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Kelemua Tesfaye
Seattle University

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Kelemua Tesfaye, Applied Mathematics

Faculty Mentor and Faculty Content Editor: Elise Murowchick, PhD, Psychology

Student Editor: Brigid Conroy

Abstract

The global maternal mortality rate (MMR) has been trending downward, while the US MMR has been increasing. When the US MMR data is disaggregated by race, it becomes apparent that the burden of the MMR is carried by Black mamas. Controlling images of Black women were created during chattel slavery to justify the control and exploitation of their bodies for profit and power. These stereotypes persist to this day in the collective social consciousness, and these racist, classist images have permeated the interactions Black mamas have with others. This paper contextualizes the racial disparity by grounding itself in the role of the physician during chattel slavery and the orientation of physicians towards enslaved African mothers. This analysis will connect this legacy to the barriers and birth outcomes Black mamas have today and discuss community-based solutions that cultivate positive birth outcomes for Black mamas and babies.

Introduction

Globally, the maternal mortality rate (MMR) has been on the decline. According to UNICEF, between 2000 and 2017, the global MMR fell 38%; meanwhile, the US MMR rose 58% (UNICEF, 2019; UNICEF, 2020). The rising MMR is often blamed on the poorer health of mothers, citing they are coming to pregnancy older and sicker (e.g., cardiovascular disease, diabetes) (McLemore, 2019). However, according to estimates by the World Health Organization (WHO) and the Institute for Health Metrics and Evaluation (IHME) in studies that control for age and chronic illness, the US MMR was far beyond that of any country of comparable wealth (McLemore, 2019). If we disaggregate the data by race, we can see that the MMR of Black women constitutes the exceedingly high rate nationally (McLemore, 2019). Black women are three to four times more likely to die from pregnancy related conditions than white women, and Black infants die at twice the rate of white infants (Martin & Montagne, 2017; McLemore, 2019; Weinstein, 2020). The racial disparity shows that quality maternal care is obviously possible and happening in the US but is not accessible to Black mothers. This paper will contextualize and investigate the racial disparity in the MMR of Black women in the US, as well as present contemporary interventions to promote positive birth outcomes of Black mothers.

It's Bad and an Underestimate

Before getting into the origins of this epidemic, it is important to note that in the US there is a lack of uniformity with respect to defining and tracking this data. McLemore (2019) details the barriers; namely, the definition of a maternal death is non-standard across the WHO and Center for Disease Control and Prevention (CDC). State level data collection becomes murkier because of the non-uniform definitions of cause of death and time of death. As of 2014, less than half of the states had a pregnancy question on death certificates. Consequently, McLemore (2020) affirms the MMR is broadly regarded as an underestimate.

Origins of the Epidemic

The Black Body and the Doctor

The racial disparity in the US MMR signals to a deeper structural issue preventing Black mothers from having more positive outcomes. Let us begin with an analysis of the origins of the relationship between US medical practitioners and the Black body. Medical professionals were an essential component of chattel slavery in the US. During the transatlantic slave trade, surgeons were aboard ships to keep enslaved Africans alive. At slave markets in the South, physicians would sign certificates of "soundness" for enslavers and were hired by insurance

companies to examine enslaved people before life insurance policies would be issued. Their function in the system was to protect the interest of enslavers and not their enslaved patients (Owens & Fett, 2019). A testament to the culture of medicine at the time, in an 1858 medical journal, the Savannah Medical College professor Juriah Harriss, proclaimed one of the primary professional competencies required by Southern doctors is the ability to accurately determine the market value of Black bodies (Owens & Fett, 2019).

Enslaved Mothers

Partus sequitur ventrem, the principle that made being enslaved a legally inheritable status to Africans and their descendants, was codified in Virginia in 1662 and led enslavers to exact their gaze upon African women (Owens & Fett, 2019). Unlike European women, African women were falsely characterized as being particularly capable of childbearing and hard field labor. The racialization of childbearing created two different realities as to how pregnancy and children would be engaged with. White mothers would give birth to heirs of wealth, and Black mothers would give birth to children who would be regarded as capital. Once the transatlantic slave trade was banned in 1808, enslavers grew obsessed over the enslaved African's womb and fertility to maintain and cultivate their wealth and the system of slavery. This development cemented African women's position as the cornerstone of chattel slavery (Owens & Fett, 2019).

Though African midwives had been providing healthcare to African mothers, enslavers began having physicians provide reproductive care for women to address infertility and difficult births. Without the abolition of slavery, there was little physicians could do to combat the 50% infant mortality rate, and pediatrics had yet to be developed (Owens & Fett, 2019). As colonizers do, instead of attributing poor nutrition, conditions, and hard labor to the high rate, they blamed mothers and midwives. Thus, creating the foundation of the abusive, racist, and gendered language and stereotypes that mar the care Black women access to this day.

Look How They Lie on Us: How Stereotypes Harm the Birth Experiences and Outcomes of Black Women

Narratives created during chattel slavery scapegoated Black women for the entirety of the plights of the Black race, citing them as having defective personal character and being unfit mothers by biology and parenting. Several stereotypes targeting Black women were created during chattel slavery as tools to justify the exploitation and control of Black women's bodies for economic power (Mehra et al., 2020). The foundational racist, sexist, and classist archetypes are the mammy, sapphire, and jezebel; each serve a unique purpose in stripping the bodily autonomy of Black women and devaluing their experiences of motherhood (Rosenthal & Lobel, 2016). Mammies are characterized as unattractive maternal figures who are happy

to care for the many children of white enslavers (Rosenthal & Lobel, 2016). The sapphire is an emasculating woman defined by aggressive and dominating behavior (Rosenthal & Lobel, 2016). Finally, the jezebel is an immoral, sexually promiscuous woman (Rosenthal & Lobel, 2016). The primary function of the jezebel stereotype was to justify the sexual violence inflicted upon enslaved women and children (Volscho, 2010). The image of the jezebel dismissed mounting allegations of sexual violence Black women made against enslavers. Citing the sexual deviance and availability of Black women was used to explain the high birth rates of enslaved women (Volscho, 2010). The compounding impact of the end of the transatlantic slave trade and the legally inheritable status of enslavement to be passed from mother to child made the fertility of enslaved women the lifeline of chattel slavery. Thus, it was critical for enslavers to create narratives about Black women that would support others having control of their bodies and maintain their inhumane status.

Identities Are NOT Strikes: An Intersectional Analysis of the Discrimination of Black Mamas

Intersectionality considers every identity of a person simultaneously. Since individuals navigate the world carrying multiple identities, intersectionality is necessary to consider (Cole, 2009). The intersectional framework reveals that the discrimination an individual at a particular intersection experiences is not merely the sum of individual forms of discrimination, rather it is a greater and distinct burden targeting the unique combination of identities (Cole, 2009; Rosenthal & Lobel, 2016). Holding the full scope of identities an individual carries and their historical and cultural context allows us to have a complete analysis and reduce bias.

Prior to Kimberley Crenshaw developing intersectional theory, social scientists would draw sweeping claims about femininity and motherhood while only considering the context and experience of privileged white women in their research (Cole, 2009). These claims were held as universally true, further othering Black women because of their different political and cultural contexts and value systems. Black women being excluded from consideration in defining the norms and standards of femininity and motherhood meant they were not able to access the protections of femininity. Namely, Black women were marginalized through "economic exploitation, stereotyping, and lack of legal protection" (Cole, 2009, p. 174).

Consequences of Apocalyptic Myths Like Good Men and Other Oxymorons: The Welfare Queen

As Black women began to gain access to public assistance in the 1960s, the image of the welfare queen was crafted. Ronald Reagan popularized the term during his 1970s bid for the presidency (Mehra et al., 2020; Volscho, 2010). The welfare queen is an uneducated poor single

Black woman who does not want to work, and, instead, purposefully has as many children as she can to take advantage of public assistance (Rosenthal & Lobel, 2016). This stereotype projects laziness and hyperfertility onto Black women and persists on the image of all Black mothers regardless of age, income, education, marital status, or parity (number of births) (Mehra et al., 2020). As opposed to being seen as a vulnerable population in need of support, low-income Black women were seen as manipulative and reckless mothers burdening society. The welfare queen trope cries back to the hypersexual image of the jezebel, and the orientation of Black mothers as "breeders" during enslavement, further devaluing them in the public consciousness (Mehra et al., 2020).

Myths Don't Lose Reception: The Modern Black Pregnancy Experience

Pregnancy is a transformative experience; it involves changes in "physical appearance, roles and responsibilities, self-perception, and social relationships, and it heralds further changes to identity and status that are associated with motherhood" (Rosenthal & Lobel, 2016, p.417). Pregnant women receive distinct treatment, and it can be positive or negative depending on the assumptions about the mother (Rosenthal & Lobel, 2016). For example, they can be treated with kindness and their identities affirmed or be met with disapproval and shaming. The latter is particularly prevalent for women assumed to be young or single, regardless of race (Rosenthal & Lobel, 2016). Pregnancy and motherhood are beautiful, unique experiences that constitute an identity and add nuance to the anti-Black stories society tells us about Black women.

In addition to the weathering experience of Black women over a lifespan of navigating a racist society that consequently obstructs positive birth outcomes, pregnant Black women are subject to an additional unique gendered racism. A 2020 study of the experiences of pregnant Black women from a variety of socioeconomic backgrounds in New Haven, Connecticut, detailed their experiences with care providers, social interactions, and navigating resources (Mehra et al., 2020). Participants faced assumptions that they were single mothers, low income, receiving government assistance, and they had multiple children, reflecting the tropes of the welfare queen and jezebel (Mehra et al., 2020). When healthcare providers hold these misconceptions, consciously or unconsciously, their orientation towards pregnant Black patients lead to discriminatory care, in turn creating disparities in health outcomes, which for Black mamas and babies are life-altering (Rosenthal & Lobel, 2016). A powerful nuance in these misconceptions is that many of the conditions Black women are assumed to be in are simultaneously believed to be self-inflicted. When in fact, the rates of single mothers are not a product of dysfunction in the home; rather, it is the result of the structural targeting of the

Black family through barriers to education, unemployment, and mass incarceration.

In the time Black women spend with providers, they feel they must prove their dignity and choices, as well as assert their right to access care or resources. Black mamas often report experiencing disrespectful and biased communication with their providers (Mottl-Santiago et al., 2020). This is reflected in the inflated rates of cesareans and maternal mortality rates of Black women in comparison to white women, even when controlled for medical and social risk factors (such as hypertension and income) (Mottl-Santiago et al., 2020). Black women have never been given the opportunity to experience care that is responsive to their unique positioning and context in this country. Particularly, their reproductive care has and continues to be shaped by the interest of wealthy white people, thus what is most lucrative for them was done unto Black women. The care Black women are offered puts them in an impossible position as the disparities they face are abhorrent, and the stereotypes projected onto them dismiss any form of self-advocacy. Africentric and Africultural coping frameworks outline "four types of responses: interconnectedness, spirituality, problem-oriented coping, and disengagement" (Mehra et al., 2020, p. 2). Participants in the study found that support from their family and community validated their personhood and pregnancy experiences (Mehra et al., 2020). They found that the only place their pregnancies were celebrated was in their communities (Mehra et al., 2020). The disdain Black women are met with while pregnant also creates more stress for the mother around the gendered racism their child will be subject to after they are born.

Accumulated Burden

In 1850, enslaved infants died 1.6 times higher than white babies, and in 2016 the CDC found the Black infant mortality rate to be 2.3 times higher (Owens & Fett, 2019). How could this be when Black mothers are in drastically better material circumstances and medical knowledge and technology has advanced bounds since chattel slavery? This shows there are more insidious dynamics at play in Black women accessing reproductive care. The triple consciousness of Black women and associated exposure to daily trauma and stress in interactions within racist heteronormative society and institutions takes a tangible toll on the health of these women. If they happen to operate at a rich intersection with other marginalized identities, such as being disabled or queer, their burden is further expanded and complicated.

Arline Geronimus coined the term "weathering" to describe how continuous stress wears away at the body (Martin & Montagne, 2017). Weathering can cause an assortment of health issues, early onset of chronic diseases, and an increase in susceptibility to infection (Martin & Montagne, 2017). Posttraumatic stress disorder (PTSD) due to a lifetime of overwhelming experiences of oppression and stress over being able to protect their child in this racist society is another mechanism at play in inflating the MMR (Weinstein, 2020).

Weinstein (2020) reports Black folks experience the highest rates of PTSD of any racial/ethnic group in the US, and Black women experience it at two to three times the rate of Black men. The experiences and legacies of ancestors is passed down generations through collective memory, oral tradition, and epigenetically (Weinstein, 2020). Part of that legacy includes the violence and trauma the US inflicted upon Black people as well as the unique orientation the medical establishment took towards the Black body and mother.

The Shift in Perspective on Black Fertility

During chattel slavery, the fertility of enslaved Black women was prioritized as their descendants were seen as capital that would multiply the wealth and productivity of enslavers (Volscho, 2010). However, since the abolition of slavery, the fertility of Black women has been sought to be constricted through sterilization racism as the fertility of Black women is no longer the source of material wealth. Sterilization racism is the "organization of racist controlling images, policies, and practices of delivering reproductive healthcare that operate to constrain, minimize, or completely eliminate the reproductive activities of women of color" (Volscho, 2010, p. 3). These practices are often under the guise of solving some other social problem, such as poverty, and often have an underlying assumption that Black women do not have the capacity to make decisions about their reproductive care or be fit mothers. Of course, not to be forgotten, is the overarching delusion of white supremacy.

Tubal ligation, a permanent form of birth control, is often offered as the default recommendation for contraception to Black women which loots Black women of their bodily autonomy (Mehra et al., 2020). It is only offered as the default because providers hold the undercurrent beliefs that Black women cannot control their sexual urges or be competent users of less permanent birth control, so they are pushed towards sterilization (Volscho, 2010). This is a stark contrast to the experience of white women whose reproductive options and fertility are prioritized, even if sterilization is requested it is often discouraged (Volscho, 2010). This difference highlights the racial stratification of reproduction and motherhood.

Black Mamas Are Not Doing Anything Wrong

There are a number of life course factors, including class or educational attainment, that are proven to improve birth outcomes, such as preterm birth, infant mortality, and maternal mortality. A postsecondary degree alone can improve the birth outcome of a white mother by 20%! (Weinstein, 2020). This additional degree results in no impact for Black mothers. For instance, a middle-class college educated Black woman is more likely to give birth prematurely than a white woman with a high school diploma (Weinstein, 2020). Women with at least

one post-secondary degree have higher MMR than non-Black women without high school diplomas (Weinstein, 2020). However, there is no combination of protective factors that can keep a Black mama and baby safe, but all risk factors do apply.

Further substantiating that structural racism is the cause for the inflated MMR of Black women is the Rosenberg, Desai, and Kan (2002) study of the birth outcomes of foreign-born Black mothers in New York City from 1988 to 1992. Though the scope of their study was limited by the sampling and accessibility of data on pregnancies and accuracy of self-reported information on birth certificates, the results signal trends that may hold up in the greater context. Their study found native-born Black mothers were 1.48 times as likely to experience infant mortality than foreign-born Black mothers (Rosenberg et al., 2002).

It's important to note the study did not include data about the life experiences of the immigrant women, a determinant factor in birth outcomes of US-born women (Rosenberg et al., 2002), which can allude to potential patterns and solutions to supporting positive birth outcomes. Rosenberg et al. (2002) claim that "immigrants' hopefulness" and social support buffers adverse results of discrimination they face (p. 6) since immigrants do not share the collective memory of trauma at the hands of the racist US medical system. Their experiences will also vary further depending on which country they originate from as the implicit bias of providers can result in different interactions that may not be as hostile as those US-born Black women are subject to. Furthermore, immigrant Black women typically have access to more social support, and knowledge of traditional nutrition to promote healing of mother and child.

Still Not Free: A Capabilities Perspective of the Predicament of Black Women

According to Nussbaum, human beings have equal intrinsic dignity regardless of their position in society, and "the primary source of this worth is a power of moral choice within them" (Garrett, 2002, p. 1). Nussbaum's capabilities approach is unique in that it considers people as individuals and acknowledges the relationships and power dynamics they operate within (Garrett, 2002). Black people in the US have a number of capabilities inaccessible to them and infringed upon by society and the state. Pregnant Black women have their capability of life and bodily health compromised by medical racism, evident in the disparity in birth outcomes, and low access to meaningful reproductive care, resources, and programing (Garrett, 2002). Accordingly, to cultivate the liberation of Black folks and restore the human rights stripped through US imperialism, we must consider how to redistribute resources such that it supports accessing and exercising all the capabilities to promote self-determination that Nussbaum highlights as inalienably human, rejecting the narrative of disposability of certain peoples.

By providing critically engaged and diverse health care providers, Black mamas can receive non-judgmental care so they may freely share information that may include risk factors, ask questions, and make informed consensual decisions in their reproductive care, being noted as engaged instead of combative (Mehra et al., 2020). Positive experiences with care providers have been linked to long term relationships with providers which is beneficial for babies and mamas (Mehra et al., 2020). A consistent positive relationship with a provider may promote the health of the mother postpartum and increase the breastfeeding rate and timely immunizations.

What Doctors Should Do Instead

Now let us turn our attention to the experience Black mothers have when they interact with their healthcare providers. Black mamas' interactions with physicians are characterized by the deeply harmful tradition of racist, sexist stereotypes that spread in the medical system. Doctors' projection of these stereotypes leads to the dismissal of key early symptoms that signal the onset of life-altering complications. A third of maternal deaths occur early on during postpartum, and the leading causes of maternal mortality, such as hemorrhage or preeclampsia are easily preventable (McLemore, 2019; Martin & Montagne, 2017).

The chronic stress of discrimination exacerbates these conditions, but there are several measures institutions can take to make gains toward promoting the well-being of Black mamas. Some of these include diversifying care providers, listening to patients, social and doula support, adjusting care plans and timelines to account for the heightened vulnerability of Black mamas, and thorough and transparent documentation (McLemore, 2019). Beyond these small concrete changes, Owens and Fett (2019) contend the most impactful change institutions must make is adopting anti-racist care frameworks to prevent more deaths. They assert that building this bold framework will be a collaborative effort among public health investigators, scholars of race studies, and medical providers. History has shown us the most sustainable and accessible solutions come from centering the margins and lived experience.

We All We Got, WE ALL WE NEED: Community Doula Programs

Community doula programs are an alternative framework for providing culturally congruent care. Community doulas are specialized community health workers who focus on the needs of pregnant people through the postpartum stage (Mottl-Santiago et al., 2020). The doulas support clients with care navigation, health education and literacy, and provide support throughout the process (Mottl-Santiago et al., 2020). Community doula programs

have shown doulas "reduce cesarean births, increase breastfeeding rates, and improve the experience of care" and they can "reduce assisted vaginal delivery and epidural rates, increase maternal-infant bonding, and reduce postpartum depression" (Mottl-Santiago et al., 2020, p. 44). These programs highlight the benefit of peer support and having advocates for mamas and babies that are exemplified in the Africentric and Africultural coping frameworks.

Where the Doulas at: Barriers to Readily Accessible Community Doulas

Despite the wealth of research detailing the success of community doula programs in promoting maternal and infant health across the country, they have not been implemented as a standard practice (Mottl-Santiago et al., 2020). Many of the barriers are due to a lack of reimbursement/funding mechanisms and standardized training, as well as responsive legislation to ensure that linguistically engaged and culturally competent community members have access to the training and certification (Mottl-Santiago et al., 2020). Several Black women's health advocacy and community groups have been pushing for legislation to support the expansion of this, and in recent years have made progress (Mottl-Santiago et al., 2020). However, there is still much work to do since the health care infrastructure falls behind with many institutions invested in maternal care not well-versed in this alternative framework of maternal support, and low-income mothers continue to experience the greatest barriers in accessing these programs (Mottl-Santiago et al., 2020).

Interventions that Support Black Mamas and Babies

Along with the transmission of generational trauma, wisdom and practices of resilience within oppressive systems are passed down generations. The bodily autonomy and agency of Black mamas can be cultivated by following the legacy of resistance and radical imagination Black mama activists and community interventions have exemplified. An excellent illustration of this legacy that continues to inform and inspire this line work is the Service to the People Programs founded by the Black Panther Party (BPP) described in Jordan Flaherty's *No More Heroes: Grassroots Challenges to the Savior Mentality*. Flaherty (2016) asserts that programs such as the free breakfast for children are an exercise of imagination of "independence from the state and community actions in principle" (p. 206). Owens and Fett (2019) echo this sentiment in their discussion of the People's Free Medical Clinics by the BPP. The clinics served to "empower patients and demystify medical procedures and medical authority," and they "challenged the idea of race as a causal determination of poor health outcomes by exposing the impact of racism and poverty on Black health and well-being" (Owens & Fett, 2019, pp. 3-4). Flaherty (2016) highlights the need for healing from these generational wounds which is an urgent need in combatting the chronic stress Black mamas face. Harriet's Apothecary, an

intergenerational, Black-led collective is one example of an organization dedicated to creating accessible healing spaces for QTBIPOC (Flaherty, 2016, p.203).

Conclusion

Nurturing positive birth outcomes of Black mamas will require systemic change and a diversity of community engaged tactics. Resources and authority need to be redistributed to Black mamas and Black-led organizations that have been doing birth work to support Black mothers. To end the stereotypes inhibiting the flourishing of Black mamas and babies, we need to examine what sustains these stereotypes today and who they benefit. We need to replace these hateful archetypes with images that celebrate and reveal the glory of Black mamas and babies. Without employing the radically imaginative solutions communities and health advocates have outlined and reinvigorating institutions with effective frameworks for rigorous and responsive care plans, Black mamas and babies will continue to experience the intergenerational consequences of the stigmatization of Black motherhood. We will have to employ the principle of Sankofa the Akan people shared with us; the US needs to reclaim and heal its past to move forward whole and with healthier mamas and babies.

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