

GOAL 2 Action 2.7

WHITE HOUSE
BLUEPRINT
EVIDENCE TO
ACTION BRIEFS

Address systemic discrimination
in health care



Maternal Health
Learning & Innovation Center™
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**THE WHITE HOUSE BLUEPRINT
FOR ADDRESSING THE
MATERNAL HEALTH CRISIS**



The [White House Blueprint for Addressing the Maternal Health Crisis](#) (White House Blueprint) has identified goals and actions to reduce the rates of maternal mortality and morbidity, eliminate disparities in maternal health outcomes, and improve the experience of pregnancy, birth, and the postpartum period for people across the United States.

The following Evidence to Action Brief highlights Action 2.7 in the White House Blueprint in an effort to ensure that those giving birth are heard and are decision-makers in accountable systems of care (Goal 2 of the Blueprint).

Maternal Health Action 2.7

Address systemic discrimination in health care by providing guidance on the prohibition of discrimination on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity), in various health programs and activities.

Contribution to Quality of Life

The [White House Blueprint](#)¹ is a “whole-of-government approach to combating maternal mortality and morbidity” so that *all people in the United States who are capable of becoming pregnant and giving birth are healthy and safe*.

To ensure that women and birthing people are not subject to systemic discrimination or bias, it is essential that all members of a health team, from health system CEOs to frontline team members, including nurses, doctors, medical assistants, front desk staff, and many more, receive education and training to strengthen their cultural humility, transparency, and accountability. Broadening awareness of the systemic forces that privilege some and harm others is a pivotal step in creating healthcare systems that serve all. These efforts are essential to mitigate the effects of stratified reproduction—the devaluing of fertility and childbearing among groups that have experienced oppression.

CALL TO ACTION

To reduce disparities and improve maternal health outcomes, we need to identify and remove structural racism, interpersonal racism, and discrimination from our health systems and our communities. We need to take the time to see, hear, and value patients whose lived experiences have led them to distrust the medical system. We need to work together to reform and reimagine healthcare. More broadly, we need to address the root causes of unjust health outcomes by creating the conditions for women and birthing people not only to survive pregnancy but to thrive.

Basic Facts

Defining Types of Racism²

- **Structural racism**—The systems of power based on historical injustices and contemporary social factors that systematically disadvantage people of color and advantage White people through inequities in housing, education, employment, earnings, benefits, credit, media, healthcare, criminal justice, and more (adapted from [Bailey et al. 2017](#)).
- **Interpersonal racism**—Discriminatory interactions between individuals based on differential assumptions about the abilities, motives, and intentions of others and resulting in differential actions toward others based on their race. Interpersonal racism can be conscious as well as unconscious, and it includes acts of commission and acts of omission. It manifests as lack of respect, suspicion, devaluation, scapegoating, and dehumanization (adapted from [Jones, CP, 2000](#)).



- **Discrimination**—Treating someone less or more favorably based on the group, class, or category they belong to resulting from biases, prejudices, and stereotyping. Discrimination can manifest as differences in care, clinical communication, and shared decision-making (adapted from [Smedley et al., 2003](#)).

Structural Racism

Structural racism systematically disadvantages people of color and advantages those who are White. Embedded in policies, protocols, procedures, and practices, structural racism impacts maternal health before, during, and after pregnancy. The Home Owners Loan Corporation, a federal agency created in the 1930s, is the forebearer of what is now known as “redlining.”³ A historic housing discrimination practice, redlining intentionally cut off lending and investment in neighborhoods that were predominantly Black. More than 90 years later, neighborhoods that were redlined have higher rates of chronic disease and adverse pregnancy outcomes.³ Blocked from obtaining mortgages, residents of Black communities were unable to purchase homes and thus could not benefit from federal programs such as the mortgage tax deduction and the GI Bill.⁴ Denied the ability to accumulate wealth across generations, Blacks today in the US have a household median wealth of \$24,000, compared with \$189,000 for White households.⁵

Immigrant mothers and infants, a group that is systematically denied equitable and respectful care based on a variety of laws and policies that limit the opportunities for care, also face structural racism.⁶ This has consequential impact on mothers, birthing people, and infants: during the perinatal period, economic vulnerability, stress, and experiences of discrimination have been identified as risk factors associated with pregnancy-related mortality.⁷

“Throughout the US history, the fertility and childbearing of poor women and women of color were not valued equally to those of affluent white women. This is evident in a range of practices and policies, including black women’s treatment during slavery, removal of Native children to off-reservation boarding schools and coercive sterilizations of poor white women and women of color. Thus, reproductive experiences throughout the US history were stratified. This ideology of stratified reproduction persists today in social welfare programs, drug policy and programs promoting long-acting reversible contraception.” – [Lisa Hariss and Taida Wolfe, Current Opinion in Obstetrics & Gynecology](#)

Interpersonal Racism

Racial bias, whether implicit or explicit, can result in healthcare providers treating patients of color differently than White patients and lead to worse health outcomes for people of color.⁸ The differential treatment of childbearing persons based on race or ethnicity is known as “obstetric racism.”⁹ Several studies have identified the differential treatment Black birthing persons receive before, during, and after pregnancy compared with White populations. Negative stereotyping (e.g., all Black women are low-income, single, receive welfare, and have multiple children), dismissal regarding pain, maltreatment by residents or trainees, and being judged by healthcare service providers are some of the most recent findings.⁹ For example, it has been shown that there is “systematic variation” in the treatment of postpartum pain for minoritized patient populations.¹⁰ A qualitative study with Asian American, Pacific Islander, Black, Latina, and Middle Eastern women found significant unequal power dynamics and vulnerability within the patient-provider relationship throughout pregnancy and the birthing period.¹¹



Discrimination

Discrimination in healthcare is defined as the “negative actions or lack of consideration given to an individual or group that occurs because of a preconceived and unjustified opinion.”¹²

Discriminatory acts consist of micro- and macro-aggressions. Women and birthing people who identify as Black, American Indian/Alaska Native, Hispanic/Latina (Hispanic), and Asian/Pacific Islander report higher rates of mistreatment, discrimination, being excluded from decision-making regarding their healthcare, and experiencing both conscious and unconscious bias from healthcare providers and the healthcare system.¹¹ The four most common forms of mistreatment during maternal care include being shouted at or scolded; being ignored or refused requests for help; suffering a violation of physical privacy; and experiencing threats to withhold treatment or experiencing forced unwanted treatment.¹³

There has been little investigation of the experiences of those who identify as part of the LGBTQ+ community, although there is evidence to suggest that members of this community perceive discrimination and bias as impacting their care during the perinatal period.

Title VII of the Civil Rights Act and the Americans with Disabilities Act (ADA) prohibit “unequal treatment based on race, sex, and disability.” Implementation of the Affordable Care Act (ACA) has played a role in reducing disparities related to health insurance coverage. Despite these protections, however, inequities and disparities persist.¹⁴ Although there may be less discrimination after implementation of the ADA and ACA, inequities in access and quality of healthcare continue to differ by race, ethnicity, geographic location, and socioeconomic status.¹⁴

The Health and Human Services Office for Civil Rights (HHS-OCR) provides guidance on preventing discrimination in healthcare, including maternal health, and enforces violations of antidiscrimination laws.^{1 pg.35} In response to the US Supreme Court’s 2020 holding in *Bostock v. Clayton County*, the HHS-OCR has proposed a new rule to strengthen nondiscrimination in reproductive healthcare which will affirm protections against discrimination based on race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity) in various health programs and activities.¹⁵

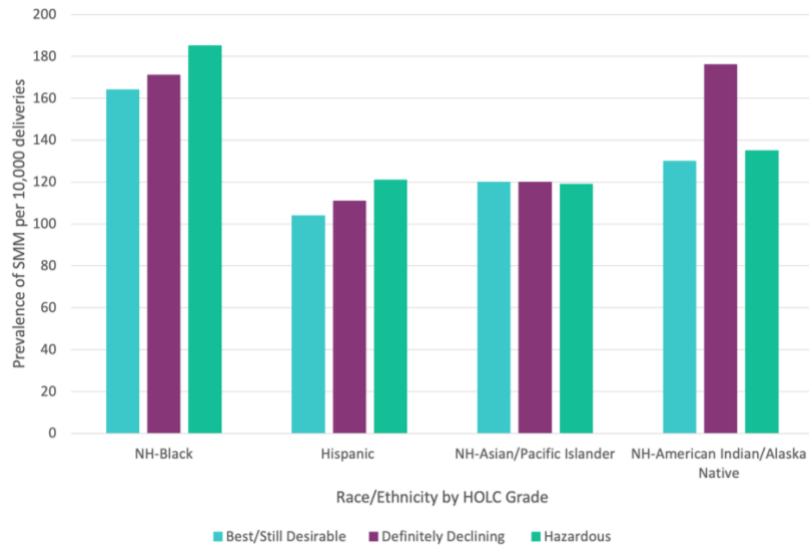
To ensure that those giving birth are heard and are decision-makers in accountable systems of care (Goal 2 of the White House Blueprint), HHS commits to addressing systemic discrimination in healthcare. HHSOCR will use the allocated \$21 million to “bolster its enforcement, technical assistance, and outreach activities by, for example, working more extensively with providers and helping more women.”^{1 pg.35}

How are we doing?

Below we highlight selected data related to Action 2.7. Racial, ethnic, geographic, and socioeconomic disparities emphasize where efforts should be focused to improve health outcomes related to the action.



Figure 1: Structural Racism in California: Black and Hispanic Birthing People Living in Redlined Neighborhoods Experienced Higher Rates of Severe Maternal Morbidity Compared to Asian/Pacific Islanders and American Indian/Alaska Natives

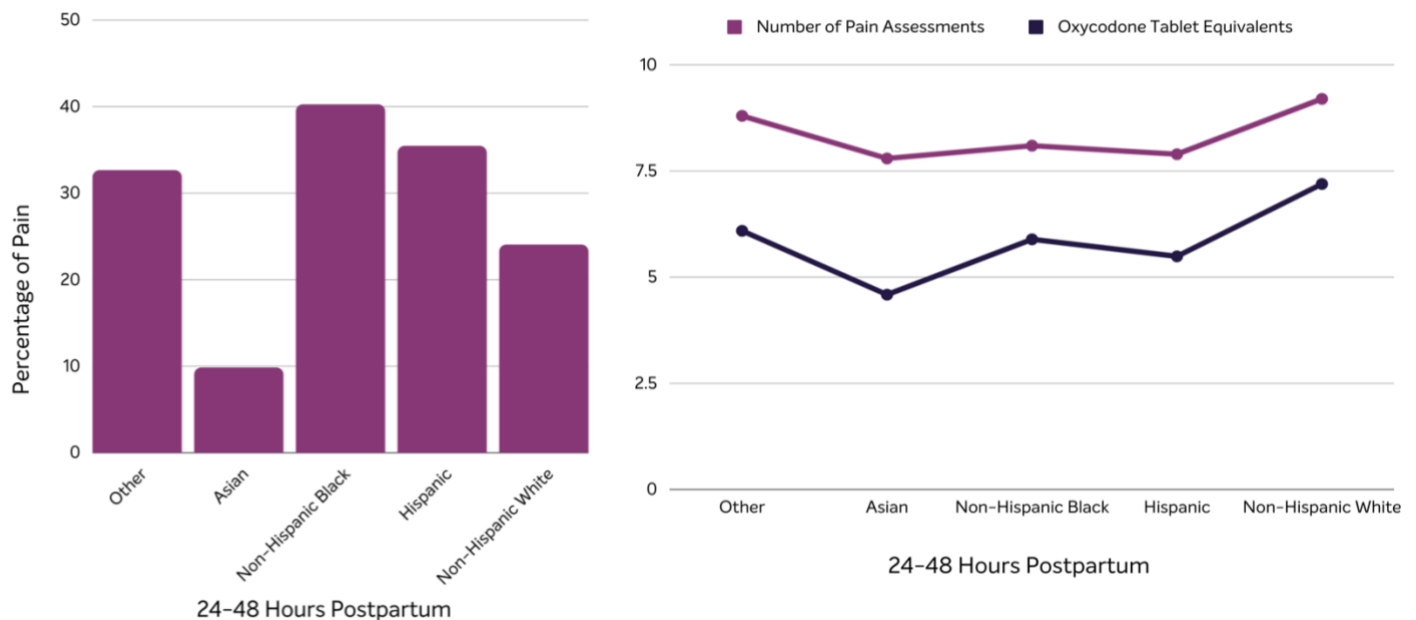


An examination of the Home Owners Loan Corporation (HOLC) redlining grades found that Black and Hispanic birthing persons living today in a neighborhood graded “hazardous” in the 1930s suffered from higher rates of severe maternal morbidity (SMM) compared with those living in neighborhoods that had been graded “best” or “still desirable.”

Note: For more information on the classification of the HOLC grading system and neighborhoods, visit <https://ncrc.org/holc/>

Source: Gao X, et al. *Remapping Racial and Ethnic Inequities in Severe Maternal Morbidity: The Legacy of Redlining in California*. *Paediatric Perinat Epidemiol*. 2023. 37(5):379-389.

Figure 2: Pain and Pain Management after Cesarean Birth, by Maternal Race and Ethnicity



The experience, assessment, and treatment of postpartum pain differs by race and ethnicity. Severe pain (a pain score >7) is more common among Black and Hispanic birthing people than it is among those who identify as White or Asian. Despite this, the number of pain assessments and the treatment for pain is lower for Black and Hispanic birthing people.

Source: Johnson JD, et al. *Racial and Ethnic Inequities in Postpartum Pain Evaluation and Management*. *Obstet Gynecol*. 2019;134(6):1155-1162.



Figure 3: Maternal Mistreatment, Stratified by Race and Ethnicity, 2019

	Black n = 320	Hispanic n = 188	Indigenous n = 64	Asian n = 90	White n = 1416
	n (%)	n (%)	n (%)	n (%)	n (%)
Your private or personal information was shared without your consent	2 (0.6)	5 (2.7)	2 (3.1)	0 (0)	17 (1.2)
Your physical privacy was violated (i.e., being uncovered or having people in the delivery room without your consent)	27 (8.4)	12 (6.4)	6 (9.4)	7 (7.8)	62 (4.4)
Healthcare providers threatened, (doctors, midwives, or nurses) shouted at, or scolded you	35 (10.9)	30 (16.0)	10 (15.6)	9 (10.0)	90 (6.4)
HCPs threatened to withhold treatment or to force you to accept treatment you did not want	21 (6.6)	11 (5.9)	7 (10.9)	6 (6.7)	51 (3.6)
Healthcare providers threatened you in any other way	6 (1.9)	8 (4.3)	3 (4.7)	1 (1.1)	26 (1.8)
Healthcare providers ignored you, refused your request for help, or failed to respond to requests for help in a reasonable amount of time	41 (12.8)	23 (12.2)	7 (10.9)	12 (13.3)	79 (5.6)
You experienced physical abuse (including aggressive physical contact, inappropriate sexual conduct, a refusal to provide anesthesia for an episiotomy, etc.)	6 (1.9)	4 (2.1)	0 (0)	1 (1.1)	16 (1.1)
Any mistreatment (one or more of the above)	72 (22.5)	47 (25.0)	21 (32.8)	19 (21.1)	199 (14.1)

Indigenous women were the most likely to report experiencing at least one form of mistreatment by a healthcare provider (33%), followed by Hispanic (25%) and Black women (23%). Women who identified as White were least likely to report that they experienced any of the mistreatment indicators (14%).

Source: Vedam S, et al. [The Giving Voice to Mothers study: inequity and mistreatment during pregnancy and childbirth in the United States](#). *Reprod Health*. 2019.16(77).

Story Behind the Data: Factors Affecting Progress

Structural Racism

Research examining the prevalence of severe maternal morbidity in neighborhoods within the graded system developed in the 1930s by the federal Home Owners Loan Corporation (HOLC) took place between 1997 and 2017. (See Figure 1.) The HOLC system was designed to reflect the risk associated with issuing home mortgages; neighborhoods with large populations of people of color were rated “hazardous” and appeared in red on maps. Using linked birth files and the parental address on file at the time of an infant’s birth, combined with the Centers for Disease Control and Prevention severe maternal morbidity index, the recent studies found that Black, Hispanic, and Asian/Pacific Islanders born in redlined areas experienced severe maternal morbidity at a higher rate than White birthing persons. Black and Hispanic birthing persons living in a grade D (Hazardous) area had 1.15 and 1.17 times the risk of severe maternal morbidity compared with those living in grade A (Best) or B (Still Desirable) areas.⁴

Historical redlining, housing discrimination, racial residential segregation, and leveraging institutional power continue to create differential access and resources to healthcare, grocery

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stores, parks, schools, and employment.⁴ Structural racism has been found to result in higher rates of stress, chronic health conditions, and adverse maternal and infant outcomes.

Interpersonal Racism

Birthing persons who identify as persons of color have been found to experience longer wait times and being ignored, refused, or delayed for treatment compared with White birthing persons. Lack of timely and appropriate prenatal care has been found to be associated with an increased rate of maternal mortality and morbidity. During COVID-19, birthing persons of color had greater challenges in accessing obstetric and mental health care compared with White persons. In addition, “visitor restriction policies were more strictly enforced for women of color compared to White women.”¹¹ (See Figure 2.)

Much of the research on racism and maternal health has focused on Black birthing persons. However, Hispanic, Asian/Pacific Islander, and American Indian/Alaska Native birthing persons also have been found to be victims of racism. Black, Hispanic, and Asian birthing persons have higher rates of intracerebral hemorrhage during the perinatal period compared with White birthing persons.¹¹ Language barriers also have been documented to reduce access to and quality of healthcare in this country.

[Nguyen](#), et al. (2022) conducted 11 focus groups with groups of Asian American and Pacific Islander, Black, Latina, and Middle Eastern women to better understand their perceptions and beliefs of how racism and discrimination affect pregnancy and birth outcomes. Authors found “participants in the Pacific Islander focus group reported how treatment varies based on skin complexion, with darker-skinned women receiving worse treatment.”¹¹ Participants that identified as Middle Eastern shared how the “Muslim ban bolstered stereotypes” while all women identified unequal power dynamics and feelings of vulnerability in the patient-provider relationships.¹¹

Discrimination

Nationally, 1 in 6 women (17%) has experienced one or more verbal and/or physical abuses and discriminations in a maternal healthcare setting; these rates, however, vary by race and ethnicity.¹³ Indigenous women reported the highest rate of mistreatment (32%), followed by Hispanic women (25%) and Black women (23%), while White women had the lowest rate of reported mistreatment (14%).¹⁴ In a national study by [Declercq](#) et al. (2014), 30% of Black and Hispanic women reported being treated poorly “because of a difference of opinion with [their] caregivers about the right of care for [herself or her] baby,” compared with 21% of White women.¹⁶ These disparities, along with other factors, result in Black and American Indian/Alaska Native women having higher rates of pregnancy-related death compared with White women. (See Figure 3.)

Structural factors such as redlining contribute to social and economic challenges that put Black, Indigenous, and people of color individuals at risk of experiencing mistreatment in a maternity care setting. Women with a history of substance abuse, incarceration, and/or intimate partner violence were found to have the highest rates of mistreatment compared with those without these social risks.¹³ People of color are more likely to experience the negative effects of certain social determinants of health such as food, economic, and housing insecurity,^{17,18} thereby placing these individuals at higher risk for experiencing mistreatment in maternity care settings. Furthermore, women and birthing people with a lower socioeconomic status (SES) are more likely to be mistreated compared with those with middle and upper SES.¹³



The rates for mistreatment in a maternity care setting increase at the intersection of multiple disadvantaged social identities, such as being a person of color and being in a low SES.¹³ For example, more than 27% of women who self-identify as a person of color and report low SES report some type of mistreatment, compared with only 19% of women who identify as White and have low SES.¹³ There also are higher rates of mistreatment among people of color with low SES who may also be young, have previously given birth, have social risk factor(s), or experience pregnancy complications.¹³

Intersectionality

Situated at the center of structural racism, interpersonal racism, and discrimination, intersectionality—a concept created by civil rights advocate Kimberlé Crenshaw—concerns the intersections of aspects of social identity (such as ethnicity, gender, class, sexuality, geography, age, ability, migration status, and religion) and forms of oppression and privilege (racism, classism, sexism, ableism).¹⁹ To curb—and ultimately eliminate—racism and discrimination in maternal care, healthcare providers, public health leaders, and policymakers must consider how social identity and systems of power and oppression act on maternal health and its care before, during, and after pregnancy.

What can be done to address the issue?

The [White House Blueprint](#) identifies actionable steps to address Action 2.7. In addition, experts from the maternal and child health (MCH) field have identified innovative, evidence-informed strategies from several databases and national repositories.

“The doctor who refused to test me for an amniotic fluid leak instead gave me an STD test I had already received during the pregnancy. I believe his assumption that I was leaking something due to an STD rather than a pregnancy complication was due to race and put my life and my newborn’s life at risk—I went a week leaking fluid after I had went in to get it checked out. I worry that [d]octor is still discriminating against other mothers and they are receiving negligent care as well.” – [Black mother who gave birth in California](#)

Maternal and Child Health Innovations

MCH experts selected the following resources for action after a review that included: the [MCHbest Database](#), a database developed to aggregate evidence-based strategies that can be used as is or adapted to fit local and state-level contexts; the [Association of Maternal & Child Health Program’s Innovation Hub \(AMCHP\)](#), a searchable repository of local and state practices, policies, and community-based innovations considered to be “what’s working” in the MCH field; the [Robert Wood Johnson Foundation’s What Works for Health \(RWJ\)](#) database, a tool that helps local communities to identify policies and programs that fit within their context and match their priorities; the [Maternal Health Learning & Innovation Center](#), a national resource for improving maternal health inequities; and a search of leading organizations and agencies working in this field.



- [Colorado Birth Equity Bill Package](#). Colorado passed its Birth Equity Bill Package in the 2021 session to protect human rights and improve outcomes, especially for birthing people of color. Included are three bills which: establish basic human rights standards in perinatal care for all people, including those who are incarcerated; align perinatal care data and systems for equity; and continue the state’s direct-entry midwifery program. (AMCHP)
- [Cultural Brokering](#). A cutting-edge practice, cultural brokering provides one-to-one emotional, informational, and systems navigational support to culturally and linguistically diverse families. The Center for Family Involvement at Virginia Commonwealth University has employed cultural brokers to represent African American, Arabic, Asian, Latino, and refugee/immigrant communities. The cultural brokers are parents to children with disabilities and special healthcare needs; they provide support to culturally and linguistically diverse families of children with disabilities and support them to effectively navigate the education, health, and disability systems. (AMCHP)
- [Cultural Competence Training for Health Care Professionals](#). This strategy focuses on skills and knowledge that value diversity, understand and respond to cultural differences, and increase awareness of the cultural norms of providers and care organizations. (RWJ)
- [Eligibility Expanded Insurance Coverage/Medicaid Eligibility](#). Adopting a protocol to ensure that all persons in maternal, child, and adolescent health programs are referred for enrollment in health insurance is an evidence-supported strategy. (MCHbest)
- [Health Equity Impact Assessment](#). The HEIA provides a structured process to guide the development, implementation, and evaluation of policies and programs that impact population health, with a goal of reducing health disparities and inequities. (AMCHP)
- [National Institute for Children’s Health Quality](#). NICHQ supports the operation of the National Network of Perinatal Quality Collaboratives, which provide expertise and resources to state PQCs to ensure the advancement of equitable programs, trainings, and resources to improve maternal mortality and morbidity.
- [PASOs Health Connections](#). This model, considered a best practice, trains community health workers (CHWs) to work closely with members of Latino households, serving as a bridge between these families and the resources they need. The CHWs build trust with immigrant families, educate them about their health challenges, connect them with resources, and follow up to assess outcomes. (AMCHP)
- [Professionally Trained Medical Interpreters](#). Supporting the development of a training program for medical interpreters is a scientifically supported strategy. (MCHbest)
- [Women of Color Health Equity Collective](#). This collective promotes the resilience and empowerment of women of color to advance health and wellness by building community capacity and advocating for just policies through evidence-based research and grassroots organizing. (AMCHP)

State Maternal Health Innovations from the Health Resources & Services Administration (HRSA) Maternal and Child Health Bureau (MCHB) Grantees

The [State Maternal Health Innovations \(MHI\)](#) initiative, funded by [HRSA’s MCHB](#), currently provides funding to 18 states to develop, implement, and evaluate state-level equity-centered innovations. Below we highlight innovations from the MHI cohorts (2019–2024) that address Action 2.7.

- [Illinois](#). The Illinois Perinatal Quality Collaborative developed an Implicit Bias Training Inventory for potential use by healthcare providers in response to Illinois Public Act

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102-0004, which requires implicit bias awareness training for healthcare professional license or registration renewals beginning January 1, 2023.

- [Maryland](#). *Awareness to Action: Dismantling Bias in Maternal and Infant Healthcare* is an in-person or virtual learning experience that provides content for healthcare professionals and nursing and medical students caring for women before, during, and after pregnancy. Developed by the March of Dimes as part of the Maryland Maternal Health Innovation Program Training Center, the training has been offered to more than 35,000 healthcare professionals.
- [Massachusetts](#). The state's Perinatal Neonatal Quality Improvement Network launched its maternal equity bundle to reduce overall rates of severe maternal morbidity and to close the Black-White gap in these rates. The equity bundle utilizes champions (i.e., clinical professionals, community partners, hospital leadership), tools, culture initiatives (e.g., engaging the community and participating in equity and bias training), and measurement to reduce maternal health inequities.
- [North Carolina](#). The North Carolina Maternal Health Innovation Program is developing and providing trainings for physicians, midlevel practitioners, nurses, and others related to health equity, implicit bias, and social determinants of health through partnerships with the NC Area Health Education Centers, Office of Minority Health and Health Disparities, and March of Dimes.
- [Ohio](#). In 2022, the Department of Health's Pregnancy Associated Mortality Review Program offered a free live-virtual training, *Managing Implicit Bias and Maternal Health* for health professionals. Continuing nursing education contact hours were awarded to nurses who attended all sessions, completed the cultural intelligence (CQ) assessment before the training, and submitted an evaluation at the end of training.

Resources from the [MCH Evidence Center's Digital Library](#)

The [MCH Digital Library](#) is a digital repository of evidence-based and -informed toolkits, briefs, white papers, and more with seminal and historic resources. The following may support Action 2.7:

- U.S. Centers for Medicare & Medicaid Services. [CMS Framework for Health Equity 2022–2032](#). 2022. Accessed September 27, 2023.
- Executives for Health Innovation. [Maternal Health Disparities: Challenges, Trends, and the Way Forward](#). 2022. Accessed September 27, 2023.
- Adamsen C, et al. National Council on Aging. [Evidence-based Health Promotion Programs Among American Indian, Alaska Native, and Native Hawaiian Communities: A Call to Action to Improve Cultural Relevance and Accessibility](#). 2021. Accessed September 27, 2023.
- Radley DC, et al. Commonwealth Fund. [Achieving Racial and Ethnic Equity in U.S. Health Care: A Scorecard of State Performance](#). 2021. Accessed September 27, 2023.

Healthcare leaders and policymakers are called upon to provide guidance on the prohibition of discrimination and enforcement of these policies. Patients, especially those who are impacted by inequities at a higher rate, must be heard and be decision-makers in their own care.²² Using the frameworks and principles of Reproductive Justice, Research Justice, and Cultural Humility, healthcare systems and providers have the opportunity to address discrimination and mistreatment among their patients.



“... Like millions of women of color, especially black women, the healthcare machine could not imagine me as competent and so it neglected and ignored me until I was incompetent. Pain short-circuits rational thought. It can change all of your perceptions of reality. If you are in enough physical pain, your brain can see what isn't there. Pain, like pregnancy, is inconvenient for bureaucratic efficiency and has little use in a capitalist regime. When the medical profession systematically denies the existence of black women's pain, underdiagnoses our pain, refuses to alleviate or treat our pain, healthcare marks us as incompetent bureaucratic subjects. Then it serves us accordingly.” – [Tressie McMillan Cottom, sociologist and award-winning writer](#)

Strategy Development Criteria to Consider for State and Local Implementation

To select impactful strategies for local implementation, an organization may consider using the following criteria, based on the Results-Based Accountability framework outlined in the book *Trying Hard Is Not Good Enough* by Mark Friedman.

- **Specificity:** Ensure strategies are clearly defined, including responsible parties and timelines.
- **Leverage:** Evaluate how strategies can improve data quality and reliability.
- **Values:** Assess alignment with community and organizational values.
- **Reach:** Consider feasibility and affordability at the required scale.

Using these criteria can aid in developing feasible and impactful strategies. Visit maternalhealthlearning.org/Blueprint for more details.



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The MHLIC is available for consultation, coaching, and technical assistance to support your implementation of any innovations to improve maternal mortality and morbidity. For more information, visit <https://maternalhealthlearning.org/connect>.

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