Women's Health Disparities: **Maternal Health**

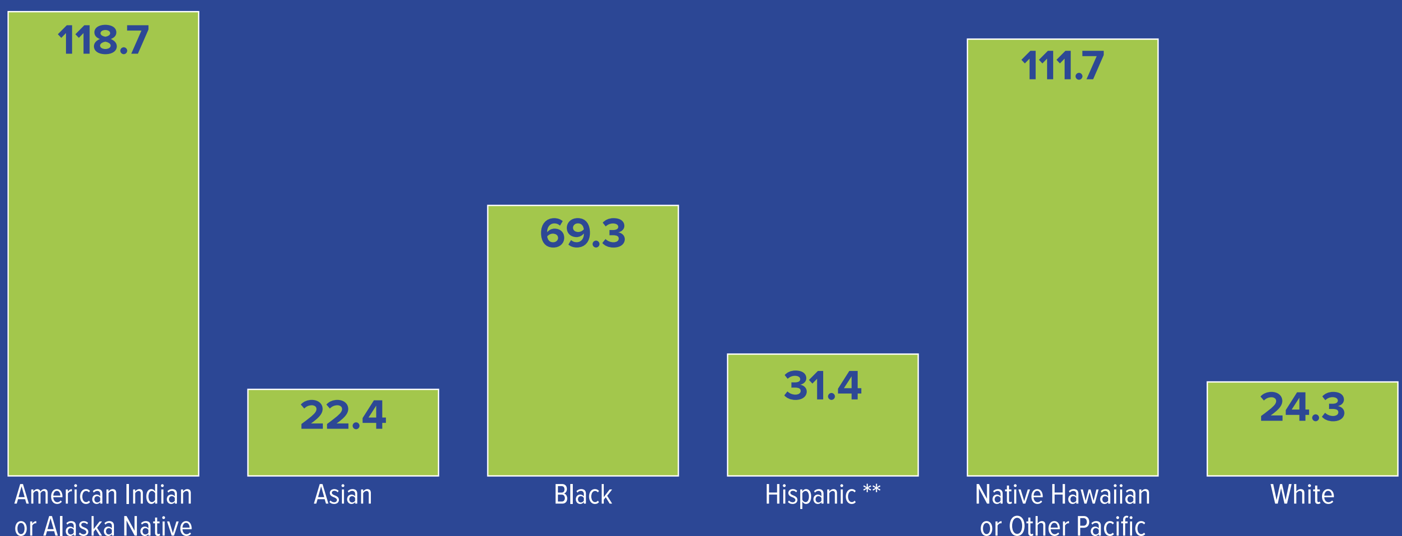
- Over **35%** of counties in the U.S. (home to **2.3 million** reproductive-age women) are maternity care deserts, without a single birthing facility or obstetric clinician.[1]
- Pregnancy-related mortality rates for Black women and American Indian and Alaska Native women are over **3x higher** than the rate for White women.[2]
- **817 women** in the U.S. died of maternal causes during or within 42 days after pregnancy in 2022.[3]

Maternal health refers to a woman's health as well as an infant's health before, during, and after pregnancy.

The United States has the highest rate of maternal death among high-income nations, with significant racial, ethnic, and geographic disparities. In 2022, the maternal mortality ratio (MMR) was approximately 22 deaths per 100,000 live births, and more than 80% of these deaths were preventable.[3,4] Across the contiguous United States, approximately 1 in 4 maternal deaths occur during pregnancy, 1 in 3 occur within the first 42 days postpartum, and another 1/4 occur between 6 weeks and 1 year postpartum, underscoring the importance of access to health care beyond pregnancy.[4]

Chronic Health Conditions During Pregnancy

Women with pre-existing health conditions have a 2-fold increased risk of severe maternal morbidity (SMM) compared to those without a health condition.[5] Individuals with conditions, such as diabetes, hypertension, cardiovascular disease, autoimmune disease, and mental illness, have a greater risk of poor pregnancy outcomes, which often disproportionately impact women from racial and ethnic minority populations.



Pregnancy-related mortality ratios are an estimate of the number of pregnancy-related deaths for every 100,000 live births.

*** Persons categorized as Hispanic may be of any race.*

Disparities

There are significant differences in pregnancy-related risks and complications among racial and ethnic groups. Pregnancy-related death rates are lower for Asian women compared to non-Hispanic White women and other women of color. Moreover, American Indian and Alaska Native, Black, Native Hawaiian, and other Pacific Islander women are at greater risk of preterm births, low birthweights, and infant death compared to White women.[6] Black women are also at higher risk for SMM, such as eclampsia and liver failure.[7]

Maternal mortality also varies by social and economic factors such as income, education, health care coverage, and geography. In a 2023 survey, 1 in 5 women and **30% of Black, Hispanic, and multiracial pregnant women reported mistreatment**, including violations of privacy or verbal abuse, during their maternity care.[8] Stress can further increase the risk of negative perinatal outcomes, including trauma associated with discriminatory health care and social practices experienced by women of color.[9] However, women who feel supported, safe, and respected are more likely to have better pregnancy experiences and a lower risk of complications.

Socioeconomic Factors that Impact Maternal Health Outcomes

- Community and support systems
- Economic stability
- Education
- Food security
- Health insurance coverage and access to care
- Physical environment and exposures

Rural Community Challenges

In the most rural communities, the PRMR is 37.9 deaths per 100,000 births compared to 23.1 deaths in metropolitan areas.[2] This reflects a lack of access across many rural counties, with over 50% absent of a hospital that provides obstetric care.[1] Hospital and obstetric department closures, workforce shortages, and access to care challenges all contribute to disparities in maternal health care for rural-living women and their babies. These pregnant women in maternity care deserts are more likely to receive inadequate prenatal care and subsequently are higher risk for pregnancy complications or worse outcomes.

Economic Impact

Poor maternal health can have disastrous economic effects on families and communities. In a study of hospitalizations in the United States from 2002-2014, women with SMM incurred **$6 billion** additional inpatient care costs compared to women without SMM.[7] With limited paid maternity leave benefits across the United States, many women are forced to return to work early in their postpartum period. Almost half of women (46%) whose employer provides paid maternity leave benefits, still work while on leave.[10] Not having sufficient time and opportunity to healthily transition through new motherhood can have serious implications, especially for women who experience complicated pregnancies and deliveries.

Women's Health Equity Initiative

The Society for Women's Health Research Women's Health Equity Initiative aims to raise awareness, educate the public and policymakers, and address longstanding disparities in women's health care access and outcomes. The initiative highlights statistics on disease states, life stages, and issues that disproportionately affect women in the United States and engages communities on solutions to improve health equity for women from diverse races, ethnicities, geographies, ages, and roles throughout society.

- **For more resources about Maternal Health, visit www.swhr.org.**

REFERENCES

1. Stoneburner A, Lucas R, Fontenot J, et al. Nowhere to Go: Maternity Care Deserts Across the US. (Report No 4). March of Dimes. 2024.
2. Pregnancy Mortality Surveillance System. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services; 2024. Accessed October 31, 2024.
3. Hoyert DL. NCHS Health E-Stats. 2023.
4. Trost SL, Busacker A, Leonard M, et al. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. 2024.
5. Gray KE, Wallace ER, Nelson KR, et al. Paediatr Perinat Epidemiol. 2012;26(6):506.
6. Hill L, Rao A, Artiga S, et al. Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them. KFF. 2024.
7. Liese KL, Mogos M, Abboud S, et al. J Racial Ethn Health Disparities. 2019;6(4):790-798.
8. Mohamoud YA, Cassidy E, Fuchs E, et al. MMWR Morb Mortal Wkly Rep. 2023;72:961–967.
9. Chambers BD, Arabia SE, Arega HA, et al. Stress Health. 2020;36(2):213.
10. Declercq ER, Sakala C, Corry MP, et al. New York: Childbirth Connection. 2008.

Updated February 2025