Maternal Health Disparities

HOW TO RECEIVE CREDIT

- Read the enclosed course.
- Complete the questions at the end of the course.
- Return your completed Evaluation to NetCE by mail or fax, or complete online at www.NetCE.com. (If you are a physician, behavioral health professional, or Florida nurse, please return the included Answer Sheet/Evaluation.) Your postmark or facsimile date will be used as your completion date.
- Receive your Certificate(s) of Completion by mail, fax, or email.

Faculty

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Faculty Disclosure

Contributing faculty, Mary Franks, MSN, APRN, FNP-C, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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The division planners and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience

This course is designed for all healthcare providers who may intervene to improve peripartum and postpartum health care and reduce health disparities.

Accreditations & Approvals

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A complete Works Cited list begins on page 19.

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NetCE designates this continuing education activity for 4 ANCC contact hours.

This activity was planned by and for the healthcare team, and learners will receive 4 Interprofessional Continuing Education (IPCE) credits for learning and change.

NetCE designates this continuing education activity for 4.8 hours for Alabama nurses.

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Social workers completing this intermediate-to-advanced course receive 4 Cultural continuing education credits.

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Individual State Behavioral Health Approvals

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Special Approvals

This activity is designed to comply with the requirements of California Assembly Bill 1195, Cultural and Linguistic Competency, and California Assembly Bill 241, Implicit Bias.

About the Sponsor

The purpose of NetCE is to provide challenging curricula to assist healthcare professionals to raise their levels of expertise while fulfilling their continuing education requirements, thereby improving the quality of healthcare.

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Disclosure Statement

It is the policy of NetCE not to accept commercial support. Furthermore, commercial interests are prohibited from distributing or providing access to this activity to learners.

Course Objective

The purpose of this course is to provide healthcare professionals with the knowledge and skills necessary to improve maternal outcomes in all races, ethnicities, and marginalized groups.

Learning Objectives

Upon completion of this course, you should be able to:

1. Outline the epidemiology of maternal morbidity and mortality.
2. Discuss how explicit and implicit bias may contribute to pregnancy-related deaths and maternal and infant health outcomes.
3. Identify cultural identity across racial, ethnic, and other marginalized groups, including historical and contemporary exclusion and oppression.
4. Identify environmental, personal, interpersonal, institutional, and cultural barriers to inclusion.
5. Describe effective approaches to communicate more effectively across racial, ethnic, religious, and gender identities.
6. Review information about racial and reproductive justice.
7. Identify measures to decrease explicit and implicit bias at the interpersonal and institutional levels.

Sections marked with this symbol include evidence-based practice recommendations. The level of evidence and/or strength of recommendation, as provided by the evidence-based source, are also included so you may determine the validity or relevance of the information. These sections may be used in conjunction with the course material for better application to your daily practice.

INTRODUCTION

Substantial differences in maternal morbidity and mortality among racial and ethnic groups exist in the United States. Black women are more than twice as likely to die related to maternal complications compared with White women [1]. The Centers for Disease Control and Prevention (CDC) reports that nearly 20% of surveyed women reported experiences of mistreatment during their pregnancy and/or the delivery of their child/children [2]. However, the reported rates were higher among Black (30%), Hispanic (29%), and multiracial (27%) patients.

Increasingly, research has shown that the quality of health care is an important lever for expanding positive outcomes for racial and ethnic minority women [1]. This course will identify underlying drivers of maternal disparities, review potential contributing factors (with the intention of supporting amelioration), and outline approaches to improve maternal outcomes. This course will also explore supportive measures, particularly in minority populations to reduce explicit and implicit bias in perinatal care.

EPIDEMIOLOGY

WORLDWIDE

The United Nations International Children's Emergency Fund (UNICEF) reports an overall global 34% decline in the maternal mortality rate, from 342 maternal deaths per 100,000 live births in 2000 to 223 maternal deaths per 100,000 live births in 2020 [3]. This decrease is consistent with achieving the sustainable development goal of 70 maternal deaths per 100,000 live births by 2030. However, the maternal mortality rates plateaued in Western Europe and North America between 2016 and 2022, and Latin America and the Caribbean noted an increase over the same period. The goal annual reduction rate is 15% for every country [3].

The location with the largest number of maternal deaths is sub-Saharan Africa, where the rate is 545 maternal deaths per 100,000 live births. Countries with the lowest rates of maternal mortality include Australia and New Zealand (with 4 maternal deaths per 100,000 live births) [3]. Among regions, women in sub-Saharan Africa face the highest lifetime risk of maternal death (1 in 41), which is approximately 268 times higher than in Western Europe (1 in 11,000), the lowest-risk region [3].

UNITED STATES

In the United States, maternal deaths represent the largest disparity among all populations within perinatal health measures. The maternal mortality rate in the United States is unacceptably high and rising. In 2021, 1,205 women died of maternal causes in the United States, compared with 861 in 2020 and 754 in 2019 [4]. The maternal mortality rate for 2021 was 32.9 deaths per 100,000 live births, compared with a rate of 23.8 in 2020 and 20.1 in 2019. More than 80% of all pregnancy-related deaths that occur in the United States are considered preventable [5].

Maternal mortality rates in the United States are higher among American Indian, Alaskan Native, Pacific Islander/Native Hawaiian, and Black women than among Asian, Hispanic, or White populations [6]. In 1933, the first time all states reported maternal deaths, the maternal mortality rate for Black women (1,000 deaths per 100,000 births) was 1.8 times greater than the rate for White women (564 deaths per 100,000 births). As of 2021, maternal death rates among Black women (69.9 per 100,000 births) had risen to 2.6 times higher than the rate noted for White women (26.6 per 100,000 births) [7].

Increases in maternal mortality rates are significantly greater among women 40 years of age and older. In this group, the mortality rate was 138.5 deaths per 100,000 live births in 2021 [7]. This represents an 83.4% increase compared with 2019. Data reported by the U.S. Government Accountability Office between 2020 and 2021 indicate the COVID-19 pandemic is a contributing factor to the increasing maternal mortality rate. This was believed to be linked to the chronic physiological stress present during pregnancy paired with severe illness from COVID-19 [8].

The CDC considers the following diagnoses/procedures as indicators of delivery hospitalizations with severe maternal mortality [9]:

- Acute myocardial infarction
- Aneurysm
- Acute renal failure
- Acute respiratory distress syndrome (ARDS)
- Amniotic fluid embolism
- Cardiac arrest/ventricular fibrillation
- Conversion of cardiac rhythm
- Disseminated intravascular coagulation
- Eclampsia
- Heart failure/arrest during surgery or procedure
- Puerperal cerebrovascular disorders
- Pulmonary edema/acute heart failure
- Severe anesthesia complications
- Sepsis
- Shock
- Sickle cell disease with crisis
- Air and thrombotic embolism
- Hysterectomy
- Temporary tracheostomy
- Ventilation

Blood transfusion is not included on this list but is considered separately as a potential indicator.

EVIDENCE-BASED PRACTICE RECOMMENDATION

The American College of Obstetricians and Gynecologists and Society for Maternal-Fetal Medicine recommend using two criteria to screen for severe maternal morbidity: transfusion of 4 or more units of blood and admission of a pregnant or postpartum patient to an intensive care unit.

(https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2016/09/severe-maternal-morbidity-screening-and-review. Last accessed October 16, 2023.)

Strength of Recommendation: Expert Opinion/Consensus Statement

In addition to mortality, obstetric morbidity is also associated with increased risk in the minority populations, particularly for non-Hispanic Black women. For every reported maternal death, 100 women experience a severe obstetric disease or life-threatening diagnosis during their hospitalization for delivery. Analysis of 2012–2015 data indicates that the incidence of severe maternal morbidity was significantly higher among deliveries to women in every racial and ethnic minority category compared with deliveries among non-Hispanic White women [10]. Severe maternal morbidity occurred at a rate of 231.1 per 10,000 delivery hospitalizations for non-Hispanic Black patients; the rate was 139.2 per 10,000 delivery hospitalizations among non-Hispanic White women. Racial and ethnic minority women have higher rates on most major morbidity indicators than White patients [1; 9].

NEW JERSEY

In 2018, the New Jersey legislature enacted P.L. 2018, c.82, which requires the New Jersey Department of Health to issue a report on hospital maternity care. This report (often referred to as the maternal health report card for the state of New Jersey) gives insights into the evolution of the maternal population as well as trends in serious maternal morbidity and mortality [10]. Over time, the maternal population in New Jersey has become more diverse. In 2020, 54% of mothers identified as a race/ethnicity other than White, compared with 46% in 2000 [10]. There has also been a trend away from hospital births, with a 2% decrease in hospital deliveries between 2019 and 2020 [10].

The report assesses five measures to track maternal morbidities and delivery complications in the state: third- and fourth-degree perineal laceration, episiotomy, obstetric hemorrhage, post-admission infections, and severe maternal morbidity (a surrogate for other complications) [10]. In 2020, non-Hispanic Black mothers in New Jersey were noted to have the highest rate of obstetric hemorrhage, defined as cumulative blood loss greater than 1,000 mL regardless of the method of delivery (i.e., vaginal or cesarean birth) or blood loss accompanied by signs

or symptoms of hypovolemia within 24 hours after the birth process. Risk factors for obstetric hemorrhage were Non-Hispanic Black or Hispanic race, cesarean delivery, placental or uterine disorders, nulliparity, premature gestational age, infection, pre-existing anemia, ICU admission, and pre-pregnancy overweight or obesity [10].

Non-Hispanic Black mothers in New Jersey also had the highest rate of severe maternal morbidity with need for blood transfusion, at a rate of 36.5 cases per 1,000 delivery hospitalizations. This represented a slight increase from the 2019 rate (35.6 cases per 1,000 delivery hospitalizations) [10]. Hispanic patients had the second highest rate (25.2 cases per 1,000 delivery hospitalizations). Non-Hispanic White mothers had the lowest documented transfusion rate (15.7 cases per 1,000 delivery hospitalizations)—a rate less than half that of Black mothers [10].

Asian mothers were identified to have the highest risk of third- and fourth-degree perineal tears without instrumentation (3.4 cases per 100 delivery hospitalizations). Hispanic and non-Hispanic Black mothers had the lowest rate of this complication (0.9 cases per 100 delivery hospitalizations) [10].

Asian mothers were also the most likely to experience episiotomies (11.6 cases per 100 delivery hospitalizations). The rate among this population is almost triple the next most likely group, Hispanic patients (4.3 cases per 100 delivery hospitalizations). Non-Hispanic Black mothers had the lowest episiotomy rate, at 2.8 cases per 100 delivery hospitalizations [10].

Postadmission infections were also most likely among Asian patients, who had a reported rate of 25.4 cases per 1,000 delivery hospitalizations. Hispanic mothers followed closely, with a rate of 21.8 per 1,000 delivery hospitalizations. The lowest rate occurred among non-Hispanic White mothers, who had a postadmission infection rate of 12.7 cases per 1,000 delivery hospitalizations (half the rate among Asian patients) [10].

Between 2016 and 2018, a total of 125 deaths with a temporal relationship to pregnancy (within 365 days) were reported in New Jersey [11]. Of these deaths, 44 (35%) were determined to be pregnancy-related, 74 (59%) were pregnancy-associated but not related, and 7 (6%) were unable to be determined. As in the rest of the country, the maternal mortality outcomes for non-Hispanic Black women continue to be largely disparate when compared to White women. The maternal mortality rate for Black women in New Jersey (39.2 deaths per 100,000 live births) is 6.6 times higher than the rate for White women (5.9 per 100,000 live births). The rate for Hispanic women (20.6 per 100,000 live births) is 3.5 times higher than the rate for White women [11].

EXPLICIT AND IMPLICIT BIAS

Bias plays a pivotal role in health care, especially patient care. Therefore, it is important to define the term. In a sociocultural context, biases are generally defined as negative evaluations of a particular social group relative to another group. Explicit biases are conscious, whereby an individual is fully aware of his/her attitudes and there may be intentional behaviors related to these attitudes [13]. For example, an individual may openly endorse a belief that women are weak, and men are strong. This bias is fully conscious and is made explicitly known. Implicit bias refers to the unconscious attitudes and evaluations held by individuals. These individuals do not necessarily endorse the bias, but the embedded beliefs/attitudes can negatively affect their behaviors [14; 15; 16; 17]. Some have asserted that the cognitive processes that dictate implicit and explicit biases are separate and independent [17].

Implicit biases can start as early as 3 years of age. As children age, they may begin to become more egalitarian in what they explicitly endorse, but their implicit biases may not necessarily change in accordance with these outward expressions [18].

Because implicit biases occur on the subconscious or unconscious level, particular social attributes (e.g., skin color) can quietly and insidiously affect perceptions and behaviors [19]. According to Georgetown University's National Center on Cultural Competency, social characteristics that can trigger implicit biases include [20]:

- Age
- Disability
- Education
- English language proficiency and fluency
- Ethnicity
- Health status
- Disease/diagnosis (e.g., HIV/AIDS)
- Insurance
- Obesity
- Race
- Socioeconomic status
- Sexual orientation, gender identity, or gender expression
- Skin tone
- Substance use

An alternative way of conceptualizing implicit bias is that an unconscious evaluation is only negative if it has further adverse consequences on a group that is already disadvantaged or produces inequities [21; 22]. Disadvantaged groups are marginalized in the healthcare system and vulnerable on multiple levels; health professionals' implicit biases can further exacerbate these existing disadvantages [21].

Implicit bias has been linked to a variety of health disparities [23]. Health disparities are differences in health status or disease that systematically and adversely affect less advantaged groups [24]. These inequities are often linked to historical and current unequal distribution of resources due to poverty, structural inequities, insufficient access to health care, and/or environmental barriers and threats [25]. As illustrated, health disparities have been clearly documented in maternal and perinatal care among racial/ethnic groups.

In an ideal situation, health professionals would be explicitly and implicitly objective, and clinical decisions would be completely free of bias. However, healthcare providers have implicit (and explicit) biases at a rate comparable to that of the general population [22; 26]. It is possible that these implicit biases shape healthcare professionals' behaviors, communications, and interactions, which may produce differences in help seeking, diagnoses, and ultimately treatments and interventions [26]. They may also unwittingly produce professional behaviors, attitudes, and interactions that reduce patients' trust and comfort with their provider, leading to earlier termination of visits and/or reduced adherence and follow-up [15].

POWER DYNAMICS

Power dynamics are inevitable in many situations, including throughout the healthcare system, when two or more individuals are attempting to balance the power among themselves. These dynamics may look different in various situations. Seven types of power dynamics have been identified: coercive, expert, reward, informational, formal, referent, and connection [27]. When power is exerted differently between the parties, inequity can result. In practice, healthcare professionals may use power to protect their autonomy and exert their expertise. This can lead to problems in interprofessional collaboration and in a failure to focus on the patient's role in making healthcare decisions, advocating for their needs and preferences, and being an empowered member of the care team. Communication, competence, and role perceptions are common factors that influence power dynamics [28].

ORGANIZATIONAL FACTORS

Larger organizational, institutional, societal, and cultural forces contribute, perpetuate, and reinforce implicit and explicit biases, racism, and discrimination. Psychological and neuroscientific approaches ultimately decontextualize racism [17; 29]. Sources of bias in organizations include internal politics, culture, leadership, organizational history, and team-specific structures. Organizational bias reaches far

beyond individuals themselves; the language used or tasks identified influence how the organization functions daily [30]. Bias within an organization can detour patients from visiting if they feel they are being viewed or cared for as a "lesser" patient. One of the primary roles and responsibilities of health professionals is to analyze how institutional and organizational factors promote racism and implicit bias and how these factors contribute to health disparities. This analysis should extend to include one's own position in this structure.

STRATEGIES TO PROMOTE AWARENESS

It is important to promote awareness of bias—both explicit and implicit biases and at personal, organizational, and professional levels. Education and training are powerful tools to identify and address issues related to bias. Reflection exercises and role play can be used, as hands-on skills are necessary in order to apply theories to practice. Creating safe environments and using skill-building exercises are key components of any program designed to reduce biases and related health disparities [31].

Harvard University sponsors Project Implicit, a research project which monitors implicit biases. Project Implicit houses the Implicit Association Test (IAT), which can be used as a metric to assess professionals' level of implicit bias on a variety of subjects, and this presupposes that implicit bias is a discrete phenomenon that can be measured quantitatively [32]. When providers are aware that implicit biases exist, discussion and education can be implemented to help reduce them and/or their impact. The IAT is available at https://implicit.harvard.edu/implicit, and anyone may complete an assessment.

Another way of facilitating awareness of providers' implicit bias is to ask self-reflective questions about each interaction with patients. Some have suggested using SOAP (or subjective, objective, assessment, and plan) notes to assist practitioners in identifying implicit biases in day-to-day interactions with patients [33]. Integrating the following questions into charts and notes can stimulate reflection about implicit bias globally and for each specific patient interaction:

- Did I think about any socioeconomic and/or environmental factors that may contribute to the health and access of this patient?
- How was my communication and interaction with this patient? Did it change from my customary pattern?
- How could my implicit biases influence care for this patient?

When reviewing the SOAP notes, providers can look for recurring themes of stereotypical perceptions, biased communication patterns, and/or types of treatment/interventions proposed and assess whether these themes could be influenced by biases related to race, ethnicity, age, gender, sexuality, or other social characteristics. A review of empirical studies conducted on the effectiveness of interventions promoting implicit bias awareness found mixed results. At times, after a peer discussion of IAT scores, participants appeared less interested in learning and employing implicit bias reduction interventions. However, other studies have found that receiving feedback along with IAT scores resulted in a reduction in implicit bias. Any feedback, education, and discussions should be structured to minimize participant defensiveness [34].

IMPACT OF BIAS ON THE DELIVERY OF PERINATAL CARE

Worldwide, the maternal mortality has decreased 43% since 1993. However, the United States is the only developed country in which maternal mortality has increased [35]. As of 2023, the United States reports the highest maternal mortality of all developed countries. The rate in New Jersey (25.7 maternal deaths per 100,000 live births) is higher than the national average (23.5 deaths per 100,000 live births). The greatest rates tend to occur in the South [36].

What is further troubling is that most maternal deaths and cases of severe morbidity are preventable [35]. This then leads to the necessary question: Why are these deaths occurring? A review of maternal deaths across nine states found that the deaths were

most commonly related to "clinician, facility, and system factors, such as inadequate training, missed or delayed diagnosis of complications, poor communication, and lack of coordination between clinicians" [37]. Improvements in clinician knowledge, skill, interprofessional collaboration, and bias could make inroads to improving maternal health care in the United States.

In a survey of 2,402 women regarding their maternal care, the following mistreatments were most commonly reported [2]:

- Receiving no response to requests for help
- Being shouted at or scolded
- Not having their physical privacy protected
- Being threatened with withholding treatment or made to accept unwanted treatment

About 30% of Black, Hispanic, and multiracial women reported mistreatment, with lower rates or reported mistreatment among White (19%), Native American/Alaska Native/Native Hawaiian/Pacific Islander (18%), and Asian (15%) patients. Mistreatment was most commonly reported by those with no insurance (28%) or public insurance (26%); only 16% of those with private insurance reported mistreatment. Patients most commonly reported discrimination and/or mistreatment during prenatal care related to age, weight, income, and race/ethnicity [2]. About 29% of women experienced discrimination, with the highest rates among Black (40%), multiracial (39%), and Hispanic (37%) women [2]. While satisfaction with maternity care overall was high (90%), satisfaction among those who reported mistreatment was considerably lower (75%). Mistreatment and discrimination impact experiences of care.

Social determinants of health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels. For example, historical economic stresses and restrictions on housing, jobs, and education have resulted in health inequalities for racial and ethnic minority groups. Healthy People 2030 groups social determinants of health into five categories [38]:

- Economic stability
- Education access and quality
- Health care access and quality
- Social and community context
- Neighborhood and built environment

These factors have a major impact on people's health, well-being, and quality of life. Social determinants contribute to maternal outcomes; however, they do not fully explain the large number of women of racial and ethnic backgrounds having higher than average maternal morbidity and mortality rates [37].

Implicit biases have been directly linked with lesser quality of care for certain patients, particularly those of minority groups. In some cases, this lower quality of care is triggered by stressful circumstances [35]. One explanation is that implicit biases are a heuristic, or a cognitive or mental shortcut. Heuristics offer individuals general rules to apply to situations in which there is limited, conflicting, or unclear information. Use of a heuristic results in a quick judgment based on fragments of memory and knowledge, and therefore, the decisions made may be erroneous. If the thinking patterns are flawed, negative attitudes can reinforce stereotypes [39].

Negative stereotyping can be a contributing factor to maternal health disparities. For example, healthcare providers may neglect to recognize the pain of non-Hispanic Black women or feel that this group's expressions of pain are more disproportionate than their actual experiences. One study found that a Black woman in New York City with a college education is nearly three times more likely to endure severe maternal morbidities compared with a White woman of similar age with less than a high school

education [37]. In one study of patients following cesarean delivery, Black and Hispanic women were evaluated for pain less frequently, had higher pain scores, and received less pain medication than White women, even after controlling for other clinical factors, suggesting that these inequities are the result of different approaches to care delivery [40]. These implicit racial beliefs also have the potential to affect the way a patient is counseled about treatment options [35].

Serious maternal complications, including hemorrhage, embolism, eclampsia, and stroke, occur in all racial and age groups; however, there is a clearly documented increased risk for racial or ethnic minority women. Failure to recognize these complications could be related to the high-stress environments in which they occur, but they may also be related to stereotypical unconscious thoughts related to minority groups [38].

Preconception counseling and care is critical to optimizing maternal health. This includes management of chronic diseases, maternal and fetal screenings, and lifestyle changes. Racial and/or ethnic minority women tend to have less accessibility to preconception and antenatal care [37]. Closing these access and engagement gaps could help address some of the disparities in birth complications.

Postnatal care is less emphasized but is a significantly important aspect of maternal care. During the eight weeks following delivery, the physical and emotional needs of the mothers should be assessed, including chronic health issues or complications that developed during the gestational period (e.g., gestational diabetes, hypertension, anemia, peripartum anxiety, peripartum depression). Unfortunately, it is reported that 16% to 36% of women do not attend a six-week follow-up visit following birth [36]. Furthermore, those who do attend the six-week visit report insufficient care and postnatal guidance, indicating a need to improve both adherence and provision of care during this period.

Healthcare professionals have a responsibility to repair biased systems that perpetuate racial health disparities. The American College of Obstetricians and Gynecologists has released a statement on racism in obstetrics and gynecology that reads, in part, [41]:

> Racial and ethnic inequities in obstetrics and gynecology cannot be reversed without addressing all aspects of racism and racial bias, including sociopolitical forces that perpetuate racism. The actualization of an equitable health care system which serves all people can only occur through acknowledgment of the historical context from which modern health inequities grew, including reproductive injustices.

EVIDENCE-BASED PRACTICE RECOMMENDATION

In order to reduce Black maternal mortality, the Centers for Disease Control and Prevention recommends that healthcare providers:

- Ask questions to better understand their patient and things that may be affecting their lives.
- Help patients, and those accompanying them, understand the urgent maternal warning signs and when to seek medical attention right away.
- Help patients manage chronic conditions or conditions that may arise during pregnancy, like hypertension, diabetes, or depression.
- Recognize and work to eliminate unconscious bias in themselves and in their office on an ongoing basis.
- Respond to any concerns patients may have.
- Provide all patients with respectful quality care.

(https://www.cdc.gov/healthequity/features/maternal-mortality. Last accessed October 16, 2023.)

Strength of Recommendation: Expert Opinion/ Consensus Statement

INTERCULTURAL COMPETENCE AND CULTURAL IDENTITY

Cultural identity is defined as the "shared characteristics of a group of people, which encompasses place of birth, religion, language, cuisine, social behaviors, art, literature, and music" [42]. Cultural identity is important as it influences how we respond to different situations. In health care, cultural identity can influence the behaviors one exhibits, the barriers upheld, and professional decisions, interactions, and performance. Cultural identity can evolve, and even if one does not consider their culture consciously, it is exhibited subconsciously [43]. It is important to remember that one's cultural identity should not impede the care provided to patients. For example, religion can influence one's practice but it should not determine how one practices or the type or quality of care given.

Providing culturally responsive care can help to avoid practice that is influenced by explicit or implicit biases. The U.S. Department of Health and Human Services has outlined steps important to incorporate in evaluation and treatment planning processes to ensure culturally competent clinical and programmatic decisions and skills [44]. The first step is to engage patients. When engaging in any patient teaching, remember that individuals may be new to the specific language or jargon and expectations of the diagnosis and care process. Patients should be encouraged to collaborate in every step of their care. Practitioners should also work to identify screening and assessment tools that have been translated into or adapted for other languages and have been validated for their particular population group(s). Typically, culturally responsive care establishes holistic treatment goals that include objectives to improve physical health and spiritual strength; utilizes strengths-based strategies that fortify cultural heritage, identity, and resiliency; and recognizes that treatment planning is a dynamic process that evolves along with an understanding of patient history and treatment needs.

As part of the cultural competence process and as a reflection of cultural humility, practitioners should strive to learn as much as possible about the specific racial/ethnic populations they serve. However, considerable diversity exists within any specific culture, race, or ethnicity [45]. Cultural beliefs, traditions, and practices change over time, both through generations and within an individual's lifetime. It is also possible for the differences between two members of the same racial/ethnic group to be greater than the differences between two people from different racial/ethnic groups. Within-group variations in how people interact with their environments and specific social contexts are also often present.

In addition to these general approaches, specific considerations may be appropriate for specific populations. While discussion of every possible patient subgroup is outside of the scope of this course, some of the most common factors are outlined in the following sections.

BLACK PATIENTS

"Black" or "African American" is a classification that serves as a descriptor; it has sociopolitical and self-identification ramifications. The U.S. Census Bureau defines African Americans or Black Americans as persons "having origins in any of the Black racial groups of Africa" [46].

Historical adversity and institutional racism contribute to health disparities in this group. For the Black population, patient assessment and treatment planning should be framed in a context that recognizes the totality of life experiences faced by patients. In many cases, particularly in the provision of mental health care, equality is sought in the provider-patient relationship, with less distance and more disclosure. Practitioners should assess whether their practices connect with core values of Black culture, such as family, kinship, community, and spirituality. Generalized or Eurocentric treatment approaches may not easily align with these components of the Black community [47]. Providers should also consider the impact of racial discrimination on health and mental health among Black patients. Reports indicate that expressions of emotion by Black patients tend to be negatively misunderstood or dismissed; this reflects implicit or explicit biases.

ASIAN PATIENTS

"Asian" is a single term widely used to describe individuals who have kinship and identity ties to Asia, including the Far East, Southeast Asia, and the Indian subcontinent. This encompasses countries such as China, Japan, Korea, Vietnam, Cambodia, Thailand, India, Pakistan, and the Philippines. Pacific Islander is often combined with Asian American in census data. The Pacific Islands include Hawaii, Guam, Samoa, Fiji, and many others [48]. There are more than 25 Asian/Pacific Islander groups, each with a different migration history and widely varying sociopolitical environments in their homelands [49].

As of 2019, 22.9 million Americans identified as Asian [50]. Between 2000 and 2019, Asians experienced the greatest growth compared with any other racial group at 81% [51; 52]. The Chinese group represents the largest Asian subgroup in the United States, and it is projected that this population will grow to 35.7 million between 2015 and 2040 [53; 54].

Recommended best practices when caring for Asian American patients include:

- Create an advisory committee using representatives from the community.
- Incorporate cultural knowledge and maintain flexible attitudes.
- Provide services in the patients' primary language.
- Develop culturally specific questionnaires for intake to capture information that may be missed by standard questionnaires.
- Emphasize traditional values and incorporate traditional practices (e.g., acupuncture) into treatment plans, when appropriate and desired.
- Explore patient coping mechanisms that draw upon cultural strengths.

While these approaches have been identified as useful for Asian patients, they may be broadly applicable across racial groups.

LATINO/A/X OR HISPANIC PATIENTS

In 2020, the Hispanic population in the United States numbered 60.6 million, comprising 18.7% of the U.S. population [55]. As such, they are the largest ethnic minority group in the United States. The majority of the Hispanic population in the United States (63.3%) identify themselves as being of Mexican descent [56]. Approximately 27% of the U.S. Hispanic population identify as Puerto Rican, Cuban, Salvadoran, Dominican, Guatemalan, Colombian, Honduran, Ecuadorian, or Peruvian [57].

When involved in the care of Latinx/Hispanic individuals, practitioners should strive to employ *personalismo* (warm, genuine communication) and recognize the importance of *familismo* (the centrality of the family). More flexible scheduling strategies may be more successful with this group, if possible, and some patients may benefit from culturally specific treatment and ethnic and gender matching with providers. Aspects of Latino culture can be assets in treatment: strength, perseverance, flexibility, and an ability to survive.

NATIVE AMERICAN PATIENTS

The Native American population is extremely diverse. According to the U.S. Census, the terms "Native American," "American Indian," or "Alaskan Native" refer to individuals who identify themselves with tribal attachment to indigenous groups of North and South America [58]. In the United States, there are 574 federally recognized tribal governments and 324 federally recognized reservations [59].

In 2020, it was reported that there were 7.1 million Native Americans in the United States, which is approximately 2% of the U.S. population. By 2060, this number is projected to increase to 10.1 million, or 2.5% of the total population [59].

Listening is an important aspect of rapport building with Native American patients, and practitioners should use active listening and reflective responses. Assessments and histories may include information regarding patients' stories, experiences, dreams, and rituals and their relevance. Interruptions and excessive questioning should be avoided if possible.

Extended periods of silence may occur, and time should be allowed for patients to adjust and process information. Practitioners should avoid asking about family or personal matters unrelated to presenting issues without first asking permission to inquire about these areas. Native American patients often respond best when they are given suggestions and options rather than directions.

WHITE AMERICAN PATIENTS

In 2021, 76.3% of the U.S. population identified as White alone [60]. The U.S. Census Bureau defines White race as a person having origins in any of the original peoples of Europe, the Middle East, or North Africa [46]. While the proportion of the population identifying as White only decreased between 2010 and 2020, the numbers of persons identifying as White and another race/ethnicity increased significantly. The White population in the United States is diverse in its religious, cultural, and social composition. The greatest proportion of this group reports a German ancestry (17%), followed by Irish (13%), English (10%), and Italian (7%) [61].

Providers can assume that most well-accepted treatment approaches and interventions have been tested and evaluated with White American individuals, particularly men. However, approaches may need modification to suit class, ethnicity, religion, and other factors.

Providers should establish not only the patient's ethnic background but also how strongly the person identifies with that background. It is also important to be sensitive to a person's multiracial/multiethnic heritage, if present, and how this might affect their family relationships and social experiences. Assumption of White race should be avoided, as White-passing persons of color have their own unique needs.

BARRIERS TO INCLUSION

Culturally diverse patients experience a variety of barriers when seeking health and mental health care, including:

- Immigration status
- Lower socioeconomic status
- Language barriers
- Cultural differences
- Lack of or poor health insurance coverage
- Fear of or experiences with provider discrimination
- Mistrust of healthcare systems

Such obstacles can interfere with or prevent access to treatment and services, compromise appropriate referrals, affect compliance with recommendations, and result in poor outcomes. Culturally competent providers build and maintain rich referral resources to meet patients' assorted needs.

Encountering discrimination when seeking health or mental health services is a barrier to optimal care and contributor to poorer outcomes in underrepresented groups. Some providers will not treat patients because of moral objections, which can affect all groups, but particularly those who are gender and/or sexual minorities, religious minorities, and/or immigrants. In fact, in 2016, Mississippi and Tennessee passed laws allowing health providers to refuse to provide services if doing so would violate their religious beliefs [62]. However, it is important to remember that providers are obligated to act within their profession's code of ethics and to ensure all patients receive the best possible care.

CULTURALLY RESPONSIVE COMMUNICATION

Styles of communication can be classified from high- to low-context [63]. High-context cultures are those cultures that disseminate information relying on shared experience, implicit messages, nonverbal cues, and the relationship between the two parties [64; 65]. Members of these cultural groups tend to listen with their eyes and focus on how something was said or conveyed [63; 66]. On the other hand, low-context cultures rely on verbal communication or what is explicitly stated in the conversation [64]. Consequently, low-context communicators listen with their ears and focus on what is being said [63; 65; 66]. Western culture, including the United States, can be classified as a low-context culture. On

the other hand, groups from collectivistic cultures, such as Asian/Pacific Islanders, Hispanics, Native Americans, and Black Americans, are from high-context cultures [63].

Communicators from high-context cultures generally display the following characteristics [64; 65; 66; 67]:

- Use of indirect modes of communication
- Use of vague descriptions
- Less talk and less eye contact
- Interpersonal sensitivity
- Use of feelings to facilitate behavior
- Assumed recollection of shared experiences
- Reliance on nonverbal cues such as gestures, tone of voice, posture, voice level, rhythm of speaking, emotions, and pace and timing of speech
- Assimilation of the "whole" picture, including visual and auditory cues
- Emotional speech
- Use of silence
- Use of more formal language, emphasizing hierarchy between parties

On the other hand, low-context communicators can typically be described as [64; 65; 66]:

- Employing direct patterns of communication
- Using explicit descriptions and terms
- Assuming meanings are described explicitly
- Utilizing and relying minimally on nonverbal cues
- Speaking more and often raising their voices (more animated, dramatic)
- Often being impatient to get to the point of the discussion
- Using more informal language; less emphasis on hierarchy, more equality between parties (more friendly)
- Being more comfortable with fluidness and change
- Uncomfortable using long pauses and story-telling as a means of communicating

Understanding the distinctions between individuals who come from high- and low-context cultures can promote cultural sensitivity. However, it is vital that practitioners take heed of several words of caution. First, it is important not to assume that two individuals sharing the same culture (e.g., low-context culture) will automatically have a shared script for communicating. Second, it is important to not immediately classify an individual into a low- or high-context culture because of their ethnicity. Third, a major criticism of the discussion of low-/high-context cultures is that they reinforce dualism and ultimately oversimplify the complexities and nuances of communication [68].

In this multicultural landscape, interpreters are a valuable resource to help bridge the communication and cultural gap between clients/patients and practitioners. Interpreters are more than passive agents who translate and transmit information back and forth from party to party. When they are enlisted and treated as part of the interdisciplinary clinical team, they serve as cultural brokers, who ultimately enhance the clinical encounter. In any case in which information regarding diagnostic procedures, treatment options, and medication/treatment measures are being provided, the use of an interpreter should be considered. Whenever possible, professional interpreters are preferred. Family interpreters should be avoided if at all possible.

Preferred language and immigration/migration status should be considered. Stressing confidentiality and privacy is particularly important for undocumented workers or recent immigrants, who may be fearful of deportation.

RACIAL AND REPRODUCTIVE JUSTICE

Racial biases in healthcare access, treatment, and outcomes and institutional racism embedded in healthcare institutions contribute to poorer health outcomes in minority populations. Many healthcare organizations are committing to the improvement of racial inequalities by dedicating resources and infrastructure to negating this problem. Healthcare organizations and practitioners have a vital role in acknowledging and dismantling structural racism [69].

Race Forward defines racial justice as "a vision and transformation of society to eliminate racial hierarchies and advance collective liberation, where Black, Indigenous, Latinx, Asian Americans, Native Hawaiians, and Pacific Islanders, in particular, have the dignity, resources, power, and self-determination to fully thrive" [70]. In the context of health care, this concept is related to eliminating race-related health disparities, ensuring access and quality of care for minority groups, and improving quality of life for all persons, regardless of race, color, or ethnicity. This requires that practitioners take a perspective of cultural humility and proactively move to dismantle harmful stereotypes and practices.

It is vital to actively listen and critically evaluate patient relationships. All practitioners should seek to educate themselves regarding the experiences of patients who are members of a community that differs from their own. Resources and opportunities to collaborate may be available from community organizations and leaders.

The term "reproductive justice" was coined by a group of Black women in 1994 [90]. This concept, linked to racial justice, is based on the core belief that sexual and reproductive justice exists when all people have the power and resources to make healthy decisions about their bodies, sexuality, and reproduction. Reproductive justice sheds light on the multiple combined forms of oppression that contribute to the reproductive oppression of women of color. This perspective asserts that intersecting systems of oppression (e.g., race, class, gender) result in the control and exploitation of women, girls, gender-expansive individuals, and others through their bodies, sexuality, labor, and/or reproduction [90]. Persons who experience multiple oppressions experience more severe maternal morbidity. Only addressing all of the systemic issues contributing to poorer maternal health outcomes in persons of color will resolve racial health disparities in the United States.

INTERVENTIONS TO REDUCE IMPLICIT BIAS AND RELATED MATERNAL HEALTH DISPARITIES

According to the CDC, interventions to address bias on multiple levels can reduce pregnancy-related deaths [2]. Healthcare systems should foster a respectful maternity culture by hiring and retaining a diverse labor force and training all healthcare staff to identify implicit bias and stigma. The CDC also recommends healthcare systems promote quality improvement measures, focusing on increasing the respectful maternity culture for all women, so all patients feel they are equal regardless of race, ethnicity, or socioeconomic status. It is also ideal for healthcare professionals to strive for all maternal patients to feel respected, understood, supported, and valued throughout their care [2].

The American College of Obstetricians and Gynecologists makes the following recommendations for obstetrician/gynecologists and other healthcare providers to improve patient-centered care and decrease inequities in reproductive health care by [71]:

- Inquiring about and documenting social and structural determinants of health that may influence a patient's health and use of health care

- Maximizing referrals to social services to help improve patients' abilities to fulfill these needs
- Providing access to interpreter services for all patient interactions when patient language is not the clinicians' language
- Recognizing that stereotyping patients using presumed cultural beliefs can negatively affect patient interactions, especially when patients' behaviors are attributed solely to individual choices without recognizing the role of social and structural factors

The CDC has also launched the Hear Her campaign to provide resources for practitioners and pregnant and postpartum women, with an emphasis on preventing pregnancy-related deaths by sharing potentially life-saving messages about urgent warning signs. The Hear Her campaign can be accessed online at https://www.cdc.gov/hearher.

Adherence to guideline-endorsed practice may also help to reduce health disparities. In a Ghanaian study, provider adherence to antenatal care guidelines beginning in the first visit improved delivery and neonatal outcomes [89]. In addition, racial and ethnic disparities in severe maternal morbidity and mortality may be at least partially explained by variation in hospital quality. The majority of Black women who deliver in the United States (75%) do so in only 25% of hospitals; only 18% of White women deliver in those same hospitals [1]. The hospitals more likely to serve Black communities have higher risk-adjusted severe maternal morbidity rates, regardless of the patient's race/ethnicity, than the national average. Improving access to high-quality maternal health care and adherence to antenatal and postpartum guidelines may thus effectively reduce racial disparities in maternal morbidity and mortality.

In addition to these strategies, practitioners should act to address their own implicit biases. Interventions or strategies designed to reduce implicit bias may be categorized as change-based or control-based. Change-based interventions focus on reducing or changing cognitive associations underlying implicit biases. These interventions might include challenging stereotypes. Conversely, control-based interventions involve reducing the effects of the implicit bias on the individual's behaviors [72]. These strategies include increasing awareness of biased thoughts and responses. The two types of interventions are not mutually exclusive and may be used synergistically.

PERSPECTIVE TAKING

Perspective taking is a strategy of taking on a first-person perspective of a person in order to control one's automatic response toward individuals with certain social characteristics that might trigger implicit biases [73]. The goal is to increase psychological closeness, empathy, and connection with members of the group [39]. Engaging with media that presents a perspective (e.g., watching documentaries, reading an autobiography) can help promote better understanding of the specific group's lives, experiences, and viewpoints. In one study, participants who adopted the first-person perspectives of Black Americans had more positive automatic evaluations of the targeted group [74].

EMPATHY INTERVENTIONS

Promoting positive emotions such as empathy and compassion can help reduce implicit biases. This can involve strategies like perspective taking and role playing [75]. In a study examining analgesic prescription disparities, nurses were shown photos of White or African American patients exhibiting pain and were asked to recommend how much pain medication was needed; a control group was not shown photos. Those who were shown images of patients in pain displayed no differences in recommended

dosage along racial lines; however, those who did not see the images averaged higher recommended dosages for White patients compared with Black patients [76]. This suggests that professionals' level of empathy (enhanced by seeing the patient in pain) affected prescription recommendations.

In a study of healthcare professionals randomly assigned to an empathy-inducing group or a control group, participants were given the IAT to measure implicit bias prior to and following the intervention. The level of implicit bias among participants in the empathy-inducing group decreased significantly compared with their control group counterparts [77].

INDIVIDUATION

Individuation is an implicit bias reduction intervention that involves obtaining specific information about the individual and relying on personal characteristics instead of stereotypes of the group to which he or she belongs [39; 73]. The key is to concentrate on the person's specific experiences, achievements, personality traits, qualifications, and other personal attributes rather than focusing on gender, race, ethnicity, age, ability, and other social attributes, all of which can activate implicit biases. When providers lack relevant information, they are more likely to fill in data with stereotypes, in some cases unconsciously. Time constraints and job stress increase the likelihood of this occurring [78].

MINDFULNESS

Mindfulness requires stopping oneself and deliberately emptying one's mind of distractions or allowing distractions to drift through one's mind unimpeded, focusing only on the moment; judgment and assumptions are set aside. This approach involves regulating one's emotions, responses, and attention to return to the present moment, which can reduce stress and anxiety [79]. There is evidence that mindfulness can help regulate biological and emotional responses and can have a positive effect on attention and habit formation [39]. A mindfulness activity assists individuals to be more aware of their thoughts and sensations. This focus on deliberation moves the practitioner away from a reliance on instincts, which is the foundation of implicit bias-affected practice [39; 80].

Mindfulness approaches include yoga, meditation, and guided imagery. One approach to mindfulness using the acronym STOPP has been developed as a practical exercise to engage in mindfulness in any moment. STOPP is an acronym for [81]:

- Stop
- Take a breath
- Observe
- Pull back
- Practice

Mindfulness practice has been explored as a technique to reduce activation or triggering of implicit bias, enhance awareness of and ability to control implicit biases that arise, and increase capacity for compassion and empathy toward patients by reducing stress, exhaustion, and compassion fatigue [82]. One study examined the effectiveness of a loving-kindness meditation practice training in improving implicit bias toward Black and unhoused persons. One hundred one non-Black adults were randomized to one of three groups: a six-week loving-kindness mindfulness practice, a six-week loving-kindness discussion, or the waitlist control. The IAT was used to measure implicit biases, and the results showed that the loving-kindness meditation practice decreased levels of implicit biases toward both groups [83].

COUNTER-STEREOTYPICAL IMAGING

Counter-stereotypical imaging approaches involve presenting an image, idea, or construct that is counter to the oversimplified stereotypes typically held regarding members of a specific group. In one study, participants were asked to imagine either a strong woman (the experimental condition) or a gender-neutral event (the control condition) [84].

Researchers found that participants in the experimental condition exhibited lower levels of implicit gender bias. Similarly, exposure to female leaders was found to reduce implicit gender bias [85]. Whether via increased contact with stigmatized groups to contradict prevailing stereotypes or simply exposure to counter-stereotypical imaging, it is possible to unlearn associations underlying various implicit biases. If the social environment is important in priming positive evaluations, having more positive visual images of members in stigmatized groups can help reduce implicit biases. Some have suggested that even just hanging photos and having computer screensavers reflecting positive images of various social groups could help to reduce negative associations [86].

CHIEF EQUITY OFFICERS

Equity teams are encouraged to help with implicit bias in healthcare institutions. A chief equity officer has strong relationships in the delivery system and works to ensure health equity is prioritized. Those in this role are leaders with practical oversight of healthcare delivery and implementation. Equity officers are distinct from chief diversity officers, who focus more on internal recruiting, retention, and inclusion opportunities. An equity officer drives an agenda that addresses internal performance in quality and access for all patients, particularly vulnerable patients [87].

Chief equity officers often concentrate on staff preparation, responsibility, and biases, and work to assess and improve how staff regard and treat all patients, regardless of race, ethnicity, gender/sex, or socioeconomic status. Chief equity officers implement approaches to engage providers and the wider community to support and address medical and nonmedical (social determinants) risks to health outcomes [87].

RESOURCES

Maternal Mortality Review Committees
http://reviewtoaction.org/tools/networking-map

CDC Working Together to Reduce Black Maternal Mortality
https://www.cdc.gov/healthequity/features/maternal-mortality/index.html

American Bar Association Diversity and Inclusion Center Toolkits and Projects
https://www.americanbar.org/groups/diversity/resources/toolkits

National Implicit Bias Network
https://implicitbias.net/resources/resources-by-category

New Jersey Maternal Care Quality Collaborative (NJMCQC)
https://www.nj.gov/health/maternal/mcqc

Ohio State University The Women's Place: Implicit Bias Resources
https://womensplace.osu.edu/resources/implicit-bias-resources

Ohio State University Kirwan Institute for the Study of Race and Ethnicity
http://kirwaninstitute.osu.edu

Partnership for Maternal and Child Health of Northern New Jersey
https://www.partnershipmch.org

University of California, Los Angeles Equity, Diversity, and Inclusion: Implicit Bias
https://equity.ucla.edu/know/implicit-bias

University of California, San Francisco, Office of Diversity and Outreach Unconscious Bias Resources
https://diversity.ucsf.edu/resources/unconscious-bias-resources

Unconscious Bias Project
https://unconsciousbiasproject.org

CONCLUSION

There is no question that maternal health disparities are a significant problem in the United States. Inequalities have been associated with many factors, including education level, literacy, age, and socioeconomic status. However, the greatest disparities have been noted among racial/ethnic minority women and have been linked to explicit and implicit biases in healthcare providers and systems. It is of the utmost importance that those caring for patients in the peripartum and postpartum period are committed to lowering the morbidity and mortality rates of all mothers of color. Promoting equity and cultural competence, effectively addressing modifiable risk factors, improving communication and monitoring, and engaging in regular training are needed to improve the health and outcomes of this population.

GLOSSARY

Pregnancy-associated death: A death during or within one year of pregnancy, regardless of the cause [88].

Pregnancy-related death: A death during or within one year of pregnancy, from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy [88].

Preventability: A death is considered preventable if there was at least some chance of the death being prevented by one or more reasonable changes to patient, family, provider, facility, system, and/or community factors. This definition is used by maternal mortality review committees to determine if a death they review is preventable [88].

Maternal death: The death of a woman while pregnant or within 42 days of termination of pregnancy, regardless of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental causes. This definition is used by the National Center for Health Statistics and the World Health Organization [88].

Maternal mortality ratio: The number of maternal deaths (as defined) per 100,000 live births. Also referred to as the maternal mortality rate [88].

Maternal mortality: Number of deaths during pregnancy, childbirth, and the postpartum period up to 365 days from the end of pregnancy [88].

Implicit Bias in Health Care

The role of implicit biases on healthcare outcomes has become a concern, as there is some evidence that implicit biases contribute to health disparities, professionals' attitudes toward and interactions with patients, quality of care, diagnoses, and treatment decisions. This may produce differences in help-seeking, diagnoses, and ultimately treatments and interventions. Implicit biases may also unwittingly produce professional behaviors, attitudes, and interactions that reduce patients' trust and comfort with their provider, leading to earlier termination of visits and/or reduced adherence and follow-up. Disadvantaged groups are marginalized in the healthcare system and vulnerable on multiple levels; health professionals' implicit biases can further exacerbate these existing disadvantages.

Interventions or strategies designed to reduce implicit bias may be categorized as change-based or control-based. Change-based interventions focus on reducing or changing cognitive associations underlying implicit biases. These interventions might include challenging stereotypes. Conversely, control-based interventions involve reducing the effects of the implicit bias on the individual's behaviors. These strategies include increasing awareness of biased thoughts and responses. The two types of interventions are not mutually exclusive and may be used synergistically.

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