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Exploring America's History of Racism in Relation to Modern Racial Disparities in Maternal
Mortality

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ABSTRACT

The study is a contribution to the conversation of racial disparities in maternal mortality. In the United States, black women are dying during labor and delivery at alarmingly higher rates than white women. The research uses the historic facts of slavery and racism in the institutions of the U.S. to analyze the common explanation of poor social determinants of health (SDOH) as a major contributor to these disparities. To determine how women of different socioeconomic status (SES) and race would rate the quality of their maternity care, the nationally representative Listening to Mothers III Survey by the National Partnership for Women and Families was examined.

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Chapter 1

Introduction

Women possess the gift of offering new life into this world, and it is something truly spectacular. However, it can quickly become dull when one realizes how long, overwhelmingly painful, and complication-prone the processes of pregnancy, labor, and delivery truly are. Because of this, there are a list of precautions and prenatal care remedies women are expected to know and follow to prepare for a safe and healthy delivery of their baby. When expecting mothers do not take these necessary precautions or are unaware of them due to lack of health education, access, or other poor social determinants of health (SDOH), poor health outcomes can occur. Unfortunately, here in the United States we have increasingly high rates of these occurrences compared to other high-income countries (MacDorman et al., 2017). Complications during pregnancy, childbirth, and the postpartum period ranked number 6 in the greatest cause of death among women between ages 20 and 34 in the United States in 2014 (Collier & Molina, 2019). The problem intensifies as the death rates vary by race/ethnicity with non-Hispanic black women—from here on out referred to as black women—being two to three times more likely to die from pregnancy related complications than their white counterparts (Davis, 2020; Owens & Fett, 2019; Ozimeck & Kilpatrick, 2018).

With 23-time Grand Slam champion tennis athlete, Serena Williams, and 28-time Grammy Awarded Singer/Songwriter, Beyonce Knowles-Carter, recently sharing their near-death labor and delivery experiences as black women, this phenomenon has been brought to the forefront of conversations within the black community. With the often trending

#BlackLivesMatter and #ProtectBlackWomen movements, the timeliness and relevance of this topic cannot be any clearer than in today's climate. The black community is constantly searching for answers as to why black people seem to be dying at disproportionate rates under many circumstances.

Chapter 2

Background

The objective of this review is to analyze recent literature on the topic of racial disparities in maternal mortality, informing the empirical analyses. It will synthesize 15 peer-reviewed texts to identify trends and gaps concerning racial disparities in maternal mortality. The study explores the research question; how does America's history of racism affect the quality of pre/postnatal care pregnant black women receive today in the United States? Its theoretical framework bridges American history and systemic and institutional racism to varying SDOH and implicit provider bias to poor health outcomes and quality of care.

Search and Review Process and Methods

The search and review process began with using the research question to identify key words and phrases pertaining to the topic. The following were specified: racial disparities, maternal mortality, and obstetric racism. Then, the Penn State library database and Google Scholar were used to retrieve articles. The Lancet, the American Journal of Obstetrics and Gynecology, and the American Journal of Public Health are just a few of the sources. Some databases used in the library include PubMed and ProQuest. A total of twenty articles were compiled with a final reduction to fifteen. Inclusion criteria included peer-reviewed journal articles or book chapters. The information in the articles and its relevance to the topic was also strongly considered. Exclusion criteria was any article that was not published within the last six

years to ensure that the information is timely. Throughout identifying useful literature, a matrix was created indicating the dates, research designs, objectives, and findings of each text. The literature map helped keep the articles and information organized, making identifying common themes and relationships amongst the articles easier. The table is as follows:

Table 1. Literature Matrix

Author(s)	Date	Research Design	Objective	Findings
Zinzi D Bailey, Nancy Krieger, Madina Agénor, Jasmine Graves, Natalia Linos, Mary T Bassett	2017	N/A	argue that a focus on structural racism offers a concrete, feasible, and promising approach towards advancing health equity and improving population health	N/A
Heather H. Burris, MD, MPH; Molly Passarella, MS; Sara C. Handley, MD, MSCE; Sindhu K. Srinivas, MD, MSCE; Scott A. Lorch, MD, MSCE	2021	population-based, retrospective cohort study	determine whether risk-adjusted black-white disparities in maternal mortality during the delivery hospitalization vary by hospital types and compare risk-adjusted in-hospital maternal mortality among black-serving and nonblack-serving teaching and nonteaching hospitals regardless of race	330 maternal deaths among 5,679,044 patients (5.8 per 100,000). Black patients died more often (11.5 per 100,000) than white patients (4.8 per 100,000) (relative risk, 2.38; 95% confidence interval, 1.89e2.98). Mortality was similar in black-serving and nonblack- serving hospitals, however, among nonteaching hospitals, mortality was significantly higher in black-serving vs nonblack-serving hospitals (adjusted relative risk, 1.47; 95% confidence interval, 1.15-1.87).

Ai-ris Y. Collier and Rose L. Molina	2019	N/A	summarize the data collection challenges, causes of maternal mortality and severe maternal morbidity, inequities in maternal health outcomes, and solutions to reduce maternal morbidity and mortality	Pregnancy-related deaths have been steadily rising in the United States and are not just a result of improved data acquisition. Cardiovascular conditions, obstetric hemorrhage, and self-harm or unintentional harm are important causes of pregnancy-related deaths; significant inequities exist between non-Hispanic black and non-Hispanic white women.
D'ana-Ain Davis	2020	ethnography	extend the framework of obstetric racism and explore three additional dimensions of it: ceremonies of degradation; medical abuse; and racial reconnaissance	N/A
Elizabeth A. Howell, MD, MPP, and Jennifer Zeitlin, DSc, MA	2017	N/A	reviews the evidence demonstrating that hospital quality is related to maternal mortality and morbidity, discusses the pathways through which these associations between quality and severe maternal morbidity generate disparities, and concludes with a discussion of possible levers for action to reduce disparities by improving hospital quality	N/A
Judette M. Louis, MD,	2015	N/A	analyze and discuss racial and ethnic	N/A

MPH, M. Kathryn Menard, MD, MPH, and Rebekah E. Gee, MD, MPH			disparities in maternal morbidity and mortality	
Marian F. MacDorman, PhD, Eugene Declercq, PhD, and Marie E. Thoma, PhD	2017	observational study	analyze recent trends in maternal mortality by sociodemographic characteristics and cause of death and to evaluate data quality	Maternal mortality rate increased by 23% from 20.6 maternal deaths per 100,000 live births in 2008–2009 to 25.4 in 2013–2014. However, most of the increase was among women aged 40 years or older and for nonspecific causes of death.
Ayah Nuriddin, Graham Mooney, Alexandre I R White	2020	N/A	reckoning with histories of medical racism and violence in the USA	N/A
Deirdre Cooper Owens, PhD, and Sharla M. Fett, PhD	2019	N/A	address historical legacies of racism and their contributions to modern racial disparities in maternal and infant health	N/A
John A. Ozimek, DO, MS, Sarah J. Kilpatrick, MD, PhD	2018	N/A	discuss twenty-first century maternal mortality and the existence of racial disparities in its rates	N/A
Sharon Parsons	2020	N/A	review the literature on racism in medicine in the United States and reflects on the persistent barriers to diminishing racial	N/A

			biases in the U.S. health care system	
Cynthia Prather, Taleria R. Fuller, William L. Jeffries IV, Khiya J. Marshall, A. Vyann Howell, Angela Belyue-Umole, and Winifred King	2018	review	argue that a careful examination of historical factors is essential to effectively address the current healthcare needs of African American women especially as they relate to chronic stress and impacts on health outcomes across a variety of conditions potentially rooted in racism, including STI (e.g., HIV) and pregnancy-related morbidity and mortality	The development of innovative models and strategies to improve the health of African American women may be informed by an understanding of the historical and enduring legacy of racism in the United States.
Mojca Ramšak	2020	N/A	analyses key examples of unethical medical experimentation on humans	N/A
Bani Saluja, MPH and Zenobia Bryant, PhD	2021	N/A	review implicit bias and the impact it can have on health care and health disparities	N/A
Virginia E. Tangel (MA), Kathy C. Matthews (MD), Sharon E. Abramovitz (MD), Robert S. White (MD, MS)	2020	retrospective cohort study	evaluate racial and ethnic disparities in severe maternal morbidity (SMM) and administered anesthesia techniques	When controlling for patient demographics, comorbidities, and hospital characteristics, black women were more likely than white women to experience any SMM (adjusted odds ratio: 1.38, 95% CI: 1.35–1.41). Black women were also more likely than white women to receive general anesthesia for cesarean

delivery (aOR: 1.44, 95% CI: 1.39–1.49) and to receive no analgesia for vaginal delivery (aOR: 1.45, 95% CI: 1.43–1.47).

Scaling the Problem of Black Reproduction

When trying to understand what may be at the root of the problem of racial disparities in maternal mortality it is important to define it. Maternal death can take on many definitions, but the World Health Organization (WHO) definition seemed to be more common amongst the literature chosen. WHO defines maternal death as the death of a woman while pregnant or within 42 days of the end of pregnancy from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes (MacDorman et al., 2017; Ozimeck & Kilpatrick, 2018). Burris et al. (2021) found that black patients (11.5 per 100,000) were more than twice as likely as white patients (4.8 per 100,000) to die in the hospital (relative risk [RR], 2.38; 95% CI, 1.89-2.98). There are numerous potential contributors to the varying maternal mortality rates across races. The ones commonly identified in the literature typically pertain to SDOH. “The key reason for differences in health between white and non-white is the relative lack of access to primary medical care, unemployment, poverty and other inequalities of people of color” (Prather et al., 2018).

It is no secret in this society that when it comes to SDOH black people are usually at a disadvantage. Poverty, lack of education, and unemployment are more common in black people and are all associated with poor maternal health outcomes. Environment is also a known

contributing factor to maternal health status and access to care (Howell & Zeitlin, 2017). African American communities are more likely to have high crime, exposure to environmental toxicants, and a lack of facilities equipped with the resources to provide quality care.

That said, some studies have found that racial disparities in maternal death are still prevalent when SDOH are controlled. According to the analysis by Tangel et al. (2020), “black women have higher odds of severe maternal morbidity (SMM) than white women, when adjusting for other demographic factors, comorbidities specific to an obstetric population, and hospital characteristics. This finding was consistent in all subpopulations of primary insurance payers, quartiles of median household income, hospital safety net burden classification, black-serving hospital status, quartile of hospital delivery volume, geographic location, and delivery type (with the exception of operative vaginal delivery).” Davis (2020) states, “these [maternal death] data do not cohere around class, so socioeconomic status is not the only culprit contributing to these birth outcomes. What it does mean is that we cannot, nor should we, make low-income Black women and low-income women of all groups the scapegoats of poor birth outcomes.”

It is also known that many of these maternal deaths are preventable (Burriss et al., 2021; Howell & Zeitlin, 2017; Ozimeck & Kilpatrick, 2018), therefore indicating hospital quality factors as a contributor. Moreover, institutional and health care provider biases or racism may lead to missed opportunities for intervention and violate medical ethics, threatening the dignity of the healthcare profession (Louis et al., 2015; Prather et al., 2018). “In the realms of public health and disease intervention in the USA, people of color have been historically penalized, oppressed, and harmed” (Nuriddin et al., 2020). The dialogue is crucial; to repair our future, we must acknowledge our past and its influence on the present.

History of Racism in Medicine

The roots of racism deeply stretch throughout the institutions of this country like a weed growing unnoticed in a garden until suddenly its presence is overwhelming. Nuriddin et al. (2020) reads, “freedom did not guarantee relief from the unhealthy living conditions and excess morbidity and mortality that existed under slavery.” American history is riddled with maltreatment of African Americans during and after slavery. The medical industry—the obstetrics/gynecology field in particular—is no stranger to violating the basic human rights of individuals simply because of their race. “Many physicians used enslaved women in other experimental reproductive surgeries, such as cesarean sections and ovariectomy, to perfect procedures that would later be used for all women” (Saluja & Bryant, 2021). In fact, its apart of its history and development. James Marion Sims, the ‘Father of Modern Gynecology’ and former president of the American Medical Association, performed many reproductive experimental surgeries without anesthesia to treat various childbirth illnesses among enslaved African American women.

Additionally, decades later in the 20th century eugenics laws were passed and validated by the Supreme Court, allowing the involuntary sterilization of Native American, African American, and Puerto Rican women (Nuriddin et al., 2020, p. 949). Further exemplification of the experimentation of black bodies in the literature includes the story of Henrietta Lacks and her non-consensual uncompensated contribution to progressing immunology, oncology, and the development of the polio vaccine. Also, the Tuskegee Syphilis Study and its unethical approach to observe the natural course of the disease without the knowledge of the black male participants.

The reality is that one can go on about the ugly past of the United States and its mistreatment of black people. “The historical narrative about racial inferiority has exacerbated

discriminatory healthcare practices, in turn negatively affecting the quality and types of healthcare provided to African American women” (Saluja & Bryant, 2021). Evidently, racism is non-incident in American medicine and is rather entrenched in it. The protections for human subjects in research in federal regulations that are now in place are a result of these types of human subjects’ violations. The examples provided here address the core ethical issues cited in the United States Belmont Report (1978): respect for persons, beneficence, and justice.

Racism in Modern Medicine

The theory of racism places people into categories based on their physical appearance and those categories serve to define intelligence, attitude, and behavior. It is more than simply not liking someone based on their race; it leads to racial discrimination which directly impacts the victims’ lives (Prather et al., 2018). Racism can take on many forms, for example institutional, structural, and medical; all in direct relation to the main contributing factors of maternal death as presented in the literature.

Structural racism is referred to in the literature as the ways historical and contemporary racial disparities are perpetuated by social, economic, environmental, and political systems, creating circumstances that lead to poor health outcomes (Nuriddin et al., 2020; Prather et al., 2018). “The literature on racial residential segregation and poor health examines several direct and indirect pathways through which structural racism harms health, including the high concentration of dilapidated housing in neighborhoods that people of color reside in, the substandard quality of the social and built environment, exposure to pollutants and toxins, limited opportunities for high-quality education and decent employment, and restricted access to

quality health care. Health outcomes associated with residential segregation documented among black Americans include adverse birth outcomes” (Bailey et al., 2017). Structural racism shows that the legacies of slavery can be seen in the patterns of SDOH known today, indicating a direct path to racial disparities in maternal death.

Prather et al. (2018) defines institutional racism as follows, “the process by which racial oppression is imposed on subordinate racial groups by dominant racial groups through institutional channels.” The article further explains that the medical care system is an institution that is no exception to reflecting the racial culture of society (Prather et al., 2018). The presence of medical racism and implicit provider bias within the healthcare systems and providers of today are prime examples of this claim.

Medical racism is defined in literature as prejudice and discrimination in medicine and the medical system that occurs when a patient’s race influences the treatment or diagnostic decisions they receive (Davis, 2020; Prather et al., 2018). The numerous stereotypes surrounding black bodies based on their race upheld in medicine for centuries have been known to cause serious harm by influencing the decisions of providers. “The enduring stereotypes of African-Americans as strong, brutish and criminally predisposed, athletically superior, more tolerant of pain, yet more susceptible to drugs, hypersexual and more sexually promiscuous, lazy, unmotivated, more childlike, ignorant, genetically flawed, ‘stereotypically as fat and in need of policing for moral failures,’ dirty and contaminated, and less personally invested in or responsible for their health have altered the medical attention provided to African-Americans” (Parsons, 2020). Based on its definition, “the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner” (Ramšak, 2020), this claim is directly related to implicit bias. Many studies have shown that implicit bias is most likely a

contributing factor to maternal death racial disparities (Bailey et al., 2017; Parsons, 2020; Ramšak, 2020). The well-established link between racism, implicit bias, and healthcare makes the evaluation of the quality of care all black people, but more specifically in this case black women, receive necessary.

Quality Implications

The literature briefly touches on the impacts implicit bias can have on delivery of care quality. According to Burriss et al. (2021), “a study of data from 7 states in the United States found that black-serving (compared with white- serving) hospitals performed worse on 12 of 15 delivery-quality indicators that included measures such as complicated cesarean delivery, obstetric trauma, and wound infection.” Care quality may differ based on structural characteristics of the hospital or by race and ethnicity of the patient. However, as previously shown, structural differences are rooted in racist theories and developments since slavery. Saluja and Bryant (2021) indicate that “the historical narrative about racial inferiority has exacerbated discriminatory healthcare practices, in turn negatively affecting the quality and types of healthcare provided to African American women.” The gap in the literature is the lack of exploration into the historic linkage of today’s health disparities; however, the aim of this study is to fill it.

Chapter 3

Methods

Data

The subject population of this study is women who have had children within the United States healthcare system. The Listening to Mothers III Survey is the dataset used to represent this population. It studies a nationally representative sample, with 2,400 total participants, excluding teens younger than 18 and mothers older than 45, women with multiple births and with babies who had died, and women who do not speak English as a primary or secondary language. The sample represents the population of women giving birth from 2011 to 2012, and the survey weights were determined by key demographic variables, as well as by a composite variable known as a propensity score. The score is intended to reflect a respondent's propensity to be online, as that is how the survey was administered. Educational attainment, age, race/ethnicity, geographic region, household income, mode of birth and number of times women have given birth were the demographic variables used for weighting.

Procedure

The data was accessible through the National Partnership for Women and Families organization website. The following are the variables the study identified and categorized from the survey response data: race, age, health insurance status, income, education, and quality.

These variables were chosen based on their relatedness to the theoretical framework, more specifically, social determinants of health. Each response category was generated as its own variable. For example, non-Hispanic white and private insurance variables were generated from race and health insurance status responses. Some were re-categorized to make the analysis clearer. Seven age categories were originally present in the data but were regenerated into four, collapsing adjacent categories: 18-24, 25-34, 35-44, 45+. Twenty-seven income categories were rearranged into 5 as shown in Table 2. Missing values were accounted for and are reported in the table as “no answer.” Lastly, a weighted ordinary least squares regression was run, with excellent/good quality care as the dependent variable and the rest of the identified sociodemographic variables as independent ones. The most prevalent category of each variable was omitted from the code for reference. The omissions were as follows: white, age category 2 (25-34), private insurance, income level 1 (< \$29,400), and a high school education or less. The models were estimated using Stata/Basic Edition 17.

Descriptive Statistics

Table 2. Descriptive Statistics

	<i>Obs (n=2400)</i>	<i>Unweighted %</i>	<i>Weighted %</i>
<i>Race</i>			
<i>White</i>	1,445	60.00%	55.00%
<i>Black</i>	309	13.00%	15.00%
<i>Hispanic</i>	452	19.00%	23.00%
<i>Other</i>	181	7.00%	6.00%

<i>No answer</i>	13	1.00%	1.00%
Age			
<i>18-24</i>	601	25.00%	32.00%
<i>25-34</i>	1,336	56.00%	53.00%
<i>35-44</i>	450	19.00%	15.00%
<i>45+</i>	13	0.00%	0.00%
Health Insurance			
<i>Medicaid or CHIP</i>	726	30.00%	37.00%
<i>Other gov. program</i>	181	8.00%	9.00%
<i>Private insurance</i>	1,317	55.00%	46.00%
<i>Out of pocket</i>	111	5.00%	5.00%
<i>No answer</i>	65	2.00%	3.00%
Income			
<i>< \$29,400</i>	475	20.00%	27.00%
<i>\$29,401 - \$37,000</i>	136	6.00%	6.00%
<i>\$37,001 - \$52,300</i>	394	16.00%	17.00%
<i>\$52,301 - \$75,300</i>	503	21.00%	19.00%
<i>> \$75,301</i>	760	32.00%	25.00%
<i>No answer</i>	132	5.00%	6.00%

<i>Education</i>			
<i>High school or less</i>	466	19.00%	42.00%
<i>Some college</i>	888	37.00%	29.00%
<i>College or higher</i>	1,046	44.00%	29.00%
<i>Quality</i>			
<i>Excellent/good</i>	2,013	84.00%	83%
<i>Fair/poor</i>	387	16.00%	17%

When comparing the unweighted and weighted percentages of each variable in the table, the results are largely similar. The education and income variables have the most major contrasts. The most prevalent unweighted education is a college degree or more, but high school or less is the most prevalent in the weighted. The most prevalent income category shifts from the highest to lowest income as you go from unweighted to weighted. Excluding income and education the most prevalent categories remain consistent in each variable.

Chapter 4

Results

The results are indicative of how race, age, health insurance status, income, and education affect the standard of excellent quality care received from maternal healthcare providers. Black women reported a significantly higher probability of excellent care ($\beta=0.62$, $p = 0.053$) compared to white women, contrary to the study's hypothesis. Income categories 4 (\$52,301 - \$75,300) and 5 ($> \$75,301$) were also statistically significant, indicating that women with higher incomes are more likely to report receiving excellent/good quality maternity care ($\beta=0.082$, $p=0.027$; $\beta=0.091$, $p=0.011$) compared to women in the lowest income group ($< \$29,400$). Older women in age categories 3 (35-44) and 4 (45+) were also found to be statistically significant in the regression results. The coefficient values were positive, demonstrating that they were more likely to report receiving excellent/good quality maternal care ($\beta=0.069$, $p=0.032$; $\beta=0.142$, $p=0.000$) compared to women aged 25-34. Out of pocket spending was marginally significant ($\beta=-0.120$, $p=0.06$). Women who paid for their care out of pocket were less likely to report receiving excellent/good quality care compared to privately insured women.

Table 3. Probability of Excellent/Good Quality Maternity Care Based on the Most Prevalent Social Determinants of Health in American Mothers (2011-2012)¹

Variable	Coefficient	P-value	95% Con. Interval
<u>Race</u>			

Black	0.062	0.053	[-0.007, 0.125]
Hispanic	0.050	0.109	[-0.011, 0.111]
American Indian	-0.187	0.263	[-0.515, 0.141]
Other Races	-0.002	0.962	[-0.095, 0.090]
No race answer	0.049	0.676	[-0.181, 0.278]
<u>Insurance</u>			
Medicaid	0.000	0.999	[-0.059, 0.089]
Other gov. program	-0.006	0.908	[-0.100, 0.089]
Out of pocket	-0.110	0.060	[-0.224, 0.004]
No insurance answer	-0.060	0.453	[-0.218, 0.097]
<u>Income</u>			
Income 2 (\$29,401 - \$37,000)	0.070	0.215	[-0.041, 0.182]
Income 3 (\$37,001 - \$52,300)	0.022	0.582	[-0.057, 0.102]
Income 4 (\$52,301 - \$75,300)	0.082	0.027	[0.009, 0.154]
Income 5 (> \$75,301)	0.091	0.011	[0.021, 0.161]
No income answer	0.035	0.546	[-0.078, 0.148]
<u>Education</u>			
Some college education	-0.007	0.804	[-0.061, 0.047]
College education or more	-0.008	0.806	[-0.068, 0.053]
<u>Age</u>			
Age 2 (25-34)	0.021	0.450	[-0.034, 0.077]
Age 3 (35-44)	0.069	0.032	[0.006, 0.133]

Age 4 (45+)	0.142	0.000	[0.064, 0.221]
<u>Constant</u>	0.747	0.000	[0.662, 0.833]

¹ The models were estimated using weighted ordinary least squares regression.

Chapter 5

Discussion

This study hypothesizes that black women would be less likely to receive care that is excellent or good. The race findings are unique in their contradiction to the hypothesis; however, the theoretical framework expands this to women on the more disadvantaged end of social determinants of health also being less likely to receive this kind of high-quality care. Black women are inherently more prevalent in these categories as shown in the background. As previously mentioned, the theory informs the empirical analysis. The income category results show that the higher a woman's income, the more likely she is to receive high quality care. It can be inferred that this group is not indicative of the United States population of black women. Black women are also more likely to be uninsured and the results of out-of-pocket spending lead back to the hypothesis that black women are more susceptible to receive lower quality care. Additionally, the prevalence of a lack of higher education in black communities could be suggestive of the women's ability to perceive the difference between excellent and poor-quality care. Their ignorance may cause them to be content with essentially whatever they get. Moreover, quality cannot be objectively measured. It is subjective to the patient. This can also be considered a limitation of the study. Older women suggesting the greater likelihood of receiving excellent or good quality maternity care could be explained by them having more experience in the healthcare system, ultimately giving them more knowledge, preparation, and room for comparison.

Strengths and Weakness

The implicit bias of the researcher, being a black woman with plans to experience United States maternal healthcare, is a weakness of the study. This bias is acknowledged, and numerous perspectives contributed to the study's approach. Another weakness of the study is that the dataset is representative of the 2011 to 2012 population. In the past decade, the black community has made numerous improvements despite the flaws of our social system. Healthcare has also made some progress in its attempts to improve quality. For example, we see the evolution of diversity and inclusion as a prime principle upheld by many organizations. The strength of this study lies in the dataset being nationally representative of the subject population. This makes the results not only applicable to the 2,400 participants, but to the nation.

Conclusion

A fair number of studies have analyzed the issue of racial disparities in maternal mortality, seeking to define the problem and understand potential contributing factors. Many discuss varying SDOH as a major contributor, however, lack deeper analysis into how slavery and racism participate in this result. Acknowledgement and understanding of the past can often help to understand the present. When remembering America's deep history of poor treatment of black people, it is clear how these principles have been passed through the minds and systems of today. Surviving black mothers are not likely to rate their care as fair/poor. Yet, neither are women who have high incomes compared to those closer to and below the poverty line. Further, neither are those who are privately insured compared to those who pay for care out-of-pocket. The simplifying of the experiences of these women into simply, excellent/good and fair/poor

may not do justice in evaluating the kind of care they receive. Further research can provide a framework defining quality healthcare and measuring it in comparison to the actual telling of black women's experiences in the maternal healthcare system.

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ACADEMIC VITA

Oluchi M. Allen

MISSION STATEMENT

I devote myself to social justice and encouraging equality to reduce health disparities and promote health equity in the United States healthcare system.

EDUCATION

Bachelor of Science in Health Policy and Administration

Expected December 2021

The Pennsylvania State University, Schreyer Honors College, University Park, PA

Language: Conversational Spanish

RESEARCH EXPERIENCE

Honors Thesis; Racial Disparities in Maternal Mortality in PA under the direction of Dr. Jeannette A.

Rogowski and Dr. Selena E. Ortiz

TEACHING EXPERIENCE

The Pennsylvania State University

Discussion Leader, *Health Policy and Administration 101*

Jan. 2021 - May 2021

- Helped students learn about health systems, using course material and ReThink Health simulation

The Pennsylvania State University

Learning Assistant, *Statistics 200*

Jan. 2020 - May 2020

- Facilitated small group interaction and other activities; capitalized on skills for identifying and addressing student difficulties

ACTIVITIES

Tour Guide/Social Media Chair, Penn State

Jan. 2020 – May 2021

Student Minority Advisory and Recruitment Team

- Recruited and retained underrepresented student populations through tour directing, events, and mentorship
- Managed social media account and successfully increased engagement by 55%

General Member/Dance Team Captain, Penn State

Aug. 2018 - Present

African Student Association

- Enhance student awareness of Africa through constructive student engagement for the community
- Lead, supported, inspired and represented members of my team

Camp Counselor and Facilitator

Jun. 2016 - Aug. 2019

McHoops Basketball Camp and Camp Awesome, Allentown, PA

- Built self-confidence, individual and interpersonal behavior development, interdependence and team values, and anti-bullying behavior in children ages 6 to 12

COMMUNITY SERVICE

Nyonblee Cares Foundation, Buchanan, Liberia
Resurrected Life Community Church, Allentown, PA

2019 - Present
2018 - Present

AWARDS AND HONORS

Finegan and DeHope Trustee Scholarship, 2019; Penn State Academic Scholarship, 2019; Bunton Waller Scholarship, 2018

OTHER WORK EXPERIENCE

Intern, Pennsylvania Office of Rural Health, State College, PA **May. 2021 – Jul. 2021**
Retail Associate and Receiving Associate, Burlington Coat Factory, Trexlertown, PA **Jul. 2020 - Aug. 2020**
Administrative Secretary, Caring Grace Home Care Agency, Whitehall, PA **Nov. 2019 - Jan. 2020**