Reducing Racial Disparities in Maternal Healthcare: A Midwifery Focus

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Abstract

When compared with other developed nations, the United States (U.S.) has the highest maternal mortality rate. Furthermore, in the U.S., Black women are dying during pregnancy or the postpartum period at a rate three times higher than that of white women. This disparity points to the question of why inequities in maternal healthcare exist and, of critical importance, what is being done to combat them. The stark reality is that systemic racism is at the core of these health disparities and must be addressed by both the individuals providing care and the healthcare systems themselves. The underpinnings of systematic racism in maternal healthcare, as well as ways to both dismantle this racism and move forward with constructive changes, are explained in this practice update. Specifically, the positive impact that midwifery care has on maternal health outcomes will be discussed.

Keywords

midwifery, practice, obstetrics, practice, women (Reproductive Health), workforce

Introduction

Pregnant persons face normal physical and psychological changes that come from being pregnant. In the United States (U.S.), these changes are further compounded and complicated for Black women due to the systemic racism that exists within the healthcare systems and structures. As Roder (2019) highlights “America is failing its Black mothers.”

The maternal death rate in the U.S. is the worst of all developing nations. Annually in the U.S., more than 700 women die as a direct result of pregnancy or childbirth complications (CDC, 2020). More than half (52%) of these deaths occur in the postpartum period and are largely caused by hemorrhage, high blood pressure, or infection (Tikkanen et al., 2020). Examining these numbers further, Black mothers are dying of these causes at a rate three times higher than their white counterparts (Artiga et al., 2020; Roder, 2019). The reasons for the disparities in mortality rates have been studied at length. Racism and marginalization have forced people to be living in food deserts and areas without access to adequate healthcare services. Further weathering, which is the chronic and daily exposure to microaggressions, takes a toll on one’s overall health (Geronimus, 1992). Ultimately, however, it is clear that the amount of melanin in one’s skin is not a biologic reason for disparities in maternal mortality; rather, the fact that those with more melanin face structural racism within healthcare encounters and systems has been identified as a root cause (Suliman, 2022). Blatantly stated, the stark reality is “it is racism, not race that is killing America’s Black mothers and babies” (Suliman, 2022). This racism presents in the form of healthcare providers dismissing the concerns of Black women, the fact that many persons of color experience weathering and/or live in food deserts that often also lack access to adequate healthcare services. These conditions must be understood with the backdrop that structural racism created these environments during the era of Jim Crow Laws and segregation.

Racism is also at play in the fact that Black women’s health concerns are more likely to be dismissed and not addressed in an adequate manner by their healthcare provider.
(Roder, 2019), which can lead to potential severe complications of pregnancy or postpartum course being completely ignored. Of note, higher income and a higher level of education are not in fact protective social determinants of health factors for Black mothers in the U.S., further signaling that racism is at the core of the issue (CDC, 2019). When Serena Williams, Shalon Irving, and Kira Johnson, among countless other Black women, have health concerns that are not being heard or addressed, and they themselves are not being respected by the healthcare team, the acknowledgement of structural racism in the system causing health disparities becomes even more abundantly clear.

This clinical practice update paper aims to provide information about the scope of this issue, evidence that midwifery lead systems and care improves maternal health outcomes, and suggestions for ways to move forward. It is evident that systemic racism, which is prevalent in the healthcare system, is the cause of the disparities in maternal healthcare (Suliman, 2022). Unfortunately, this issue pervades into infant health as well with non-Hispanic Black infants two times more likely to die than non-Hispanic white infants (OMH, 2022).

**Brief Review**

In 2018, there were 17 maternal deaths for every 100,000 live births in the U.S.—a ratio more than double that of most other developed, high-income countries (Tikkanen et al., 2020). This statistic, along with the racial disparities discussed above, is gravely alarming and necessitates looking deeply into what differences exist in the maternal health care system in the U.S. compared to that of other developed nations such as Germany, Norway, Sweden, Denmark, Australia, and Canada, who do not have these disparities in their maternal mortality rates.

A significant and clear difference between the U.S. and its developed nation counterparts is noted in the relatively small percentage of midwives and a large percentage of obstetrician/gynecologists providing prenatal care and attending births in the U.S. healthcare system when compared to provider ratios of other developed nations. For example, in the U.S., less than 10% of all births are attended by midwives, compared to between 50% and 75% of births being attended by midwives in other developed nations, notably all nations which have more positive maternal health outcomes than the U.S. (Goodman, 2007).

A midwifery research team of Vedam et al. (2018) has set out to underscore the importance of midwives to maternal child health outcomes. Vedam et al. (2018) have extensively developed a scoring system to look at the integration of midwives and to compare this integration to maternal outcomes for women in areas of the U.S. This seminal study demonstrates that areas with higher integration of nurse midwives “were associated with significantly higher rates of spontaneous vaginal delivery, vaginal birth after cesarean, and breastfeeding, and significantly lower rates of cesarean, preterm birth, low birth weight infants, and neonatal death” (Vedam et al., 2018, p. 1). Importantly, when there are lower rates of cesarean birth, there will be lower rates of infection and hemorrhage, which were two of the leading causes of postpartum deaths for women in the U.S. Midwives promote physiological birth, and when they attend births, have a higher rate of spontaneous vaginal births thereby decreasing the risk of some postpartum complications. Overall, midwives demonstrate positive birth outcomes in geographic areas where they are well integrated in the U.S. (Vedam et al., 2018).

**Discussion of Ways Forward**

Vedam et al.’s (2018) work speaks to the importance of creating more midwifery educational programs and clinical sites for midwifery students throughout the U.S. in order to ensure more midwives are entering the healthcare system and caring for birthing persons. Additionally, training midwives alongside medical residents has excellent potential for residents to see physiological birth, learn management of low-risk patients, and in the long term to create a team approach among providers in order to improve birth outcomes.

Furthermore, to address structural racism, teaching diversity, equity and inclusion (DEI) related to maternal child health must begin in every undergraduate and graduate classroom. A publication in the Harvard Public Health Magazine by Roder (2019) is an important piece to use for the clinician and student reading alike. Reading and reflecting on this article can then open up the dialogue to discussing these important issues. Specifically, the concept of weathering from Geronimus (1992) is explained in depth. This seminal hypothesis demonstrates how social disadvantage through racism corrodes health (Geronimus, 1992). Geronimus (1992) explains weathering in this manner: “the health of African-American women may begin to deteriorate in early adulthood as a physical consequence of cumulative socioeconomic disadvantage” (p. 207). Roder’s article (2019) also presents the real case studies of two women, Serena Williams, who is alive today and educating others about the racism she experienced in the healthcare system during her experience with a pulmonary embolism postpartum, and Shalon Irving, who died of complications in the postpartum period and who’s family speaks out on her behalf to expose the flaws and racism in the maternal healthcare system. It is through these (and more) women’s experiences that the grave problems in the healthcare system, as well as a hopeful path forward through advocacy and change are prominently explored. Most importantly, through these readings and conversations, space is made for future nurses and women’s healthcare providers to see how they may in fact be a part of the transformation toward improved care and outcomes.
Additionally, for clinically practicing perinatal nurses, midwives, and all women’s health providers, utilizing the Hear Her Concerns campaign (CDC, 2022) is of clear benefit for their future patients. This campaign urges providers to listen intently to all patient concerns, and urgently address those concerns that are indicative of potential complications in order to reduce disparities in mortality. The campaign is aimed to educate both provider and pregnant people, through providing clear tips for talking about urgent healthcare concerns. Training to explore and address implicit bias should be standard for all providers and a large part of continuing education.

Lastly, and importantly, increasing diversity within the healthcare professionals themselves is a needed way to move forward. It is well researched that patients rate their healthcare experience higher when they see a provider who resembles how they themselves look (Takeshita et al., 2020). Specifically, a study of 117,589 Press Ganey survey scores found that racial/ethnic concordance between a patient and their provider greatly improved the patient experience (Takeshita et al., 2020). Patients want a provider who understands their own lived experience. Efforts to increase the diversity within women’s health providers must take a center stage through funding and scholarships specifically aimed at increasing diversity. Outcomes will improve through these efforts.

Conclusion

Addressing, reducing, and aiming to eliminate racial disparities in maternal healthcare is imperative and of primary concern to perinatal nurses, midwives, and all women’s health providers. Several ways forward such as creating more midwifery programs and clinical sites, prioritizing ways to ensure education of a more diverse group of health-care providers, creating a curriculum that is diversity, equity and inclusion (DEI) focused, and utilizing the CDC’s (2022) Hear Her Concerns campaign are clear and effective ways to move forward to create more just and positive health outcomes for Black birthing persons in the U.S. The research on the positive outcomes that midwives have on the care of birthing persons must be highlighted at both the local and the national levels. Moreover, everyone employed in the healthcare sector needs to be working in earnest to dismantle systemic racism. Healthcare providers and systems are called to move forward to implement constructive changes aimed at improving the lives and health of Black birthing persons and infants.

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