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Black Maternal Mortality and Reduced Abortion Access

Black women, regardless of education or wealth, have always been more likely than White women to die due to pregnancy related complications. Abortion restrictions, which have also decreased the availability of maternal care, have led to even higher Black maternal mortality rates. The maternal mortality rate (MMR) is defined as the number of maternal deaths during a given time period per 100,00 live births during that same time period (World Health Organization). Although an abortion can refer to both a spontaneous abortion, typically referred to as a miscarriage, the term abortion typically refers to an elective procedure that removes the products of conception or fetus from the uterus (Harvard Health, 2019). In 1973, the US Supreme Court decided in Roe v. Wade that women had a constitutional right to abortion (US Supreme Court, 1973). However, shortly after Roe was decided, states began passing laws that challenged this right. In 2022, the US Supreme Court effectively overturned the Roe decision (US Supreme Court, 2022) and states have begun passing even more restrictive abortion laws. Reducing access to safe and legal abortion increases a Black woman's risk of dying due to pregnancy related complications.

Maternal mortality, according to the World Health Organization (WHO), results from a number of complications related to pregnancy or childbirth and can occur up to one year after the termination of a pregnancy, either by birth, miscarriage, or abortion. A maternal death includes any female death related to or aggravated by pregnancy or its management during pregnancy or childbirth or within 42 days of termination of pregnancy. A late maternal death is one that occurs between 43 days and one year of termination of pregnancy (World Health Organization). Maternal death can occur not only due to physical complications of pregnancy, but also mental health complications such as postpartum depression, which can lead to suicide (Eugene Declercq, 2020).

Unsafe abortions have a significantly higher mortality rate than safe abortions and are often a choice made by desperate women. Unsafe abortions are those performed in an environment that does not conform with minimal medical standards or by a person lacking the necessary skills, or both.

According to WHO, 4.7 to 13.2% of maternal deaths worldwide are attributable to unsafe abortions and that in developed regions, 30 women die for every 100,000 unsafe abortions (World Health Organization, 2021).

Black maternal mortality rates in the United States have been significantly higher than White maternal mortality rates since records began being kept in 1915. In 1915 the overall maternal mortality rate was 608 deaths per 100,000 live births. However, Black women were 1.8 times more likely to die due to pregnancy related complications. Even as advances in healthcare decreased the overall maternal mortality rate, the disparity between death rates for Black and White women grew reaching 4.3 in 1957. The overall maternal death rate that year was 41 deaths per 100,000 live births; however, the rate for White women was 28 deaths per 100,000 live births while there were 118 deaths for nonwhite women (mostly Black in 1957) (DUNN, 1958, p. CXIII). More recent numbers show that even though the overall maternal mortality rate has been reduced, Black women are still more likely to die due to pregnancy complications than White women. In 2018, 37.1 Black women died for every 100,000 live births compared to 14.7 for White women (Eugene Declercq, 2020). The numbers were even worse in 2021, the second year of the Coronovirus, with a maternal mortality rate for Black women of 69.9 deaths per 100,000 live births versus 26.6 for White women (Hoyert, 2023).

There are a number of reasons why Black maternal mortality rates are higher than Whites, but one primary reason is tied is a lack of access to appropriate health care. Margo Snipe, a reporter who has studied maternal mortality among Black women in Georgia said that black women are dying because they are more likely to live in maternity care deserts (Santhanam, Ellis, & Kuhn, 2023). The March of Dimes defines a maternity care desert as a county with no birth centers, no OB/GYN, no hospitals providing obstetric care and no certified nurse midwives. A county was classified as having low access to maternity care services when there were fewer than 60 OB providers per 10,000 births, there were no or one hospitals offering OB services, and 10 percent or more women had no health insurance.

Currently, seven million women live in areas where there is no or low access to maternal health care (March of Dimes, 2022)and these women are disproportionately Black. For instance, Georgia's Hancock county is classified as a maternal care desert (March of Dimes, 2023)and has a 71.2% Black population (Index Mundi, 2023). In contrast, Bacon county women have full access to maternal health (March of Dimes, 2023) and has a population that is 80 percent White (Index Mundi, 2023). There is a direct connection between living in a maternal health care desert and systematic racism started with slavery, continued into the Jim Crow era, and is still embedded in today's societal structures (Braveman, Elaine Arkin, Kauh, & Holm, 2022).

Systematic racism may be the cause of maternal health deserts that impact access to care for poor Black women, but more blatant interpersonal racism and discrimination impacts Black women across the socioeconomic spectrum. Black women report that they are not listened to when they express concerns about their health; are not given autonomy to make their own decisions during labor and delivery; and they are often pressured into having a cesarean section, which leads to a higher risk of mortality (Eugene Declercq, 2020). Part of the reason for racism and discrimination against Black women is that some physicians exhibit significant implicit bias toward Black women including assuming that they are uneducated, of low socio-economic status, uninsured, or on drugs. Physicians also sometimes failed to provide adequate information to Black women. For instance, one Black woman was advised to have a cesarean section and when she questioned her doctor, she was told not to worry about it (Renbarger, Phelps, & Broadstreet, 2023). Wealthy and educated women are not immune to this bias. Despite being a superstar tennis player and being able to afford the best health care, Serena Williams was not immune to bias. After giving birth, she reported to her nurse that she was having pain, and due to her past history, asked for a CT scan and heparin. She was initially ignored, but continued to advocate for herself until she got the medical care she needed to save her life (Dwass, 2022).

Maternal death rates overall went down after the Supreme Court's January 22, 1973 decision in Roe v. Wade, which declared abortion a constitutional right (US Supreme Court, 1973). In 1972, the overall maternal mortality rate was 18.1 per 100,000 live births. This rate dropped to 15.5 in 1973 and continued a downward trend until 1987 when it reached 6.6 (PUFFERY, 1993, p. 122). Although, Black women were still dying at a higher rate than White women during this period with a rate of 3.59 times higher in 1973 and a rate of 2.87 times higher in 1987 (Eugene Declercq, 2020), a lower overall maternal mortality rate meant that fewer Black women were dying due to pregnancy related complications. One reason that Black women's mortality rate remained higher during this time period is that Black women have more limited access to abortion care (DEHLENDORF, HARRIS, & WEITZ, 2013). Overall maternal death rates in the US have been on the rise in the 21st century going from 12 in 2000 to 21 in 2020 (Maternal Mortality, 2020). During this same period, Black maternal death rates have been approximately three times as high as the rate for White women (Eugene Declercq, 2020).

One reason for the increased mortality rates and their continued disproportionate impact on Black women is the increasing number of abortion restrictions passed at the state level. Although abortion was legalized at the federal level in 1973 with the Roe decision, states began passing restrictive laws almost immediately and between 1973 and 2021 passed over 1,300 abortion restrictions between. These laws include counseling and waiting periods, require ultrasounds, and place restrictions on providers (Nash, 2021). Although these laws were challenged, some were allowed to stand. One of the landmark laws that allowed states to place restrictions on abortion was the Supreme Court's 1992 decision in Planned Parenthood of Southeastern Pennsylvania versus Casey. The decision upheld that abortion was a legally protected right, but allowed states to impose restrictions as long as they were not deemed to be an undue burden. In this instance, Pennsylvania was allowed to implement restrictions on abortion including a requirement that abortion seekers be given information about abortion, wait for 24 hours prior to obtaining an abortion, and that minors must obtain parental consent (Seward, 2009).

Multiple studies have shown that decreased access to safe and legal abortion increases the risk of maternal mortality, especially for Black women. A study analyzing publicly available data between 1995 and 2017 found that after 2009 states with restrictive abortion laws had an average maternal mortality rate of 28.5 per 100,000 births compared to 16.1 in states that protected abortion rights. The burden was even heavier on Black women with a maternal mortality rate of 47.2 in restrictive states and 13.4 in protective states (Vermaa & Shainkerb, 2020). Another study found that reducing the number of Planned Parenthood clinics, which provide abortions as well as other reproductive services, by 20% increased maternal mortality by 8% and that the maternal mortality rate increased by 38% in states that passed restrictive abortion laws (Hawkins, Ghiani, Harper, Baum, & Kaufman, 2020).

Laws restricting access to abortion increase maternal mortality directly by forcing women to choose unsafe abortions and forcing women to carry pregnancies to term. Laws restricting access to abortion do not eliminate abortion, but often force women to choose unsafe abortions which have a higher risk of death (Ravi, 2018). There were 16.1 million legal abortions in the United States between 1998 and 2010 and there were only 108 deaths related to these abortions, yielding an abortion mortality rate of 0.7 deaths per 100,000 abortions. For Black women this rate was 1.1 (Zane, et al., 2015). In contrast, illegal abortions carry an increased risk of death. Although recent statistics for the United States were not readily available, a World Health Organization study has shown that up to 13.2 percent of maternal deaths are related to unsafe abortions (World Health Organization, 2021).

Carrying a pregnancy to term is riskier for women than an abortion and restrictive abortion laws force women to carry pregnancies to terms in a number of ways. These include eliminating access to abortion, which forces women to travel out of state for abortions, something poor women cannot afford. Some restrictive abortion laws also force women to return for multiple visits, something that may not be possible for some women (Nash, 2021). Other restrictive abortion laws do not contain exceptions for maternal health or are so poorly worded that doctors are afraid to perform abortions even when

medically necessary for fear of legal ramifications. In one instance, a Texas woman was forced to carry her dead fetus for two weeks due to restrictive Texas law. Although, this woman lived, doctors say that forcing a woman to carry a dead fetus can lead to complications including death (Martinez, 2022)

Laws restricting abortion access also impact women indirectly as clinics offering abortion services as well as other services often close when abortion access is restricted. A 2016 study found that in Texas, where state funding to clinics providing abortion was cut, 60 clinics providing women's health care were shuttered. As a result of these closures, women lost access to reproductive services including breast cancer screenings, pap smears, contraceptive counseling, and prenatal care (Lu & Slusky, 2016). As Black women are already less likely to have access to contraceptive counseling and use contraception (Dehlendorf, et al., 2014), which can lead to a higher rate of unintended pregnancy (Finer & Zolna, 2011), further restricting access to women's health care is likely to exacerbate this problem.

One small town in Mississippi is emblematic of the issues with reduced women's health care. Clarksdale, MS' population is overwhelmingly Black and poor and the maternal mortality rate in Mississippi is the second highest in the nation with 43 deaths per live births and Black women in the state are four times more likely than White women to die of pregnancy related complications. The Clarksdale Women's Clinic is one of few women's clinics in the Delta region, which is larger than the state of Delaware and every time an OB/GYN in the area retires, it receives an influx of new patients. The lack of care in the region means that it can be a four-week which for appointments, which means some pregnant women are not able to see a doctor until later in their pregnancy than is desirable. The Clarksdale Women's Clinic is only equipped to handle routine pregnancies, which means that mother's with high risk pregnancies need to take a three hour round trip to receive care and many are unable to make this trip due to financial and other concerns (Alter, 2023),. These means that they are not receiving the care they need to reduce their risk of dying in pregnancy.

Black women have always been more likely than White women to die during pregnancy and anti-abortion restrictions have exacerbated this risk. In 1915, the first year that maternal mortality statistics were compiled in the United States, Black women were almost twice as likely to die from pregnancy related complications as White women and even today are about three times more likely to die than their White counterparts. The reasons for this discrepancy are complicated, but much of the reason stems from systematic racism that has its roots in slavery. Black women are generally poorer than White women and are more likely to live in maternal care deserts, which increases their risk of death. Women also report not being listened to and treated differently than their White peers. Abortion restrictions have increased the risk for Black women as they are more likely than White women to live in areas without access to care and to seek out an illegal abortion. Reducing access to abortion has also led to the closure of women's health clinics, which means expectant mothers must travel farther for care and, due to poverty, may not be able to access care. In conclusion, restricting abortion access has led to an increase in the deaths of Black women due to pregnancy related complications.

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