The Dark Side to Delivery: Illuminating the U.S. Black Maternal Health Crisis

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Abstract: In the United States, pregnant and postpartum women are dying at the highest rate among developed countries. This crisis disproportionately impacts Black women, who are three times more likely to die during childbirth than white women (Centers for Disease Control and Prevention [CDC], 2020). A plethora of factors contribute to this disparity. Black women are more likely to experience lower quality healthcare or be unnecessarily recommended riskier surgeries such as cesarean sections even in low-risk births. Additionally, they have lower access to affordable healthcare plans that administer maternal care (Martin et al., 2019). The CDC reports that 60 percent of maternal deaths are preventable, highlighting the urgent need to improve maternal health quality and accessibility in the United States. This paper argues that poor Black maternal health and Black maternal mortality constitute a public health crisis in the United States. While existing research highlights socioeconomic barriers as key contributors to health inequities, this paper identifies implicit bias as the underlying driver of these disparities. Drawing on the lived experiences of Black women and systemic racial bias in healthcare, it provides a nuanced understanding of Black maternal mortality. During the recent Biden-Harris administration initiatives demonstrating an interest in Black maternal health, they advocate for holistic solutions, including eliminating racial biases, ensuring equitable and patient-centered care, and improving maternal healthcare quality.

"No, you have to do something!"

"Just go home. Let it abort. You can get pregnant again because that is what you people do" (Murphy, 2021).

U.S. Representative Cori Bush was devastated by these words from her doctor when she went into preterm labor at 16 weeks during her second pregnancy. Her terrified mind spiraled back to a similar situation she had been in just months before. During her first pregnancy she suffered from hyperemesis gravidarum, a severe form of morning sickness characterized by persistent nausea, vomiting, and dehydration (Murphy, 2021). She had sat in her doctor's office at five months pregnant, encouraged by a sign on the wall that read: "If you feel something is wrong, something is wrong. Tell your doctor." However, when Bush told her doctor she was hastily dismissed and repeatedly told she was "fine" and should "go home" (Murphy, 2021). So, she returned home. One week later, Bush went into labor at only 23 weeks gestation, and her son Zion was born.

"His ears were still in his head. His eyes were still fused shut. His fingers were smaller than rice, and his skin was translucent…We were told he had a zero percent chance of life," Bush recalled (Murphy, 2021). Bush's son survived, but her concerns about not being listened to during her pregnancy were brushed aside yet again in her second pregnancy.

Bush later testified before Congress, sharing how dismissive and biased medical care nearly cost her and both her children's lives: "My children almost became a statistic. I almost became a statistic" (Bush, 2021).

Bush's harrowing experience highlights a crisis that disproportionately impacts Black women in the United States. While Bush survived, many do not. Every year, over 50,000 women in the U.S. experience life-threatening pregnancy complications (Dent, 2020), and Black women are three times more likely to die during childbirth than white women (CDC, 2023).

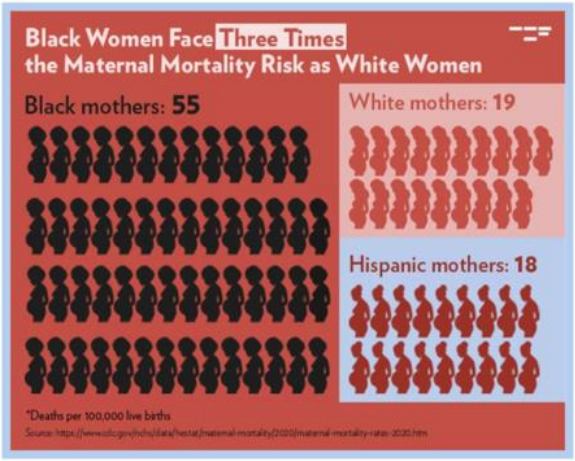
This paper will demonstrate that poor Black maternal health and Black maternal mortality constitute a public health crisis in the United States. Socioeconomic barriers that contribute to health inequities are discussed as they play an important role in Black maternal mortality (Singh, 2021). However, this paper goes further to evaluate how implicit bias is the underlying driving cause of maternal health inequity. It will provide a more nuanced understanding of Black maternal mortality rooted in the lived experiences of Black women in the United States to inform more effective policy solutions that address the causes of maternal mortality more holistically, particularly considering the Biden-Harris administration's voiced dedication to addressing Black maternal health (Congress.gov, 2021).

Reframing Black Maternal Mortality as a U.S. Public Health Crisis

Lived experiences like that of Congresswoman Cori Bush are often portrayed in the media as individual misfortunes rather than as evidence of systematic racial health disparities in the United States. This section examines the broader public health crisis, highlighting alarming statistics, systemic factors, and the global context that positions the U.S. as an outlier among industrialized nations.

Figure 1

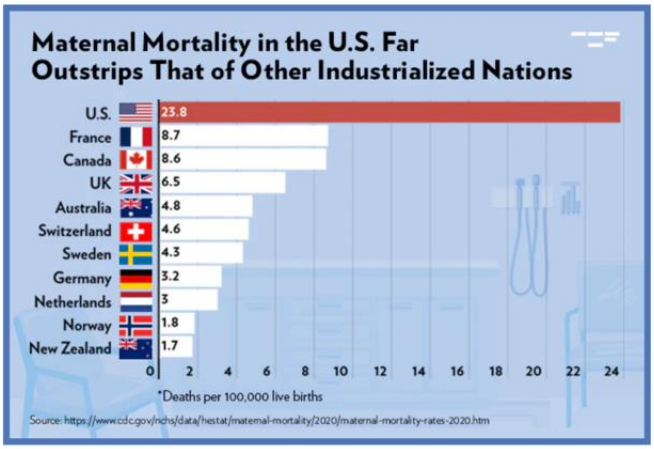
A comparative perspective on Black women's maternal mortality rates in the United States



Note: Adapted from *Maternal Mortality Rates in 2020,* by Centers for Disease Control and Prevention (CDC), National Center for Health Statistics, 2020, CDC (https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2020/maternal-mortality-rates-2020.htm). Copyright 2020 by the CDC

Figure 2

A comparative perspective of U.S. maternal death rates in the industrialized global context



Note: Adapted from *Maternal Mortality Rates in 2020,* by Centers for Disease Control and Prevention (CDC), National Center for Health Statistics, 2020, CDC (https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2020/maternal-mortality-rates-2020.htm). Copyright 2020 by the CDC

In 2020, the maternal mortality rate in the U.S. was 23.8 deaths per 100,000 live births (Hoyert, 2020), with Black women disproportionately affected. Black women face a mortality rate three times higher than that of white women (Figure 1). The Centers for Disease Control and Prevention (CDC) further highlights these disparities: Black women are 22 percent more likely to die from heart disease, 71 percent more likely to succumb to cervical cancer, and a staggering 243 percent more likely to die from pregnancy- or childbirth-related causes compared to white women (Martin et al., 2017). This stark inequity persists despite the United States being the world's wealthiest nation and spending $4.3 trillion on healthcare in 2021 (CMS.gov, 2022). These figures reveal a systemic failure to prioritize Black women's health.

U.S. Maternal Health in the Global Context

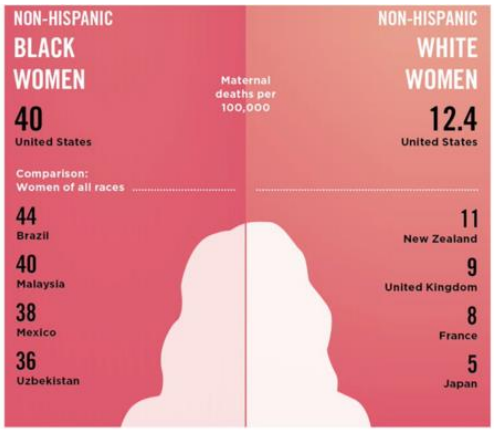
Despite disproportionately affecting Black women, maternal death rates in the U.S. are significantly higher than in comparable industrialized economies (Taylor, 2022). In 2020, the U.S. maternal mortality rate was nearly three times higher than that of France, the industrialized country with the next highest rate (Figure 2). The World Health Organization (WHO) reported in 2015 that Black expectant and new mothers in the U. S die at about the same rate as women in countries such as Mexico and Uzbekistan, where large proportions of the population live in poverty (Figure 3). As a result, the United States remains one of the riskiest countries for Black women to give birth (Figure 4).

Rising Yet Preventable Maternal Deaths

U.S. Maternal death rates have been increasing over time (Figure 5). In 1986 the CDC implemented a pregnancy mortality surveillance system that monitored maternal deaths (CDC, 2022). Since then, the system has recorded a consistent rise in maternal mortality in the United States. Some researchers suggest that the reason rates appear to be rising is because new classification codes in data collection methods have improved the accuracy of the record (Joseph, 2017). However, despite minimal improvements in data collection in recent years, maternal mortality rates have still increased from 20.1 in 2019 to 23.8 in 2020 to 32.9 in 2021 per 100,000 live births (CDC, 2023). This stands in stark contrast with other industrialized countries that are experiencing a decline in maternal mortality despite similar improvements in data collection methods (Cox et al., 2018).

Figure 3

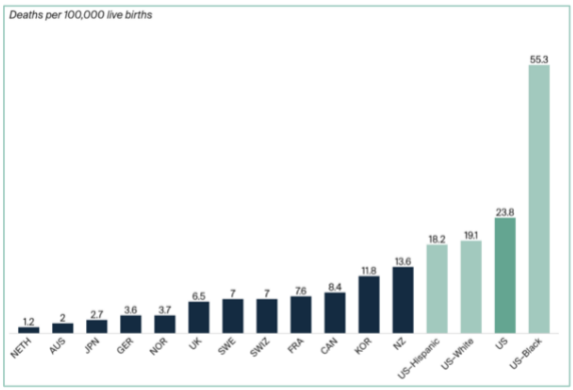
Mortality gap for U.S. mothers



Note: Adapted from *U.S. Ratios (2011-2013).* CDC Pregnancy Mortality Surveillance System, and Global Ratios (2015), UNICEF, by Habitat at Home, n.d., Habitat at Home (https://habitathome.us/america-is-failing-its-black-mothers/) Data sources: CDC Pregnancy Mortality Surveillance System and UNICEF

Figure 4

New data shows U.S. maternal mortality rate exceeds that in other HICs, particularly for Black women

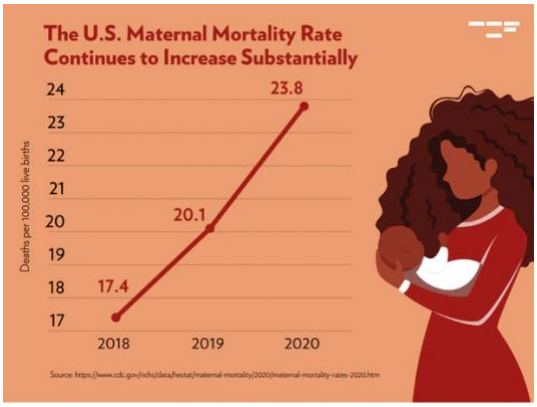


Note: Adapted from *New Data Shows U.S. Maternal Mortality Rate Exceeds That in Other High-Income Countries, Particularly for Black Women,* by M. Z. Gunja, E. D. Gumas, and R. D. Williams II, 2022*, The Commonwealth Fund (*https://www.commonwealthfund.org/publications/issue-briefs/2024/aug/health-care-women-how-us-compares-internationally). Copyright 2022 by The Commonwealth Fund

The tragedy is that not only are U.S. maternal mortality rates high and rising, but most of these deaths are preventable. In 2021, the CDC estimated that 2 of every 3 maternal deaths in the United States could have been prevented (CDC, 2023). Common causes of maternal mortality, such as heart conditions, infections, hemorrhage, cardiovascular disease, and embolisms, can often be detected, monitored, and treated. It is senseless that so many women, particularly Black women, are dying from these preventable conditions. The rising and preventable nature of Black maternal mortality across the nation underscores the urgent need to address the quality of Black maternal health in the United States.

Figure 5

U.S. maternal mortality rates over time



Note: Adapted from *Maternal Mortality Rates in 2020,* by Centers for Disease Control and Prevention (CDC), National Center for Health Statistics, 2020, CDC (https://www/cdc.gov/nchs/data/hestat/maternal-mortality/2020/maternal-mortality-rates-2020.htm). Copyright 2020 by the CDC

Evaluating the Causes of Black Maternal Mortality

To effectively address Black maternal mortality, a comprehensive understanding of the causes of Black maternal mortality is essential. The disparity in maternal death rates between Black and white women in the U.S. is not driven by genetic factors, but rather by a history of—and more critically, ongoing—inequities that Black women face within the U.S. healthcare system. This section explores three key contributors: the historical medical mistreatment of Black women's bodies, the socioeconomic factors that limit access to healthcare and exacerbate inequities, and implicit bias, which is a critical driver that not only fuels these other factors but also perpetuates poor maternal health outcomes.

Historic Maltreatment of Black Women's Bodies

Historically, in the United States, the reproductive rights of Black women were abused, and Black maternal health was neglected. An example of this is the legacy of forced sterilizations and nonconsensual experimentation that systematically occurred to Black pregnant women in the name of advancing gynecology (Prather, 2017). Dr. Marion Sims, a former president of the American Medical Association, performed vaginal surgeries and procedures on enslaved Black women without anesthesia (Holland, 2018). Despite this abuse, he is still revered in U.S. medical history as the 'father of gynecology,' highlighting how many doctors who contributed to the mistreatment of Black individuals continue to be glorified by the U.S. healthcare system (Sartin, 2004). In addition to Sims' experimentation, Black women were disproportionately subjected to forced sterilization programs throughout the 20th century, particularly during the eugenics movement. For example, in North Carolina, between 1929 and 1974, doctors performed approximately 7,600 sterilizations. Black women made up 60 percent of those sterilized by the

1960s, despite being only 25 percent of the population (Kaelber, 2012). These sterilizations were often framed as necessary for "public health" or "genetic improvement" but were rooted in systemic racism and efforts to control Black reproduction. Consequently, today many African Americans hold high levels of medical mistrust in the United States due to legacies of racism and medical malpractice combined with current race-based medical inequities (Kennedy, 2007).

Instead of recognizing this history and working to repair it, many physicians and media outlets portray pregnant Black women as irrational for harboring medical distrust. They usually assume Black women need education about how healthcare services have improved. However, this furthers the misconception that overt and covert discriminatory medical biases and inequitable policies do not still exist in the present day when they do. Instead of blaming the victims of marginalized communities for non-adherence, the U.S. healthcare system needs to work towards building an institution that can overcome present maternal health injustices and instill trust in Black mothers.

Socioeconomic Disparities

Historical mistreatment of Black women's bodies laid the foundation for poor maternal health outcomes, and in conjunction with social determinants of health, they continue to sustain maternal health disparities in the present day. The World Health Organization defines the social determinants of health as the conditions in which people are born, grow, work, live, and age that affect their health outcomes (WHO, 2024).

A 2021 investigation by Johns Hopkins Medicine, published in the *Journal of American Medical Association*, examined preeclampsia, a serious blood pressure condition that can develop during pregnancy. The study found that Black women born in the United States consistently had a 26 percent higher risk of preeclampsia during pregnancy than those who immigrated from other countries (Johns Hopkins, 2021). Additionally, Black women who had lived in the United States for more than 10 years had a higher risk of preeclampsia compared to those who had lived in the United States for less than 10 years. These findings suggest that living in the United States not only increases the likelihood of preeclampsia but that the risk grows with prolonged exposure. The researchers attributed this to the compounded effects of social determinants of health in the United States that disadvantage Black women, contributing to higher rates of maternal mortality. This reflects broader trends showing that socioeconomic factors, such as access to safe housing, nutritious food, stable income, and safe environments, are disproportionately distributed in the U.S., particularly affecting Black women. For instance, in 2023, Black women working full-time, year-round were paid only 66 cents for every dollar earned by a white non-Hispanic man (National Women's Law Center, 2024). Limited access to high-quality healthcare and systemic barriers to these critical determinants of health can mean the difference between life and death for Black pregnant women.

Poor social determinants of health contribute to limited access to high-quality healthcare, resulting in higher maternal mortality rates for Black women. Nationally, Black women are, on average, three times more likely than white women to die from pregnancy-related causes (CDC,

2023). However, in New York City, this disparity is even more severe, with Black women experiencing a maternal mortality rate 8 times higher than that of White women (NYC Department of Health and Mental Hygiene, 2019). A study published in the *American Journal of Obstetrics and Gynecology* examined how the disparity in maternal mortality rates between Black and white women in New York City is influenced by the hospitals where they give birth (Howell, 2016). Hospital quality is closely tied to factors such as income and location, which are social determinants of health. Those with higher socioeconomic status are more likely to access higher-quality hospitals. The study found that Black women are disproportionately more likely to deliver in hospitals with higher rates of severe maternal complications compared to white women. While 65 percent of white deliveries occur in the safest hospitals, only 23 percent of Black deliveries take place in these facilities (Howell, 2016). This disparity reflects the enduring effects of socioeconomic inequities and historical segregation, as hospitals serving predominantly Black populations often remain lower in quality and have significantly higher rates of life-threatening complications. The intersection of inadequate social determinants of health and systemic healthcare inequities prevents many Black women from accessing high-quality care, exacerbating maternal health disparities.

Underlying Driver of Black Maternal Mortality: Implicit Bias

Often research tends to highlight historical and socioeconomic factors as the primary contributors to maternal health disparities in the U.S. However, as demonstrated in this paper, other industrialized countries facing similar socioeconomic challenges have significantly lower maternal mortality rates than the United States. This discrepancy underscores the role of implicit bias as a crucial, yet often overlooked, underlying driver of Black maternal mortality.

Implicit bias in healthcare refers to unconscious attitudes and beliefs that influence clinicians' behaviors, affecting their understanding, decision-making, and treatment outcomes (Joint Commission, 2018). Implicit biases in healthcare are deeply rooted in structural racism and the historical mistreatment of Black bodies in the United States as previously discussed. These biases are influenced by cultural stereotypes that depict Black individuals as stronger, more resilient, or less sensitive to pain, which are often ingrained through repeated exposure to societal messages (Saluja & Bryant, 2021). According to Preshuslee Thompson, a training and development specialist at Ohio State's Kirwan Institute, the more individuals are exposed to these stereotypes, the stronger these implicit associations become (Rao, 2020). This leads clinicians to rely on assumptions about Black patients' physicality, such as beliefs that they have thicker skin, stronger bones, or less sensitivity to pain, which in turn affects the care they receive (Saluja & Bryant, 2021). These false beliefs manifest in healthcare settings, where studies have shown that Black patients, particularly Black women, are less likely to be given appropriate pain management. For instance, Rust et al. (2015) found significant racial disparities in the administration of epidural analgesia, with Black non-Hispanic patients receiving it at significantly lower rates than their white counterparts. As healthcare providers are exposed to or

operate with these stereotypes, their unconscious biases are solidified, leading to discriminatory practices that further entrench maternal health disparities.

In maternal care, this bias manifests during pregnancy and the postpartum period, manifesting in high-stress medical settings like labor and delivery rooms or emergency departments. In these environments, where quick decision-making is critical, clinicians often rely on automatic or unconscious processes, which can activate harmful stereotypes and unconscious beliefs (Saluja & Bryant, 2021).The quotes below are the responses four well known Black women or their family members received from their doctors in the United States when expressing the concerns they had when believing their health or their baby's health was in danger:

"I think all this medicine is making you talk crazy," Serena Williams' doctor told her (Williams, 2022).

"There is nothing we can do; you just have to wait, give it more time" Shalon Irving's doctor told her (Martin et al., 2017).

"Your wife just isn't a priority" Kira Johnson's doctor told her husband Charles Johnson (Pahr, 2024).

"Just go home. Let it abort. You can get pregnant again because this is what you people do anyway" US Representative Cori Bush's doctor told her (Murphy, 2021).

A common theme emerging from these quotes is the racial stereotyping and invalidation of pain experienced by Black women. In these instances, their lived experiences and concerns about their own health, and that of their babies, were not taken seriously. This reflects a broader systemic issue within the U.S. healthcare system, where racial biases erode trust in the patient-doctor relationship, often with fatal consequences. Trust is critical in maternal care, and its absence exacerbates racial health disparities.

Figure 6
Serena Williams

Figure 7
Shalon Irving

For instance, despite being highly educated, financially stable, and insured, all four women experienced poor maternal care. Serena Williams, a global tennis star, faced significant medical challenges during her pregnancy (Figure 6). As an elite athlete, one would assume she would have a strong understanding of her body. However, she was repeatedly ignored by medical staff when she correctly requested a CT scan and heparin drip to address her growing complications, leaving her dangerously close to death (Williams, 2022). Despite her clear knowledge of her own body and medical needs, she had to advocate relentlessly for herself before receiving the appropriate care.

Similarly, Shalon Irving, a public health leader and former epidemiologist at the CDC, tragically lost her life due to high blood pressure complications despite her extensive health knowledge (Figure 7). She had raised alarms to her doctors multiple times, but her concerns were dismissed. She died after suffering complications related to preeclampsia, an issue she, as an epidemiologist, was keenly aware of (Martin, 2017).

Figure 8
Kira Johnson

Figure 9
U.S Rep Cori Bush

Charles Johnson, the husband of Kira Johnson, also experienced a devastating loss. Charles fought desperately for his wife's medical attention after watching her Foley catheter "turn pink with blood" (Howard, 2020). His concerns were invalidated for hours, and despite his pleas for help, Kira was not treated as a priority. This delay led to the discovery that she had been internally bleeding for 10 hours and had lost over 3.5 liters of blood. Tragically, Kira died on the operating table, underscoring the deadly consequences of her concerns being ignored and invalidated by medical professionals (Figure 10).

Finally, the last quote comes from U.S. Representative Cori Bush, who felt unseen in both of her traumatic pregnancies, as detailed previously (Figure 9). Despite serving the people of her district every day, she was left unheard by the healthcare system at her time of greatest need. Cori Bush's experiences further highlight how, even for those in positions of power and influence, Black women's concerns are often dismissed within the healthcare system. This dismissiveness, compounded by implicit bias, underscores the devastating impact that healthcare disparities have, regardless of one's status or role in society.

Understanding Implicit Bias as the Underlying Driver of Black Maternal Disparities

"Being heard and appropriately treated was the difference between life and death for me," Serena Williams said on April 5, 2022.

In that moment it wasn't her class, her education, her income, or any other socioeconomic indicator but her voice being heard, acknowledged, or valued which would have made the difference for her. In the larger U.S. healthcare system, as reflected in Serena's story, even when adjusting for socioeconomic standing, implicit bias still perpetuates racial medical disparities. These cases highlight a key insight: implicit bias, not socioeconomic status, was the decisive factor in their maternal health outcomes. The commonalities between these women are striking they are educated leaders, are involved in their communities, occupy stable jobs, are financially secure, and have health insurance. These are all factors that should, in theory, protect them from poor health outcomes. However, despite their socioeconomic privilege, they all experienced poor maternal care perpetrated by the implicit biases they experienced as Black women. Tragically, Shalon Irving and Kira Johnson lost their lives. Their status and privilege did not shield them from the biases and violence inherent in the healthcare system. This demonstrates that the issue is not simply a matter of access to care, but a deep-rooted systemic bias that affects the quality of care particularly for Black women, regardless of their social or economic status.

The impact of implicit bias is especially evident when examining the role of education in maternal health outcomes. Despite higher levels of education or financial stability, Black women continue to face worse maternal health outcomes because of implicit racial bias in medical practice. For example, Black women with college degrees are twice as likely to experience maternal mortality as white women without a high school diploma (Hill, 2022). This stark contrast highlights the powerful impact of implicit bias and racial discrimination in healthcare, challenging the narrative that Black women's poor maternal health outcomes are solely due to socioeconomic factors.

Beyond dismissive rhetoric, implicit bias influences clinical decisions in numerous ways. For example, studies show Black women are more likely to undergo cesarean deliveries than white women, even when adjusting for medical necessity (Saluja & Bryant, 2021). A cesarean section (C-section) is a surgical procedure used to deliver a baby through incisions in the abdomen and uterus when a vaginal delivery would pose a risk to the mother or baby. Cesarean sections, while sometimes necessary, come with increased risks of maternal and infant mortality, including hemorrhage, complications of anesthesia, and infection (Roth, 2012). This racial disparity underscores how unconscious biases shape clinical practices, disproportionately subjecting Black women to riskier procedures.

Further compounding these disparities fueled by implicit biases is the exclusion of Black women from medical research (Le et al., 2022). Historically, Black women have been underrepresented in clinical trials, which directly affects their health outcomes. For instance, a study examining U.S.-based obstetric trials between 2007 and 2020 found that Black participants were notably underrepresented in trials focused on hypertension and obstetric anesthesia (Jecca et al., 2023). In hypertension trials, Black participants represented a disproportionately low

percentage, despite their higher rates of hypertensive disorders during pregnancy. Similarly, obstetric anesthesia trials enrolled a minimal number of Black participants, and these trials were the least likely to report race and ethnicity data, further limiting the understanding of how treatments may affect different racial and ethnic groups. Hence when health professionals operate on the results of biased research results it exacerbates black maternal health disparities.

Strategies for Tackling Implicit Bias in Maternal Health

To address the Black maternal mortality crisis effectively, policy solutions must begin with raising awareness and educating healthcare providers on the real impact of implicit bias in maternal care. Many healthcare providers struggle to recognize the impact of their personal implicit biases on the care they provide to patients (Saluja & Bryant, 2021). Studies, such as one from the Society for Maternal-Fetal Medicine, highlight a gap between clinicians' awareness of disparities and their acknowledgment of personal biases in patient care. While 83% of providers recognize the existence of disparities, only 29% believe that their personal biases influence their care decisions (Jain & Moroz, 2017). Therefore, it is crucial to mandate regular implicit bias testing for healthcare providers to allow them to confront and reflect on their biases in a structured way, ideally through tools such as the Implicit Association Test (IAT), which is not self-reported but instead measures unconscious associations. Regular testing and reflection will help make implicit bias more visible and lead to more intentional care practices.

Additionally, improving the quality of implicit bias training is essential. One approach is to incorporate compulsory post-care conversations with Black women, allowing them to share their experiences to clinicians directly. This feedback is crucial in identifying where patients felt unheard, overlooked, or mistreated, providing opportunities for improvement in care. Such conversations can also help build trust, as patients feel that their voices are valued and their concerns are addressed. Training should emphasize not just listening but actively reflecting on non-verbal cues, tone, and gestures to ensure that providers recognize and correct any biases that may be subtly influencing patient interactions.

To further this effort, healthcare providers should be trained to slow down when they can and listen to patients' concerns, particularly those of Black women. Adopting a mindset where healthcare providers consider their patients' concerns as valid until proven otherwise—rather than dismissing them outright—will allow for more accurate diagnoses and better patient outcomes. This approach can prevent scenarios like that of Serena Williams, where an underestimation of concerns led to life-threatening consequences.

Implicit bias training must occur on both an individual and institutional scale. Hospitals, medical schools, and health systems must implement comprehensive, ongoing training and foster environments that emphasize accountability, collective responsibility, and continuous learning. Addressing implicit bias should not be limited to individual practitioners but must be a systemic effort to create meaningful, long-term change.

Conclusion

Black women are dying in the United States at the highest rate among industrialized nations. Black maternal mortality rates are high and rising, yet preventable. Each death is a life lost too soon, too often due to the failure of the U.S. healthcare system to value Black women's maternal health and well-being. Black maternal mortality must be acknowledged as a public health crisis founded on a systematically inequitable healthcare system; shaped by implicit bias, discriminatory practices, and the historical maltreatment of Black women; and compounded by socioeconomic barriers many Black women face.

As explored in this paper, the causes of Black maternal mortality are multidimensional and require equally multifaceted solutions. Often, socioeconomic factors are considered in policy, but if implicit bias and the legacies of historic maltreatment are not addressed when implementing these solutions, these policies are unlikely to effectively eradicate maternal health disparities. Implicit bias in medical training, decision-making, and care practices must be recognized and actively challenged to ensure that Black women's health concerns are taken seriously and treated with the urgency they deserve.

In conclusion, to effectively address the Black maternal mortality crisis, the United States needs a comprehensive and equitable maternal health system that includes holistic, targeted initiatives to address both historical and current barriers to high-quality Black maternal healthcare. Key measures include regular implicit bias testing for healthcare providers, enhanced training through post-care conversations with Black women, and adopting a systemic approach to tackle these issues at both individual and institutional levels. Only by confronting and dismantling implicit bias, alongside tackling the socioeconomic and systemic inequities at play, can we begin to reduce maternal mortality rates among Black women and ensure a healthier future for all.

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