁹ *Id.*

operate on White women under anesthesia.⁸⁰ With this history in mind, it is no wonder that there is an undercurrent of mistrust between Black women and their doctors. This stereotype of an inability to feel pain manifests itself today in a multitude of ways—from obstetricians ignoring their Black patients’ pain and performing medically unnecessary caesarean sections to blatantly discrediting and minimizing their health concerns and needs. However, there were other stereotypes and archetypes of Black women – specifically, the Jezebel, the “Welfare Queen,” and the Sapphire – which have also impacted the ways in which physicians perceive Black motherhood, and the free exercise of reproductive rights by Black women.

A. *Stereotypes Affect Social Ideas of Black Women*

American society has historically framed Black women as less than human. To justify the misuse and abuse of the Black female body, the archetype of the Jezebel was created by the media and sustained by White society. The Jezebel is governed only by her erotic desires and her sexual prowess led men to wanton passion.⁸¹ As a Jezebel, the Black woman was viewed only as a sexual object for men, devoid of any morals or dignity.⁸² This archetype is in strong contrast to the imagery of the White woman as chaste and pure.⁸³ One researcher wrote that the Jezebel was a “. . . construct of the licentious temptress [which] served to justify White men’s sexual abuse of Black women.”⁸⁴ “The stereotype of Black women as sexually promiscuous also defined them as bad mothers.”⁸⁵ Later, the promiscuity of the Jezebel birthed the archetype of the so-called “welfare queen.” The typical illustration of the welfare queen depicted a Black woman, who was a lazy mother on public assistance, deliberately breeding children at the expense of taxpayers in order to collect a check from the state.⁸⁶ This picture of reckless Black fertility frightened and angered White Americans, significantly more so than the Jezebel archetype did – the “welfare queen,” after all, symbolized not only that Black women were inherently promiscuous, but also that they purposely bore children into poverty to manipulate and play the system.⁸⁷ This stereotype portrayed Black women not as individual who were entirely incapable of rational decision making; rather, Black women were calculating parasites

⁸⁰ *Id.*

⁸¹ *Id.* at 11.

⁸² *Id.*

⁸³ *Id.*

⁸⁴ *Id.*

⁸⁵ *Id.* at 11.

⁸⁶ *Id.* at 17.

⁸⁷ *Id.*

deserving of harsh discipline.⁸⁸ This thought was compounded by media coverage, which connected the welfare debate to infamous cases of neglectful mothers, which left the impression that all welfare mothers take advantage of the system and squander their benefits while allowing their children to suffer.⁸⁹

Racialized stereotypes such as these, depicting Black mothers as reckless and promiscuous allowed state agents to rationalize the control of Black female reproduction. For example, in the 1970s, it was revealed that doctors had coerced hundreds of thousands of Black women into agreeing to sterilization by conditioning medical services on consent to the operation.⁹⁰ Some doctors refused to deliver babies or perform abortions for Black women on low incomes unless they first agreed to be sterilized.⁹¹ These “policies” targeted low-income Black women because they were deemed unfit mothers due to laziness, promiscuity, and drug use. “[W]ith these disparaging images of Black mothers, the media increasingly portrayed Black children as incapable of contributing anything positive to society.”⁹² This ideal birthed the panic over “crack babies” back in the 1980s and 90s. The media pushed the erroneous narrative that crack babies were irreversibly damaged by their mothers’ usage of crack cocaine, which had allegedly caused neurological injuries and stunted emotional development in these children. White parents feared these brain-damaged crack babies would turn into criminals, who would rob, kill, and rape their White children. The moral devaluation of Black motherhood along with “science devoted to proving Black biological inferiority, cast Black childbearing as a dangerous activity,” which has clearly negatively impacted the continuing relationship between Black, pregnant women and their physicians.⁹³ And, while the effects of these stereotypes – that is, of the Jezebel and the “welfare queen,” – are still felt throughout the American medical field, there is an additional (and more recent) stereotype which may be having even more of a significant impact: the Sapphire.

The Sapphire, also known as the Angry Black Woman (ABW) archetype depicts exactly that—a bitter and angry Black woman who is rude, loud, stubborn, and overbearing.⁹⁴ The Sapphire has been popularized in television and movies with images of a Black woman with her hand on her hip, yelling and arguing with anyone that stands in her way, which leads to any Black woman who speaks her mind to be viewed

⁸⁸ *Id.*

⁸⁹ *Id.* at 19.

⁹⁰ *Id.* at 176.

⁹¹ *Id.*

⁹² *Id.* at 19.

⁹³ *Id.* at 21.

⁹⁴ *Id.*

as the ABW.⁹⁵ This is a dangerous stereotype as it punishes Black women for speaking their minds in violation of societal norms that encourage them to be docile, passive, and unseen. For Black women accessing obstetric care, this can lead to any complaint or concern to be labeled as the ramblings of an angry Black woman, which then justifies a physician ignored or minimizing that concern. This stereotype can also have a chilling effect on the initial expression of those concerns by Black women, who may feel as though they are being pressured into remaining silent in order to not come off as an angry Black woman.

The historical mistreatment of Black women in medical settings has sparked distrust and fear of White-dominated healthcare programs. The archetypes of Black women as the Jezebel, the “welfare queen,” and the angry Black woman are given life as doctors view pregnant Black women either as promiscuous women who purposely got pregnant to secure a welfare check, or loud and angry troublemakers whose concerns require no action or even consideration. The stereotypes mentioned above are pervasive even amongst educated physicians and nurses.⁹⁶ And, while they may be conscious or unconscious, these biases negatively affect the ability of these medical care providers to treat Black women with the level of care that ensures a healthy and safe delivery. Maternal mortality not only impacts Black mothers, but Black children and their families – and, to properly address this issue, and to mitigate these negative impacts, these biases must be addressed. However, aside from bias-reduction training for medical providers, there are other solutions to the Black maternal mortality problem currently plaguing the United States, some of which can be found via the examination of this issue through a human rights framework.

IV. ADOPTING A HUMAN RIGHTS FRAMEWORK TO COMBAT MATERNAL MORTALITY

The maternal health crisis in the United States rivals that of third-world countries.⁹⁷ The U.S. government has a responsibility to ensure access to quality health care services for all women regardless of race. The gross maternal health disparities between Black and White women violates the human right to life, health, and to be free from discrimination.⁹⁸ This portion will discuss maternal health as a human right that creates an obligation from the state and federal government to

⁹⁵ *Id.*

⁹⁶ *Id.*

⁹⁷ Eliana Dockterman, *U.S. Ranks Worst Developed Country for Maternal Health* (May 6, 2015), <https://time.com/3847755/mothers-children-health-save-the-children-report/>.

⁹⁸ *Id.*

respect, protect, and fulfill these human rights. Moreover, this section argues that various levels of government within the United States are responsible for guaranteeing a healthcare system that ensures these rights universally and equitably. By adopting a human rights-based approach to addressing maternal mortality, the United States government can create legislation and policies that are inclusive and that ensure the accessibility, availability, acceptability of quality maternal healthcare.

A. International Human Rights Standards that Focus on the Right to Health, Life, and to be free from Discrimination

The United States has currently ratified two key international human rights treaties – the International Covenant on Civil and Political Rights (ICCPR) and the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) – that guarantee some of the rights which are implicated by the current maternal mortality crisis: the right to health, life, and to be free from discrimination.⁹⁹ Under the Article 6 of the ICCPR, every human being has the right to life and it “shall be protected by law.”¹⁰⁰ The Human Rights Committee (the body charged with interpreting the ICCPR) has noted that protecting the right to life “requires that States adopt positive measures.”¹⁰¹ Positive measures require the government to take active steps to ensure the right to life in all communities. For Black women in the United States, that means that states must not only work to reduce preventable maternal deaths but provide access to comprehensive reproductive and sexual health education as part of their obligation to protect the right to life under the ICCPR.

In signing and ratifying the ICERD, the United States has committed to “prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone . . . the right to public health [and] medical care.”¹⁰² The ICERD prohibits policies or practices that are discriminatory in either purpose or effect. Therefore, policies or practices that have a disproportionate impact on a marginalized group may be

⁹⁹ Office of the High Commissioner for Human Rights (OHCHR), *Ratification Status for United States of America*, https://tbinternet.ohchr.org/_layouts/TreatyBodyExternal/Treaty.aspx?CountryID=187&Lang=EN (last visited Nov. 2, 2019).

¹⁰⁰ Art.6, International Covenant on Civil and Political Rights (ICCPR) (Mar. 23, 1976), <https://www.ohchr.org/EN/ProfessionalInterest/Pages/CCPR.aspx>.

¹⁰¹ Human Rights Committee (HRC), *General Comment No. 06: The Right to Life (Art. 6) (Sixteenth Session)*, in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies* at 127, U.N. Doc. HRI/GEN/1/Rev.6 (May 23, 2003).

¹⁰² Art. 5 (e)(iv), International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) (Jan. 4, 1969), <https://www.ohchr.org/EN/ProfessionalInterest/Pages/CERD.aspx>.

discriminatory in effect and in breach of international law.¹⁰³ The UN Human Rights Committee has also noted that the ICCPR's prohibition of discrimination should be understood to encompass both discriminatory purposes and effects.¹⁰⁴ However, under American law, federal courts only protect against discrimination that can be shown to arise from discriminatory intent. However, there is a lack of research which would be able to illustrate the role of racial animus in the current maternal mortality crisis – as such, utilizing a human rights framework (which requires only discriminatory effects, rather than intentions as well) can fill in the gap that American jurisprudence leaves open. The Committee on the Elimination of Racial Discrimination has found that the United States government is falling short in its duty to eliminate racial inequalities. The Committee noted that “wide racial disparities continue to exist in the field of sexual and reproductive health, particularly with regard to the high maternal and infant mortality rates among women and children belonging to racial, ethnic and national minorities, especially African-Americans, the high incidence of unintended pregnancies and greater abortion rates affecting African-American women.”¹⁰⁵ In addition, in June 2009 the United States supported a resolution adopted by the UN Human Rights Council, which “. . . recognized that preventable maternal mortality and morbidity are a human rights challenge that requires the promotion and protection of the human rights of women and girls.”¹⁰⁶

Moreover, racial disparities in maternal health outcomes trigger right to health protections. The most authoritative and complete statement of the “right to health” can be found in the International Covenant on Economic, Social, and Cultural Rights (ICESCR) in Article 12, which grants everyone the right “. . . to the enjoyment of the highest attainable standard of physical and mental health.”¹⁰⁷ However, the United States has yet to ratify this treaty. Therefore, the United States needs to take steps to ensure the right to health for all citizens. The components of the right to health care include the availability, accessibility, acceptability, and quality of health facilities, goods, and services.¹⁰⁸ The accessibility of health facilities, goods, and services means that services are non-discriminatory,

¹⁰³ *Deadly Delivery*, *supra* note 53 at 15.

¹⁰⁴ *Id.* at 16.

¹⁰⁵ Committee on the Elimination of Racial Discrimination (CERD), *Concluding observations of the Committee on the Elimination of Racial Discrimination, United States of America*, ¶ 33, U.N. Doc. CERD/C/USA/CO/6 (Mar. 5, 2008).

¹⁰⁶ *Deadly Delivery*, *supra* note 53 at 13.

¹⁰⁷ Art. 12, International Covenant on Economic, Social, and Cultural Rights (ICESCR) (Jan. 3, 1976), <https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx>.

¹⁰⁸ CESCR, *General Comment No. 14 The right to the highest attainable standard of health (Art. 12)*(Twenty-second session), U.N. Doc. E/C.12/2000/4, ¶ 12 (b) (Aug. 11, 2000).

physically accessible, affordable, and the information is easily accessible.¹⁰⁹ The acceptability of health facilities, goods, and services means that they must be respectful of medical ethics, culturally appropriate, and sensitive to gender and life-cycle requirements.¹¹⁰ Although this right is dependent on resources, it contains a minimum core of non-discrimination, equitable distribution of health services and goods, essential medicines, minimum essential food, potable water, basic shelter, and sanitation.¹¹¹ It also includes national public health strategies and plans of actions adopted through a participatory process. Additionally, these national public health strategies and plans must include standards to measure progress. Despite these commitments to its human rights obligations, the U.S. is the only high-income country in the world where pregnancy-related deaths are rising.¹¹²

B. Addressing Maternal Mortality in the United States and Abroad

Maternal mortality rates are exceptionally high around the world.¹¹³ According to the World Health Organization (WHO), 295,000 women died either during pregnancy or following childbirth in 2017.¹¹⁴ In 2010, a study by the United Nations Human Rights Office (OHCHR) called maternal mortality a human rights issue and attributed the maternal deaths of women and girls globally to discrimination.¹¹⁵ It noted that the widespread scale of maternal mortality and morbidity reflected systemic inequality and discrimination that was perpetrated by “formal laws, policies and harmful social norms and practices.”¹¹⁶ As maternal health has become a global health priority, the failure of the United States to adequately address racial disparities in maternal health outcomes has faced international scrutiny. The *Save the Children Federation* ranked the U.S. 33rd on its *Mothers’ Index* noting that while the U.S. did well on indicators such as economic and educational status, it fell behind all the other top-ranked countries on maternal health, child well-being, and political

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

¹¹¹ *Id.*

¹¹² Black Mamas Matter Alliance, *supra* note 15 at 9.

¹¹³ WHO, *Maternal Mortality Fact Sheet* (Sept. 19, 2019), <https://www.who.int/news-room/fact-sheets/detail/maternal-mortality>.

¹¹⁴ *Id.*

¹¹⁵ OHCHR, *Information note: Maternal mortality is a human rights issue, says a new UN study* (2010), https://www.ohchr.org/Documents/Issues/MDGs/Infonote_maternal_mortality.pdf.

¹¹⁶ *Id.*

status.¹¹⁷ In the United States, women have a 1 in 1,800 risk of maternal death which leaves a woman in the U.S. more than 10 times likely to die of a pregnancy-related cause than a woman in Austria, Belarus, or Poland.¹¹⁸

Across the globe, progress has been made to improve maternal health outcomes for women of all backgrounds. During a convening hosted by the U.S. Department of Health and Human Services, global experts on maternal health shared insight on how various countries improved their maternal health outcomes and addressed the challenges that they continued to face.¹¹⁹ Through the global initiative, Saving Mothers Giving Life (SMGL), cases of maternal mortality were reduced by about half in targeted districts of Uganda and Zambia.¹²⁰ The initiative focused on the critical period of labor, delivery, and 48 hours postpartum, when most maternal deaths and about half of newborn deaths occur.¹²¹ The program also connected women and children to other essential services, including HIV prevention, care, and treatment.¹²² Experts from Canada, Finland, and the United Kingdom noted that their publicly funded healthcare systems removed barriers for women of reproductive age seeking care.¹²³ These services included home visits, counseling, family education and planning during the early postpartum period.¹²⁴ Additionally, access to paid maternity and paternity leave also helped to improve maternal health outcomes in these countries.¹²⁵ The global representatives provided approaches to improve maternal health outcomes for all women.¹²⁶ These approaches emphasized listening to patients and respecting women and their needs and increasing access to comprehensive and continuous care across the lives of women within the context of their culture.¹²⁷ The experts also noted the importance of collaboration, “the utilization of data, the amelioration of unconscious biases among providers, and the inclusion of all provider groups in the provision of

¹¹⁷ Save the Children Federation, Inc., *State of the World's Mothers 2015*, 55 (2015), <https://www.savethechildren.org/content/dam/usa/reports/advocacy/sowm/sowm-2015.pdf>.

¹¹⁸ *Id.* at 59.

¹¹⁹ HRSA Maternal Mortality Summit, *Promising Global Practices to Improve Maternal Health Outcomes Technical Report*, U.S. DEP'T OF HEALTH AND HUM. SERVICES HEALTH RESOURCES AND SERVICES ADMIN., 8 (Feb. 15, 2019), <https://www.hrsa.gov/sites/default/files/hrsa/maternal-mortality/Maternal-Mortality-Technical-Report.pdf>.

¹²⁰ *Id.*

¹²¹ *Id.*

¹²² *Id.*

¹²³ *Id.* at 9.

¹²⁴ *Id.*

¹²⁵ *Id.* at 10.

¹²⁶ *Id.*

¹²⁷ *Id.*

care.”¹²⁸ Although not citing to international human rights jurisprudence, these approaches encompass the ideals of anti-discrimination and accessible healthcare services for all women.

While the remainder of the world, it seems, is at the very least attempting to ameliorate maternal mortality rates, the United States government has taken only minimal measures, which have not as of yet had any marked effect in improving the status of our maternal mortality crisis. As previously discussed, the U.S. federal government recently attempted to at least somewhat address maternal health disparities through the passage of the *Preventing Maternal Deaths Act of 2018*, which sets up federal infrastructure and allocates resources to analyze maternal deaths in every state.¹²⁹ The bill is intended to support current maternal mortality review committees (MMRCs) in states and tribal nations across the country with the support of federal funding and the reporting of standardized data.¹³⁰ “MMRCs collect information to try to understand factors related to deaths during pregnancy, delivery, and the postpartum period, including health care and clinical factors, some also focus on social determinants of health, such as housing, food access, violence, community safety, structural racism, and economic circumstances.”¹³¹ As of today, there are only 38 states with active MMRCs and the state MMRCs vary in which data is collected, as well as in methodologies for collecting data.¹³² Furthermore, some states only mandate the collection of data and internal review, with no required subsequent action, while other states do mandate follow-up action.¹³³ This is troublesome because without mandatory follow up action, MMRCs are largely useless – what good, after all, is data collection if it is not being used to inform and create evidence-based law and policies to improve maternal health outcomes for Black women?

In a recent report from the CDC compiling data from fourteen MMRCs from 2008-2017, pregnancy-related deaths occurred not only during pregnancy and childbirth, but up to a year postpartum.¹³⁴ Moreover, this report noted that for these states, the leading underlying causes of pregnancy-related deaths among Black women were: cardiovascular conditions, hemorrhage, infection, embolism,

¹²⁸ *Id.*

¹²⁹ Katy B. Kozhimannil et al., *Beyond The Preventing Maternal Deaths Act: Implementation And Further Policy Change*, HEALTH AFFAIRS BLOG (Feb. 4, 2019), <https://www.healthaffairs.org/doi/10.1377/hblog20190130.914004/full/>.

¹³⁰ *Id.*

¹³¹ *Id.*

¹³² *Id.*

¹³³ *Id.*

¹³⁴ Nicole L. Davis et al., *Pregnancy-Related Deaths: Data from 14 Maternal Mortality Review Committees, 2008-2017*, CDC (2019), https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/MMR-Data-Brief_2019-h.pdf.

cardiomyopathy, preeclampsia, and eclampsia.¹³⁵ Yet, it was also reported that the vast majority of these deaths – 65.8% of them, in fact – were preventable.¹³⁶ The bill is a good first step in placing the issue of maternal mortality on the federal agenda, but there is more work to be done on the state level, where legislation to improve maternal health outcomes should be passed. The impact of state legislation in this area is likely understated currently, with some advocates remarking that “the policies that [states] pursue influence our health status, our access to care, and the resources that exist in our communities.”¹³⁷ One case study which illustrates the impact that state governments have on maternal health outcomes is the debate about Medicaid expansion through the Patient Protection and Affordable Care Act.

Despite the passage of the Affordable Healthcare Act (ACA), fourteen states have rejected the Medicaid expansion.¹³⁸ Medicaid covers nearly half of all births and must cover pregnant women through 60 days postpartum.¹³⁹ However, after the 60 days, the choice to expand coverage is left to the state legislators to decide.¹⁴⁰ While babies born under Medicaid are provided for up to the first year, this same level of care is not given to their mothers, which leaves uninsured pregnant Black women without access to coverage during one of the most medically vulnerable phases of their lives.¹⁴¹ States must fulfill the right to health by expanding Medicaid coverage for pregnant women to one year postpartum. In a recent statement by the President of the American College of Obstetricians and Gynecologists, the organization supported expanding Medicaid coverage for twelve months postpartum.¹⁴² By providing health insurance up to a year after childbirth, states can reduce maternal deaths, including those linked to cardiovascular disease, cardiomyopathy, and overdose and suicide, which occur in the postpartum period.¹⁴³ If the remaining fourteen states would either expand Medicaid or provide a suitable alternative,

¹³⁵ *Id.*

¹³⁶ *Id.*

¹³⁷ Black Mamas Matter Alliance, *supra* note 15 at 29.

¹³⁸ Black Mamas Matter Alliance, *supra* note 15 at 31.

¹³⁹ Usha Ranja et al., *Expanding Postpartum Medicaid Coverage*, Kaiser Family Found. (KFF) (May 22, 2019), <https://www.kff.org/womens-health-policy/issue-brief/expanding-postpartum-medicaid-coverage/> (The states are: Texas, Alabama, Missouri, Mississippi, Florida, Georgia, Kansas, North Carolina, Oklahoma, South Dakota, Wyoming, South Carolina, Wisconsin, Tennessee).

¹⁴⁰ *Id.*

¹⁴¹ *Id.*

¹⁴² The American College of Obstetricians and Gynecologists (ACOG), *ACOG Statement on AMA Support for 12 Months of Postpartum Coverage under Medicaid* (Jun. 12, 2019), <https://www.acog.org/About-ACOG/News-Room/Statements/2019/AMA-Support-for-12-Months-Postpartum-Medicaid-Coverage?IsMobileSet=false>.

¹⁴³ *Id.*

Black mothers would have access to a primary care that can help prevent pregnancy complications, manage chronic conditions that can be exacerbated by pregnancy, and provide care in postpartum period.¹⁴⁴ If the remaining states refuse to expand Medicaid, a new bill entitled the *Maximizing Outcomes for Moms through Medicaid Improvement and Enhancement of Services* (MOMMIES) Act (which was introduced in May 2019) may be the key to ensuring coverage for women for up to a year postpartum.¹⁴⁵ If passed, it would also ensure that all pregnant and postpartum women have full Medicaid coverage, rather than coverage that can be limited to pregnancy-related services; and increasing access to primary care providers and women's health providers.¹⁴⁶ With 17% of Black women reporting that they have no personal doctor/health care provider, the passage of this bill could make all the difference in saving Black mothers.¹⁴⁷ Introduced in the U.S. Senate and supported by several democratic presidential candidates, this bill is one of the most far-reaching proposals ever introduced in Congress on maternal health.¹⁴⁸

C. *Effective Solutions Must Include the Community Most Impacted – Black Women*

For the United States to succeed in eliminating racial disparities in maternal health outcomes, Black women must be given the opportunity to be their own advocate and to get involved in legislation and policy making. “The limited options available to women in terms of maternal health care reflect the failure to include community members and advocacy groups in the decision-making process regarding what constitutes appropriate, quality maternal care.”¹⁴⁹ “An individual woman's ability to actively participate in her care is hampered by a lack of information about care options and the failure to involve women in decision-making regarding their own health care.”¹⁵⁰ A true movement to decrease maternal deaths among Black women must involve stakeholders from various communities, including: policy makers, public health

¹⁴⁴ Black Mamas Matter Alliance, *supra* note 15, at 31.

¹⁴⁵ Press Release, Cory Booker United States Senator for New Jersey, Ahead of Mother's Day, Booker, Pressley, Colleagues Introduce Bill to Improve Maternal Health Outcomes (May 8, 2019), https://www.booker.senate.gov/?p=press_release&id=921 [Booker].

¹⁴⁶ *Id.*

¹⁴⁷ KFF, *Percent of Women who Report Having No Personal Doctor/Health Care Provider 2015-2017, by Race/Ethnicity*, KAISER FAMILY FOUND., <https://www.kff.org/disparities-policy/state-indicator/no-personal-doctor/?currentTimeframe=0&selectedDistributions=non-hispanic-Black&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

¹⁴⁸ Booker, *supra* note 146.

¹⁴⁹ *Deadly Delivery*, *supra* note 53 at 17.

¹⁵⁰ *Id.*

representatives, community advocates, and Black mothers and supporters. “To improve maternal health outcomes, advocates need to hold state and local decision-makers responsible for these policy choices, while also pushing forward new ideas that respect, protect, and fulfill our human right to safe and respectful maternal health care.”¹⁵¹

Here, too, it is evident that state governments are in a unique position to adopt human rights language to make local policies more progressive. The *Black Mamas Matter Alliance* Toolkit lists three steps to help states adopt a human rights approach to addressing racial disparities in maternal health outcomes.¹⁵² First, states must examine and address both the immediate and underlying causes of maternal mortality, morbidity, or mistreatment during pregnancy and childbirth.¹⁵³ As mentioned previously, poverty, access to care, quality of care, and racial discrimination – many of which are caused by racism – all contribute to the maternal health crisis for Black women. “The intersection of discrimination on the basis of gender, race, indigenous status, immigration status, language and poverty may create a climate where women’s needs and rights are routinely disregarded.”¹⁵⁴ Many states do not have legislation requiring that medical students or physicians complete cultural competency courses as part of their licensing or accreditation programs. Discriminatory attitudes among clinicians prevent and discourage Black women from accessing the health care they need leading to serious health consequences.¹⁵⁵ Second, states need to identify responsibility for each of these factors, some of which may transcend the health sector.¹⁵⁶ The issue of maternal health disparities touches health, education, housing, transportation, and employment. Third, states should suggest and prioritize actions that different actors can take to change the conditions that are causing the problem.¹⁵⁷ As mentioned previously, there is a cultural history of distrust between Black women and medical care providers. Health institutions should make Black women aware of other child birthing options that involve more holistic methods. Many low-income Black women may not know how to access this service option, cannot afford it, or are not aware of it.¹⁵⁸ Policymakers on the local level need to ensure access doula and midwifery care.¹⁵⁹ During such an

¹⁵¹ *Id.*

¹⁵² *Id.*

¹⁵³ *Id.* at 30.

¹⁵⁴ *Deadly Delivery*, *supra* note 53 at 22.

¹⁵⁵ *Id.* at 23.

¹⁵⁶ Black Mamas Matter Alliance, *supra* note 15 at 30.

¹⁵⁷ *Id.*

¹⁵⁸ *Id.* at 47.

¹⁵⁹ *Id.* at 48.

emotionally charged time as childbirth, the presence of an advocate or community-based health care setting can make all the difference.

V. CONCLUSION AND FINAL THOUGHTS

While the human rights instruments are largely aspirational and not binding on the United States in the ways federal, state, and local laws are, the ideals within the human rights system provide valuable guidance for countries – and states – that are looking to create progressive policies to respect, protect, and fulfill the human rights of everyone within its borders. Across the globe, countries are effectively responding to challenges in maternal health care and focusing on eliminating disparities that impact marginalized women. Right now, the United States is failing in that responsibility as more Black women die due to pregnancy-related complications. With maternal health disparities drawing a thick line between Black and White, solutions to maternal mortality cannot ignore racial stereotypes and racial bias among medical care providers. Movements for change must be both legal and social in nature and focus on reducing physician bias as well as insulating American law policies which respect the rights of all mothers, regardless of their socio-economic status and racial background.

This Note intends to raise awareness about the issue of maternal mortality in the Black community and its connection to race. The mistreatment and abuse of the Black female body is not a new phenomenon. Viewed as the Other, Black women during slavery were objects that could be manipulated for scientific gains with no regard for their humanity. Later, racialized stereotypes of Black women as terrible mothers still negatively impact the quality of care that they receive in comparison to their White counterparts today. Addressing maternal health disparities among Black women will take a joint effort between the federal and state governments to reevaluate the way doctors, nurses, public health officials, and state actors respond to medical emergencies during childbirth and how they investigate maternal deaths afterwards. In adopting a human rights-based approach, the United States government has the unique opportunity utilize international human rights standards of the right to life, health, and freedom from discrimination to get multi-level stakeholders involved and to empower Black women to advocate for themselves and for their own communities.