Black Herstory and the Maternal Mortality Crisis among African American Women

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I am young, I am a physician, and I am highly educated. I have financial advantages that are above average. I have access to healthcare, healthy foods, clean water, and a safe environment.

And yet…

If I have a child, none of these things will save me from having a substantially increased risk of an adverse outcome, or even death. Why? Because in addition to all of the things I described; I am an African-American woman. And, more than any of the things that define me, this is the label that most profoundly informs my chances at a healthy life before, during, and after pregnancy.

Here are the facts:

Within the field of obstetrics and gynecology, disparities in pregnancy-related mortality among African-American women have led to a mortality rate greater than three times that of their white counterparts.[1]

While racial and ethnic disparities in maternal mortality disproportionally affect African-American women nationwide, nowhere is this disparity more prominent than in the state of Texas where African-American women make up only 11.4 percent of the population of women who give birth, yet account for 28.8 percent of maternal deaths.[2]

Even amidst claims of calculation errors leading to an inflated overall maternal mortality rate;[3] the notion that African-American women face profound disparities in maternal morbidity and mortality is so glaringly apparent in the data that it has remained the most unwavering fact in the crisis of rising U.S. maternal mortality rates.

So why are black women dying? Why are they facing complications and adverse outcomes, and why are all of things happening at such a profound rate, and with such a sharp disparity?

The reports by the Texas Maternal Morbidity and Mortality Taskforce show that a rise of chronic disease: pre-pregnancy obesity, diabetes, and hypertension may partly be to blame, yet the rates are rising for everyone.

So, why are black women dying?

When the task force evaluated causes of death by race and ethnicity, they found that pre-eclampsia and cardiovascular disease were among the leading causes of death for all women, but again black women were disproportionately affected.

So, why are black women dying?

Is it simply a matter of physiological predisposition? The same way that African-American people are more likely to have sickle cell anemia, or Ashkenazi Jews to have Tay-Sachs disease (a rare neurologic disorder). Should we just accept that black women have higher rates of chronic disease and fare worse than others as a matter of

predetermined genetics?

While this reasoning may seem attractive, it oversimplifies a complex problem. Though genetic predisposition may play a small role, mounting evidence suggests that the social determinants of health: education, poverty, geographic location, etc. have a much greater impact on health, and preventable mortality.[4]

However, I opened this piece with a proclamation that even with all the social advantages, African-American women still fare worse in pregnancy.

So, why are black women dying?

It seems that of all the social determinants of health, race and ethnicity most strongly predict the quality and intensity of care received. The 2002 Institute of Medicine Report Unequal Treatment found that racial and ethnic disparities contribute to worsened healthcare outcomes independent of factors related to access to care. Furthermore, the report implicated physician bias, stereotyping, and prejudice as important contributors to this problem.[5]

Based on this, I submit that that there is perhaps an alternative narrative, one that is darker, one that is more uncomfortable, one that asks you to consider the history that shaped the treatment of black women in the healthcare system and what impact this has on the present state.

Here is the history:

Modern gynecology was perfected through the unimaginable exploitation of black women's bodies. Dr. Marion Sims (hailed as the father of modern gynecology) performed countless gynecological procedures on his slaves without the use of pain medication or anesthetic. He asked other slaves to hold each "patient" down and muffle their screams as he went about his work, inviting other colleagues to observe the horrific experimentation. He then went on to addict these women to opioids; furthering the reach of his control over their bodies.

Across the country, Dr. Marion Sims has statues erected in his honor, and while recognition of his contributions to the field of obstetrics and gynecology are plentiful; the costs of those contributions are rarely mentioned. And worse yet, the reproductive exploitation of black women did not stop with him. It continued on in history in many ways. It occurred in the form of federally-funded reproductive health procedures which amounted to coerced sterilization; and persisted in segregated healthcare practices that denied black women the standard of care. This is all part of the historical context that shaped society's valuation of black women's bodies.

And while understanding the historical context is only one of the myriad considerations for addressing disparities in maternal mortality; the systematic oppression of black women and the impact that this repetitive and unyielding trauma (both physically and emotionally) has had on their bodies; is a story that is too often discredited as relevant to the problem.

But how does this help us move forward toward improving maternal mortality disparities? I make no conscious claims to having the solution for this problem. As with all wicked problems, the solution is multifaceted. However, I do have a proposition on where to begin.

Here is what I know:

I am a primary care provider; I believe that lifestyle changes and medications can reduce chronic disease. I believe that in conjunction with good obstetric care and follow up, access to a primary care provider prior to and in the year following pregnancy can help black women have healthier lives through conception and beyond.

And yet…

I know that solving this complex problem is not just about healthcare. That it is also about recognizing the social and environmental factors that influence a black woman's health, and about empowering her to choose behaviors that promote self-care.

Even with these things, however, acknowledgment remains the first act of any lasting recovery. And so, we must acknowledge.

Acknowledge that the black woman may still be healing from historical wounds, that she is perhaps trying to build trust within a healthcare system that has cultivated generations of mistrust. That she is trying to teach herself and her community that her strength is not measured by her capacity to endure pain and suffering, and that prioritizing her own health is not a fatal flaw, that it is, in fact, the opposite, a radical act of self-preservation.

That for all we ever try to accomplish to solve this problem, our interventions will be inane unless they acknowledge, respect and incorporate her story.

References

1. Creanga AA, Syverson C, Seed K, Callaghan WM. Pregnancy-Related Mortality in the United States, 2011–2013. Obstet Gynecol. 2017.
2. Shirley A. Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report. 2016.
3. Baeva S, Saxton DL, Ruggiero K, et al. Identifying Maternal Deaths in Texas Using an Enhanced Method, 2012. Obstet Gynecol. 2018;131(5):762-769. doi:10.1097/AOG.0000000000002565.
4. McGinnis JM, Williams-Russo P, Knickman JR. The Case For More Active Policy Attention To Health Promotion. Health Aff. 2002;21(2):78-93. doi:10.1377/hlthaff.21.2.78.
5. Smedley BD, Stith AY, Nelson AR. Unequal Treatment. National Academies Press (US); 2003. doi:10.17226/12875.