

BLACK MATERNAL HEALTH AS A REPRODUCTIVE JUSTICE ISSUE

Black women and birthing people in the United States (U.S.) have unacceptable and inequitable maternal and infant health outcomes—including staggering rates of preventable illnesses and deaths related to pregnancy and childbirth.

At the heart of the U.S. maternal health crisis is a fragmented health care system that perpetuates vast racial disparities in maternal and infant morbidity and mortality. Black women have the highest rates of maternal mortality in the country, and are two-to-four times more likely to die of pregnancy- and childbirth-related causes compared to women of other races and ethnicities. Black newborns also have worse outcomes than their counterparts: they face the highest rate of infant death compared to all other groups—specifically, more than double the rate of white infant death.

The impact of structural racism is clear: In Our Own Voice's most recent national poll reveals that nearly one-quarter of Black women aged 18 to 44 who were surveyed were worried about their health and safety during pregnancy or childbirth because of their race. Nearly 20 percent reported feeling that a health care provider didn't take their pain seriously during pregnancy or childbirth due to their race and/or gender. Another poll we conducted across 10 states revealed that Black families rely on Medicaid and public insurance to safely deliver their children; these families are now at critical risk, since Congress eliminated more than \$1 trillion in Medicaid funding in July 2025.

Achieving better outcomes for Black women, birthing people, and their babies requires a commitment to birth justice—including dismantling systemic barriers to care; supporting public health programs; addressing maternal mental health; and increasing the availability of Black midwives and doulas. We urge you to not ignore, erase, or obscure the unique burden of adverse maternal and infant health outcomes in Black communities caused by systemic inequities and racism. We advocate for passage of comprehensive legislation focused on addressing, improving, and transforming Black maternal health.

Reproductive Justice can only be achieved when Black women, girls, and gender-expansive individuals can experience pregnancy and childbirth without endangering our lives. The U.S. has the highest maternal and infant mortality and morbidity outcomes of all industrialized, high-resource nations.¹ The country's overall rate of 17.9 maternal deaths per 100,000 live births, and overall infant mortality rate of 5.6 deaths per 1,000 live births is the highest of all industrialized, high-resource countries.^{2,3}

It is important to note, however, that not all women and infants face the same risks. Black birthing people and newborns in the U.S. have unacceptably poor outcomes—including staggering rates of death related to pregnancy and childbirth. Black women have the highest rates of maternal mortality in the country; they are more than three times more likely to die of pregnancy- and childbirth-related causes compared to women of other races/ethnicities.^{4,5}

Black newborns also have worse outcomes than their counterparts; they face the highest rate of infant death compared to all other races/ethnicities, with a mortality rate that is more than double that of white babies.⁶

At the heart of America's maternal health crisis is a woefully fragmented health care system that perpetuates vast racial disparities in maternal and infant morbidity and mortality, which disproportionately impacts Black birthing people and babies. Structural racism and the resulting biased health care system contribute to Black women's and babies' poor health outcomes, including morbidity and mortality.

Systemic barriers faced by Black women and birthing people include racism and sexism in the health care setting, income inequality that results in lower wages; and reduced access to public health services. As a result, too often, we have to pick and choose among essential resources like safe housing; child care; food; and medical services, including timely medical care.

Black women who are insured are often covered by public insurance; they have benefitted from the Affordable Care Act (ACA), and state expansion of Medicaid coverage from 60 days to 1 year postpartum. All states now have the option to expand Medicaid coverage, and 49 states, the District of Columbia, and certain territories have opted to do so. In 2024, our poll of 5,000 Black adults across 10 states revealed that Medicaid and other forms of public insurance are a lifeline for Black families.^{7,8}

Since the poll was conducted, that lifeline has been severed. In July 2025, Congress passed *H.R. 1*, which reduced Medicaid and the ACA funding by approximately \$1 trillion over the next decade. The legislation will cause lasting and severe consequences for maternal health care nationwide. Because Medicaid finances nearly half of all births in the U.S., and two-thirds of births for Black women, these cuts threaten the majority of Black women who are of reproductive age. If a state chooses to account for a reduction in federal funding and balance their budgets by reducing access to its Medicaid programs, many Black mothers will no longer be able to access, prenatal care through Medicaid.

Even for Black families who choose not to have children, Medicaid remains a lifeline. Medicaid provides 75 percent of all public family

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planning funds, and is utilized by 21 million people nationwide. The convergence of these budget cuts, new work mandates, and the end of ACA tax credits will likely result in 15 million people losing their health insurance entirely.⁹

On a broader level, implicit biases, stereotypes, and institutional and structural discrimination harm Black people and their families. Black women experience higher rates of chronic health conditions that require dedicated care and may worsen maternal and infant health outcomes—including diabetes, hypertension, obesity, and cardiovascular disease.^{10 11} Although high-quality care is especially critical for Black women, research points to substandard care at hospitals, driven by anti-Black racism and discrimination (including overt acts of interpersonal discrimination), which increase disparities across the care continuum.

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The inequities and racism that Black women experience throughout their lives, including while seeking health care, increase their health risks, and drive racial disparities in preventable maternal and infant deaths. Another example lies in mental health and well-being. While approximately 1 in 5 new mothers experience postpartum depression, almost 40 percent of Black mothers experience postpartum depression—double the overall rate.^{12 13} This staggering figure may be an underestimate, considering that maternal mental health (MMH) conditions are often underreported, especially in Black communities. More than 50 percent of postpartum and perinatal depression cases are undiagnosed due to patients' reluctance to disclose symptoms; and Black women are one of the most under-treated groups for depression in the U.S.^{14,15} Further, in comparison to white women, Black women are twice as likely to experience MMH conditions—but half as likely to receive treatment.¹⁶ Single Black mothers are six times more likely than the general population to experience depressive symptoms.¹⁷

Structural racism's negative impact is clearly illustrated by findings about what happens when newborn Black babies are cared for by Black providers (such as pediatricians, neonatologists, family practitioners, midwives, and doulas). For example, when Black babies are treated by Black doctors, their mortality rate compared to white newborns is cut in half.¹⁸

Black midwives were, and remain, critical practitioners, especially in rural and remote areas where care from physicians is inaccessible or harmful to Black people. Black midwives have been a pillar of Black communities since the Antebellum period. Forcibly, they cared for enslaved Black women and their infants on plantations and provided critical care to newly freed Black women. In the late 19th and early 20th century, however, the privatization of medicine, increased hospitalization of childbirth, and racist stigmatization of Black health care providers decimated Black midwifery. White male physicians, eager to "found" the field of obstetrics and gynecology, often collaborated to push Black midwives out of the delivery room through legislation and misinformation.¹⁹

Achieving better outcomes for Black women, birthing people, and babies requires a commitment to birth justice—including increasing the availability of Black providers. As defined by Ancient Song Doula Services:

Birth justice is achieved when individuals can make informed decisions during pregnancy, childbirth, and postpartum, that is free from racism, discrimination of gender identity, and implicit bias. Birth justice requires that individuals fully enjoy their human rights regarding reproductive and childbirth-related health decisions, without fear of coercion, including coercion to submit to medical interventions, reprisal for refusal of care, and/or face the threat of inadequate medical care. Birth justice centers the intersectional and structural needs of individuals and communities.²⁰

Progress To-Date and Threats to the Future

Thanks to the efforts of countless Reproductive Justice and Black birthing advocates across the country, reducing Black maternal mortality and morbidity has become a central policy priority for many federal and state policymakers in the past several years. This focus has led to some policy successes—the most promising being the Biden-Harris Administration’s American Rescue Plan’s incentivizing states to expand Medicaid coverage to 1 year postpartum. Today, 49 states, the District of Columbia, and the U.S. Virgin Islands have answered this call to action and implemented expanded coverage expansion; Wisconsin, the last holdout state, will do so imminently.²¹

Yet, in 2026, this progress is at risk. Since January 20, 2025, legislative victories and funding to improve Black maternal health programs have been under attack. These devastating efforts include efforts pushing provisions to restrict access to contraceptives and abortion care; firing Centers for Disease Control and Prevention (CDC) experts who issued essential contraception guidance and tracked reproductive health care access and outcomes; gutting Medicaid; and slashing social services such as nutrition assistance.

In addition to a \$1 trillion reduction in life-saving health care, *H.R. 1* also included the largest reduction in funding for the Supplemental Nutrition Assistance Program (SNAP) \$187 billion slashed from our nation’s largest front-line program to battle hunger, which supports 41 million people and 1 in 5 U.S. children; approximately 6 million low-income individuals receive assistance from SNAP every month.²² The nonpartisan Congressional Budget Office estimates that these cuts, combined with new SNAP work requirements, will make 2.4 million people ineligible for SNAP and increase food insecurity. A new study from the Center for American Progress found that these changes will result in nearly 70,000 avoidable deaths by 2040—including among mothers and children.²³

H.R. 1 did not explicitly cut funds for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)—an evidence-based public health program that provides critical nutrition and health services to approximately 6 million low-income pregnant and postpartum women, young children, and roughly 40 percent of all U.S. infants each month. WIC benefits are associated with increased health outcomes, including reduced risk of premature birth, low birthweight, and infant mortality.²⁴ While *H.R. 1* didn’t

specifically cut WIC funds, we know that SNAP cuts will impact WIC eligibility, result in lost benefits, and worsen health outcomes. Currently, families can qualify for WIC by proving their participation in other programs like SNAP. Changes to SNAP mean that hundreds of thousands of new mothers and infants will likely lose their automatic eligibility and face the administrative hurdle of providing proof of income during an already delicate period.²⁵

This burden is even more costly for Black families because nearly half of Black families who are eligible for WIC already miss out on its services and public health benefits, and that number will only get worse.²⁶ That means Black families will miss out on the associated lower risk for preterm delivery, low birth weight, and infant mortality, as well as higher rates of child preventive care, such as immunizations.²⁷ If enacted, the latest federal budget proposal would make matters worse; it aims to decrease WIC funding by nearly \$300 million, and cut benefits for breastfeeding mothers from \$52 to just \$13 per month.²⁸

Further, the current Administration’s attacks on “diversity, equity, and inclusion” have eliminated longstanding federal studies into maternal and infant health outcomes in Black communities.²⁹ As just one of many examples, last year, University of North Carolina at Chapel Hill Associate Professor Jaime Slaughter-Acey received notice that her \$2.4 million National Institutes of Health grant to longitudinally study how social and biological factors affect birth outcomes for more than 500 Black women in Detroit had been terminated, freezing more than \$581,000 in remaining funds.

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Another canceled study was investigating innovative treatments for uterine fibroid tumors, which disproportionately impact Black women and affect up to 80 percent of all women younger than 50. Another was investigating racial and ethnic differences in hypertensive disorders, like preeclampsia, which are one of the leading causes of maternal mortality.³⁰ These are just a few of the hundreds of evidence-based research grants related to women’s health that have been cut by the current Administration because of what is called government “efficiency.”

The current Administration’s rhetoric has also chilled the work of Members of Congress and allies who have previously championed efforts to address racial health inequities. For instance, in the 119th Congress, the word “Black” was eliminated from the Black Maternal Health Momnibus Act—the bill was reintroduced as the Maternal Health Momnibus Act.

To address declining Black maternal and infant health outcomes, current champions of Reproductive Justice cannot rely solely on improving public health care programs like Medicaid,

SNAP, and WIC that are increasingly under attack. Transforming perinatal care for Black mothers and infants will require innovative and transformative policies—particularly those that expand the pool of qualified providers who understand the particular risks Black families face in choosing whether or not to conceive, and—for those who choose to—in delivering and raising a child in a safe and healthy environment.

2026 Policy Recommendations

- Acknowledge and address racial health inequities in maternal health outcomes.
- Support the extension of comprehensive, holistic maternity care and newborn care for a minimum of one year postpartum by supporting policies such as the MOMMIES Act.
- Remove cost-sharing for preconception care; labor-, delivery-, and pregnancy-related labs; mental health; and postpartum visits.
- Expand scope of practice for midwives to include complete perinatal care.
- Require coverage for doulas and midwifery care in insurance programs, and increase funding for doulas and midwifery care in federal health care programs.
- Authorize and appropriate funding for a National Maternal Mortality Review Board that oversees an epidemiological infrastructure to accurately tabulate morbidity and mortality across all states and U.S. territories.
- Authorize and appropriate funding for a Federal Office of Sexual and Reproductive Health and Wellbeing (OSRHW) to fully address racial/ethnic health disparities and ensure a comprehensive and holistic approach to sexual and reproductive health is prioritized at all levels of government.
- Implement monthly financial supplements or universal incomes for low-income pregnant people.
- End coercive, non-consensual drug testing and criminalization of substance use for patients, including pregnant people.
- Expand funding and infrastructure for medical schools and health programs at historically-Black universities towards reducing implicit and explicit biases among health care providers and in health care settings.
- Pass the *CARE for Moms Act*, *Kira Johnson Act*, *Extending WIC for New Moms Act*, *Social Determinants for Moms Act*, *Justice for Incarcerated Moms Act*, and other comprehensive legislation that advance Black maternal health outcomes.

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