

Disparities in Maternal Healthcare Access and Outcomes Among Black Mothers in North America: A Narrative Review

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ABSTRACT

Background: Maternal morbidity and mortality continue to pose serious public health challenges in the United States, where outcomes remain poorer than those reported in comparable high-income nations. These adverse outcomes are unevenly distributed. Maternal health disparities remain markedly pronounced among Black women with an elevated risk of pregnancy-related complications and death.

Objective: This review synthesises existing evidence on racial and ethnic inequities in maternal health outcomes in the United States, with particular attention to the lived realities of Black women and the multifactorial drivers underlying these disparities.

Methods: A literature review of peer-reviewed research published over the past two decades was conducted. Studies addressing maternal mortality, severe maternal morbidity, and pregnancy-related complications across racial and ethnic groups were examined, alongside evidence related to social determinants of health, healthcare delivery, structural racism, and quality improvement strategies.

Results: The literature consistently shows that Black women experience markedly higher pregnancy-related mortality rates than White women, even after accounting for medical comorbidities and timing of prenatal care. Persistent inequities are strongly linked to structural and social factors, including systemic racism, implicit bias in healthcare settings, gaps in insurance coverage, barriers to reproductive healthcare access, and socioeconomic disadvantage. While system-level interventions, such as standardized obstetric care protocols, have improved maternal outcomes and reduced disparities, uneven implementation may limit their effectiveness.

Conclusion: Significant racial and ethnic differences in maternal health outcomes continue to be observed in the United States and are largely driven by social and structural forces. Meaningful progress will require equity-focused clinical practice, inclusive research, policy reform, and broader social advocacy.

Keywords: Black Mothers, Pain Management, maternal health, Racial Health Disparities.

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INTRODUCTION

In recent times, the United States of America has posed a significant public health difficulty through a troubling rise in pregnancy-related complications, positioning it as unfavourable against other high-resource nations in terms of maternal mortality rates. This crisis requires immediate and robust interventions¹. At the heart of this issue lies a deep racial divide, with Black women disproportionately at likelihood of pregnancy-associated death compared to women from other racial groups, a disparity that underscores the broader, systemic issues of structural racism and discrimination².

From the modern era, the U.S. has witnessed persistent Variation in pregnancy-related deaths by race and ethnicity, affecting historically marginalized racial and ethnic communities significantly. These disparities are not confined to maternal deaths but also extend to fetal deaths, emphasizing the widespread inequity across maternal and

child health parameters. The alarmingly high risk faced by Black women highlights an urgent call for action aimed at reducing these disparities. This concept in maternal healthcare highlights a very critical issue yet an overlooked reality. Various studies have shown that the tragedies and lives lost are just the tip of a bigger and deeper problem. The devastating maternal deaths that we witness are just a fraction of the hardships and struggles faced by women in the domain of maternal health³.

Furthermore, the analysis of enhanced vital records has brought to light the crucial need for health policy and practice reforms, specifically designed to meet the varied needs of diverse racial and ethnic groups, thereby improving maternal health outcomes. Hence, this Review study was conducted to analyze the racial issues in maternal healthcare outcomes and training strategies for maternal healthcare providers aimed at mitigating these gaps.

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METHODOLOGY

The objective of this literature review was to examine maternal mortality in the United States of America, with emphasis on prevailing trends, contributing factors, and effective interventions. A comprehensive literature search was conducted using reputable scientific databases and authoritative online sources to identify relevant evidence.

Primary databases included Google Scholar and PubMed, selected for their extensive coverage of clinical and public health research. In addition, official government and public health websites—such as those of the White House, Hospital Association, and the Centres for Disease Control and Prevention (CDC)—were reviewed to obtain current reports, surveillance data, and policy documents related to maternal mortality.

The search strategy incorporated a broad range of keywords and combinations, including maternal mortality in the United States, maternal health disparities, interventions, Black mothers, implicit bias, pain management, socioeconomic factors, racial health inequities, epidemiology, and community-based participatory research. All relevant literature published up to January 2024 was considered. Inclusion criteria required that sources focus on maternal mortality or morbidity, contribute to public or clinical understanding, and consist of peer-reviewed studies, government reports, or credible policy analyses.

Selection Process

The initial search yielded 95 potentially relevant sources. Article titles and abstracts were independently reviewed to identify and exclude studies that failed to satisfy the predefined inclusion criteria and were not directly related to maternal mortality. Full-text review was subsequently performed to assess relevance and depth of analysis. Studies lacking sufficient focus or robust data were excluded. Ultimately, 24 sources—comprising both peer-reviewed research and government or policy publications—were included.

Data synthesis focused on identifying key themes such as risk factors, healthcare inequities, epidemiological patterns, and intervention effectiveness, with particular attention to Ohio-specific challenges. This methodological approach supported an evidence-based evaluation of maternal mortality and informed recommendations aimed at improving maternal health outcomes at both state and national levels.

RESULTS

All 24 studies included in this literature review were published within the past two decades, from 2004 to 2024. The literature reviewed consistently focused on racial gaps in maternal health, per the inclusion criteria. 8 articles had a specific focus on the prevalence of racial discrimination in maternal health in the United States. 6 articles focused on Complication in Pregnancy among Black women. 4 articles focused on Outcome and management of Racial discrimination in maternal health.

After analyzing the data, the following patterns in the current literature were identified:

Prevalence of Racial discrimination in maternal health in the United States

In comparison with other developed nations, the United States remains an outlier, with maternal mortality rates continuing to increase. These outcomes reveal pronounced racial disparities, particularly among women of colour. Black women bear a markedly disproportionate burden, as their likelihood of death associated with pregnancy or childbirth is approximately three to four times greater among Black women compared with White women. According to estimates from the Centres for Disease Control and Prevention, approximately 50,000 women in the United States experience severe complications related to pregnancy each year. National estimates indicate that the maternal mortality ratio increased from 20.1 deaths per 100,000 live births in 2019 to 23.8 per 100,000 in 2020, corresponding to an estimated 861 maternal deaths.

Among Black women, the maternal mortality ratio is estimated to be approximately 44.1 deaths per 100,000 live births, corresponding to nearly 1,800 maternal deaths and representing the highest burden observed among all racial and ethnic groups. This rate has shown a persistent upward trajectory over recent years (Figure 1). Although each case of maternal mortality or severe morbidity arises from unique clinical and social circumstances, the most commonly identified causes in the United States include hypertensive disorders of pregnancy, thromboembolic events such as pulmonary embolism, obstetric haemorrhage, infectious complications, cardiovascular disease, including cardiomyopathy, and other non-cardiac medical conditions⁴.

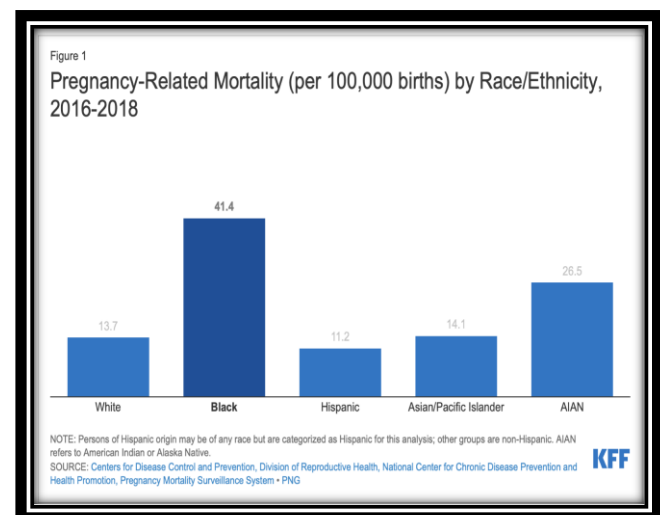


Fig 1: Pregnancy-related mortality by Race/ Ethnicity

At present, the United States represents the highest-risk setting for childbirth among high-income nations, with Black women experiencing disproportionately elevated risks of maternal death and severe pregnancy-related complications. Compared with peer high-income countries, the United States continues to demonstrate disproportionately elevated maternal mortality rates by more than threefold, and the risk among Black women is

approximately three times higher than that observed among White women. In addition, the incidence of severe maternal morbidity continues to rise, affecting more than one in every hundred births, with racial inequities playing a significant role in determining vulnerability⁵. (Figure 2).

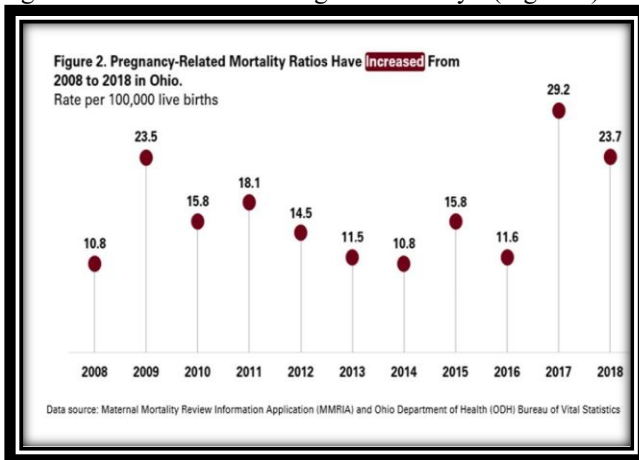


Fig 2: Pregnancy-related mortality has increased from 2008 to 2018 in the United States

2. Factors Contributing to Pregnancy Complications among Black Women

Recent evidence indicates that pregnancy-related complications among Black women are shaped not only by clinical risk factors as well as by wider social and structural determinants. Experiences of racial discrimination, marginalization, and trauma, along with structural barriers encompassing institutionalised influence of structural racism and unconscious bias within the healthcare system provision of healthcare services, significantly influence maternal outcomes. limited health insurance coverage, restricted availability and accessibility of reproductive health services, and adverse socioeconomic conditions further compound these risks⁶.

Collectively, such social and structural health determinants highlight that adverse maternal conditions among Black people are driven by forms of racism embedded within healthcare structures that disproportionately affect marginalized populations. Intersecting factors—including socioeconomic status, race, age, and other social identifiers—intensify these inequities over time, particularly within communities lacking adequate resources and educational opportunities, thereby widening persistent gaps in access to equitable maternal healthcare⁷.

A clear understanding of the historical roots of racism within healthcare systems is essential to addressing the institutionalized inequities that continue to affect Black women's experiences and outcomes. Such insight is critical for informing health policies and practices that actively protect Black women from systemic harm. Meaningful reductions in maternal morbidity and mortality among Black women require comprehensive social and structural reforms rather than isolated clinical interventions. Consequently, persistent problems in inequitable reproductive health outcomes experienced by Black women demand greater attention to the intersecting influences of

racism, discrimination, and broader social health determinants, all of which play a crucial role in shaping disease risk and maternal mortality⁸.

Frequently cited explanations for disparities in maternal health outcomes include lower socioeconomic status and inadequate access to prenatal care. Although each of these determinants independently contributes to elevated maternal mortality rates, they do not fully account for the persistent gap in maternal mortality observed between Black and White mothers⁹.

Timely initiation of adequate prenatal care is typically linked to a reduced risk of maternal mortality, whereas delayed or absent care is linked to poorer outcomes. Nevertheless, racial disparities persist even when Black women access prenatal services early in pregnancy. Evidence from multiple studies examining maternal mortality in relation to when prenatal care is initiated demonstrates that Black women experience up to an approximately fourfold elevated risk of maternal death in comparison with White women, even when prenatal care is initiated across all trimesters¹⁰.

3. Outcome of racial discrimination in maternal health among adults and children.

Research exploring associations between racial discrimination and preterm birth in African American women has produced inconsistent findings. In one small cohort, racial discrimination experiences were significantly linked with greater psychological distress; however, no direct association with preterm birth was observed, and participants reported relatively low levels of perceived discrimination¹¹. Similarly, research conducted in an urban population found no significant association between lifetime exposure to racial discrimination and preterm birth. In contrast, women with elevated racism scores demonstrated a significantly higher risk of preterm delivery, with this association moderated by the presence of depressive symptoms¹². Supporting this latter finding, a case-control study from Chicago, Illinois, reported that African American women who delivered preterm infants experienced higher levels of recent racial discrimination compared with those who delivered at term¹³. Collectively, these findings suggest that while racial discrimination may contribute to adverse birth outcomes under certain conditions, the overall evidence linking discrimination to preterm birth remains mixed.

Another study involving African American women reported that more than half of participants (56%) perceived experiences of racial discrimination. Hierarchical multiple regression analyses identified tobacco use, prenatal care utilization, and age- and disability-related discrimination as significant predictors of birth weight. Although perceived racial discrimination was associated with higher odds of low birth weight, this relationship was mediated by maternal depressive symptoms. Consistent with this finding, experiences of everyday discrimination were linked to increased levels of depressive symptomatology among mothers, which in turn was strongly associated with the delivery of low-birth-weight infants after adjusting for

education, parity, and gestational age. Path analysis further demonstrated that each unit increase in reported everyday discrimination corresponded to an approximate 49–50 g reduction in infant birth weight¹⁴.

4. Best practices in training healthcare providers for reducing these gaps in maternal health.

Addressing structural racism affecting Black mothers requires integrating education focused on diversity, equity, and inclusion within maternal and child health across all undergraduate and graduate classrooms. Evidence indicates that the health trajectories of African American women may begin to worsen in early adulthood as a result of the cumulative physiological impact of persistent socioeconomic disadvantage¹⁵. These women's experiences underscore the deep issues within the healthcare system while also offering a constructive pathway forward grounded in advocacy and policy reform. These readings and discussions are especially important as they create a space for upcoming nursing professionals and women's healthcare clinicians to envision their role in fostering transformative improvements in care and outcomes¹⁶.

For clinicians involved in perinatal nursing, midwifery, and women's health care in clinical practice, incorporating the Hear Her Concerns campaign, conducted by the Centres for Disease Control and Prevention, USA, can significantly benefit individuals under their future care. This campaign emphasizes the importance of actively listening to patients and promptly responding to concerns that may signal emerging complications, to reduce disparities in maternal mortality. It seeks to inform both healthcare providers and pregnant individuals by offering practical guidance on how to communicate urgent health concerns effectively. In addition, training focused on recognizing and addressing implicit bias should be routinely incorporated into professional education and established as a core component of ongoing continuing medical education for all providers¹⁷. Increasing diversity among healthcare professionals is essential for advancing patient care. Research shows that patients have a more positive healthcare experience when treated by providers who resemble them, with one study finding that shared racial and ethnic backgrounds between patients and providers greatly enhances the patient experience. Patients seek providers who understand their lived experiences. Therefore, prioritizing diversity among women's health providers should be at the forefront, with dedicated funding and scholarships aimed at fostering this diversity. Such efforts will lead to improved healthcare outcomes¹⁸.

5. Best practices in training healthcare providers for retention and effectiveness.

The implementation of standardized clinical protocols has been shown to improve maternal outcomes and, in some contexts, reduce racial disparities. For example, Participation in a state-wide obstetric haemorrhage quality initiative in California was associated with reduced severe maternal morbidity and diminished Black–White disparities. Similarly, the use of standardized labour induction protocols was associated with decreased racial

differences in caesarean delivery rates and neonatal morbidity¹⁹. However, standardization does not uniformly promote equity and may, in certain circumstances, exacerbate existing disparities. In one California hospital, the introduction of a standardized policy for reporting prenatal substance use resulted in Black mothers being referred to child protective services at nearly five times the rate of White mothers, contrary to the policy's intended goal. Moreover, when standardized quality improvement initiatives are applied across diverse healthcare settings, disparities may widen if under-resourced systems—often those serving the most vulnerable populations—lack the capacity to implement these measures effectively²⁰.

Addressing these challenges requires targeted investment in interventions specifically designed to reduce Black–White disparities in maternal health, along with pilot testing before widespread implementation to prevent the unintended amplification of inequities. The endorsement of the Black Maternal Health Omnibus Act of 2021 by the American College of Obstetricians and Gynaecologists exemplifies an approach through which funding can be strategically allocated to under-resourced healthcare systems serving large Black populations, thereby strengthening their capacity to implement, evaluate, and sustain quality improvement initiatives effectively²¹.

Equally important is the consistent application of data-driven clinical standards across all patient populations. Guideline-adherent care has been shown to reduce, and in some cases eliminate, racial disparities in health outcomes, as observed in ovarian cancer survival. However, equitable benefit for Black women depends on their adequate representation in clinical research. In response, the Black Mamas Matter Alliance Research Working Group developed a framework to promote equitable, community-engaged maternal research, prioritizing meaningful inclusion of Black women as both researchers and study participants²².

DISCUSSION

This literature review examined the prevalence of racial discrimination in maternal healthcare, its causes and consequences for mothers and children, and the role of provider training in reducing disparities and improving workforce effectiveness. The findings underscore the importance of advocating for and implementing policies that improve maternal health outcomes among Black women, with broader implications for public health.

Additionally, this review explored the lived experiences of Black pregnant women to better understand the drivers of persistent inequities in birth outcomes. Evidence indicated frequent exposure to pregnancy-specific forms of gendered racism, described as racialized pregnancy stigma, across social and institutional contexts. Such experiences contributed to perceptions that Black pregnancies are undervalued and may negatively influence maternal and infant outcomes through heightened stress, reduced access to quality care and support services, and increased material hardship. These factors can lead to delayed care-seeking,

resource insecurity, and diminished protective coping mechanisms²³.

Initiatives aimed at addressing racial and ethnic inequities in maternal healthcare must extend beyond improvements in the quality or utilization of medical services alone, as such measures are insufficient to achieve true equity for marginalized populations. Broader socioeconomic conditions play a critical role in shaping health outcomes, with barriers as fundamental as limited transportation to clinical appointments contributing to persistent inequities. Accordingly, advocacy must move beyond the confines of clinical medicine to encompass a broader social justice framework. Healthcare providers can play a pivotal role by advocating for policies that expand access to stable housing, nutritious food, and reliable transportation, alongside comprehensive healthcare services. Additional priorities include ensuring contraceptive coverage for high-risk populations, re-evaluating and redesigning the traditional six-week postpartum visit, integrating education on maternal health disparities into professional training and maintenance of certification requirements, and developing targeted educational resources to improve provider awareness and responsiveness to maternal health inequities²⁴.

The findings of this review were constrained by the complex and indirect relationship between maternal mortality and racial discrimination. Intersecting social positions, including socioeconomic advantage or disadvantage, both shape and are shaped by experiences of racial discrimination, influencing health outcomes in multifaceted ways. Although lower socioeconomic status among racialized populations is associated with poorer maternal outcomes, structural and systemic racism play a central role in creating and sustaining racialized poverty, rather than socioeconomic disadvantage operating independently of race.

Despite this complexity, much of the existing literature inadequately addresses intersectionality. Most studies have been conducted in the United States and focus primarily on African American populations, with limited inclusion of other marginalized racial or ethnic groups. Additionally, commonly used measures of racial discrimination were largely developed within the U.S. context and may not capture the full range of discriminatory experiences across diverse cultural and ethnographic settings, limiting the generalizability of findings.

The overall evidence base was limited in both scope and methodological quality, restricting robust synthesis and precluding advanced meta-analyses. Considerable heterogeneity across studies reflected variations in study design, measurement tools, sample characteristics, and analytical approaches, with mixed findings often reported within individual studies. Furthermore, restricting the search to peer-reviewed literature may have excluded relevant grey literature and introduced publication bias.

Racial and ethnic disparities in maternal morbidity and mortality remain a pressing public health concern. Addressing these inequities requires a coordinated, equity-centred approach that integrates targeted interventions into

broader maternal health strategies. By shifting focus toward modifiable provider- and health system-level factors, meaningful progress can be made in reducing maternal morbidity and mortality and improving care for all women.

CONCLUSION

Marked racial and ethnic inequities in maternal outcomes persist in the United States, underscoring an urgent need for meaningful action. Reducing—and ultimately eliminating—inequities in maternal healthcare must be regarded as a central responsibility of all healthcare providers. An expanding body of evidence highlights the role of structural racism in driving these disparities, emphasizing that they arise from complex, interconnected social and healthcare system factors. Accordingly, addressing racial and ethnic differences in severe maternal morbidity and mortality requires a coordinated, multipronged strategy. Comprehensive quality improvement efforts spanning the entire continuum of care—from preconception through pregnancy, postpartum, and interpregnancy periods—are essential to achieving sustained reductions in maternal health inequities.

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