listening to black mothers

Listening to Black Mothers:

A Call for Liberated Black Births



POLICY BRIEF

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national partnership for women & families

BMMA BLACK MAMAS MATTER ALLIANCE

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Introduction

For generations, Black women, families, and communities have built networks of care, advocacy, and mutual support in response to a maternity care system that has too often failed to protect their health, respect their autonomy, or meet their needs. Black midwives, doulas, birth workers, community organizations, and birth justice advocates have pioneered culturally congruent care, collective well-being, reproductive autonomy, and Black joy. Their leadership reflects a long tradition of resistance, resilience, and community innovation. Yet **Black women should not have to rely on extraordinary resilience, unpaid labor, or constant self-advocacy to experience safe, respectful, and joyful births.**

The urgency of transforming maternity care is profound. Black childbearing people[i] face a maternal mortality rate three times that of White women.[ii][1,2] Yet, nearly 90% of pregnancy-related deaths are preventable.[3] These disparities persist even controlling for income, education, age, and prior health status.[4,5,6]

The Black maternal health crisis cannot be separated from the broader systems of oppression that shape Black women's lives. These inequities are not the result of individual choices or biological differences, but are rooted in generations of structural and gendered racism that shape access to care, economic opportunity, environmental conditions, and the treatment Black women receive within health institutions.[7] The legacies of slavery, segregation, redlining, discriminatory economic policies, policing, and race-based medical practices continue to influence where Black families live, the resources available to them, and the quality of care they receive.

These longstanding injustices converge with renewed threats to maternal health. Hard-won maternal health gains (e.g., Medicaid expansion from 60 days to 12 months postpartum in 49 states and greater public awareness of the benefits of doulas) are vulnerable. Medicaid cuts and coverage restrictions, maternity unit closures, limitations on abortion and reproductive health care, and persistent economic insecurity threaten the health and well-being of Black families. At the same time, reductions in public health infrastructure, attacks on diversity and equity initiatives, and restrictions on research and the collection of race- and ethnicity-disaggregated data undermine our ability to identify inequities and hold institutions accountable.

i We recognize and respect that those who are pregnant, birthing, postpartum, and parenting have a range of gendered identities and do not always identify as "women" or "mothers." In recognition of the diversity of identities, this report uses both gendered terms such as "women" or "mothers" and gender-neutral terms such as "respondents," "participants," and "childbearing families."

ii Black childbearing people, along with American Indian/Alaska Native (AI/AN) communities, continue to have the highest rates of maternal morbidity and mortality compared with White women. Non-Hispanic AI/AN people are four times more likely to die from pregnancy-related complications than non-Hispanic white people.

Against this backdrop, ***Listening to Black Mothers***,[iii] offers essential evidence grounded in Black women's experiences and recommendations for action. This brief examines the experience of more than 1,600 Black mothers across the United States, including their perspectives on safety, respect, quality of care, mental health, provider choice, economic security, and community support. Using an anti-racist approach, the analysis centers structural racism rather than attributing disparities to individual behaviors, genetics, or purely socioeconomic factors.

The findings reveal the strengths, preferences, and solutions that Black women and their communities bring to maternity care. The goal is not simply to reduce disparities, but to build a maternity care system in which Black mothers have the power, resources, choices, and support to experience healthy pregnancies, safe births, and lives defined by dignity, autonomy, and joy.

iii *Listening to Black Mothers* is a part of *Listening to Mothers IV*, a nationwide initiative to hear from childbearing people directly about their experiences with being pregnant, giving birth, and supporting themselves and their babies postpartum. More than 4,500 respondents from all 50 states and the District of Columbia completed in-depth questionnaires about their views and experiences of childbearing. The questionnaires were available in English or Spanish, and participants, at least 18 years old at the time of the survey, shared their experiences about 2023, 2024, and 2025 U.S. hospital births.

Listening to Black Mothers: Their Top 6 Concerns

1. Limited access to continuous, comprehensive, Black-led maternity care
2. High rates of unwanted labor and birth interventions
3. Too many Black women experience disrespect, mistreatment, and being ignored
4. Persistent, untreated mental health needs amid efforts to prioritize well-being
5. Insurance gaps, lapses in coverage, and unaffordable costs delay care
6. Structural racism and social inequities harm Black women's health



Black Mothers Described Six Top Concerns

Listening to Black Mothers reflects the experiences of over 1,600 Black mothers from all 50 states and the District of Columbia. Their experiences illustrate six most pressing concerns.[iv]

1 Access to continuous, comprehensive, Black-led maternity care remains limited.

Access to high-quality care and support before pregnancy, during pregnancy and childbirth, and the extended postpartum period is crucial to supporting and protecting maternal and infant health. Yet our data found that Black childbearing people face significant barriers to access at all stages.

Before Pregnancy

Pre-pregnancy care, including primary care and family planning services, makes it more likely that childbearing people can become pregnant when they want to and enter pregnancy as healthy as possible, which reduces the risk of pregnancy complications.

- **Physical health before pregnancy.** Black respondents were most likely to have had high blood pressure during the three months before they became pregnant (14%), significantly more than Asian (3%), AIAN-NHPI[v] (4%), Latina[vi] (6%), and White respondents (7%).
- **Unmet family planning needs.** Only 37% of Black respondents intended to become pregnant when they did, compared with more than half of White respondents (52%). An additional 37% of Black women became pregnant sooner than hoped, nearly twice the rate for White women (20%). And 15% of Black respondents became pregnant later than they had hoped.

iv We aim to center Black respondents' experiences by presenting data from Black mothers alone when comparisons with other racial and ethnic groups are not informative. When comparisons offer meaningful insight into inequities, we compare Black mothers' experiences with those of White mothers and other racial and ethnic groups. This approach avoids positioning White mothers' outcomes as the default or benchmark, recognizing that maternal health outcomes for White mothers must also improve. We also assess differences between monoracial Black and Multiracial Black respondents when meaningful trends emerge.

v The authors committed to preserving the voices of American Indian or Alaska Native (AIAN) and Native Hawaiian and Pacific Islander (NHPI) respondents, who are often excluded from analyses because of small sample sizes. Although we collected enough AIAN responses for meaningful analysis, we had too few NHPI responses for separate analysis. Based on recommendations from several NHPI advisors and partners, we combined NHPI and AIAN respondents rather than grouping NHPI respondents with Asian populations. This approach reflected shared cultural and socioeconomic experiences often shaped by histories of U.S. imperialism, colonialism, and indigeneity.

vi The authors of this brief strive to center gender equity across our work and acknowledge that the term "Latine" better reflects the gender diversity of this community. We also recognize that people of all gender identities may become pregnant and may need or choose to end a pregnancy. However, due to limitations of data collection, this analysis uses the term "Latinas" when referring to individuals who identify as "women" and "Hispanic/Latino" in our research.

During Pregnancy

Many Black women experienced difficulties obtaining early prenatal care and care from the provider type that they preferred.

- **Initial prenatal visit.** Almost a quarter of Black mothers could not schedule an initial prenatal visit as early as they wanted (23%) because no earlier visit was available (50%), their provider would not see them that early (16%), or they struggled to find providers accepting new patients (11%).
- **Provider choice.** Black respondents more often had no choice of maternity care provider (16%), compared with 10% of White respondents.
- **Midwifery care and community birth were valued but underutilized.** Just 7% of Black respondents received most of their maternity care from a midwife, but 73% wanted or would consider a midwife in a future pregnancy.
    - **Birth centers.** Black mothers (57%) were more likely to be interested in giving birth in a freestanding birth center in the future than Asian (44%), White (45%), and Latina (47%) respondents, but less likely than AIAN-NHPI respondents (62%).
    - **Home birth.** Black mothers (48%) were most likely to be interested in giving birth at home for a future birth compared with Asian (14%), Latina (24%), White (25%), and AIAN-NHPI mothers (44%).
- **Doula care was valued but underutilized.** Black mothers were more likely than AIAN-NHPI, White, and Multiracial[vii] respondents to have doula support at any time. During pregnancy, 17% of Black mothers received doula support, 17% at birth, and 9% at home postpartum.
    - **Future interest in doula support.** More Black mothers indicated that they would definitely want a doula at their future birth (32%), compared with 18% of White respondents.

Postpartum Care

Most pregnancy-related deaths occur in the postpartum period, making continued access to care after birth essential to identifying, treating, and monitoring complications, recovery, and healing, and to support breastfeeding.

vii Multiracial respondents self-identified as two or more of the race and ethnicity categories, except for AIAN-NHPI. The authors of this brief acknowledge that race and ethnicity are distinct social constructs but use the term "Multiracial" as shorthand for Multiracial throughout.

- **Delayed postpartum care.** Black mothers (26%) were more likely to have their first postpartum visit six or more weeks after birth, compared with White mothers (17%). However, Black respondents had more visits with a maternity care provider between leaving the hospital and 12 weeks after childbirth, compared with White, Asian, Latina, and Multiracial respondents. This may indicate that Black mothers may have greater difficulty accessing postpartum care, despite a greater need for it.
- **Lactation.** Compared with other groups, Black mothers most frequently had formula introduced to their babies in the hospital: 47% were given free formula samples or coupons (versus 39% for White mothers), and 4% said their baby was fed formula without their permission. Black mothers (47%) were also less likely to be connected with a lactation specialist at the hospital compared with White mothers (62%).



2 Black mothers reported high rates of unwanted labor and birth interventions.

Black women have particularly high rates of procedures that are widely recognized as being overused and that are not supported by evidence showing them to be clearly beneficial. Black women are also less likely to be given the information and opportunity to make decisions about their care.

Unnecessary medical interventions were common

Nearly half of Black respondents' births were scheduled before labor started on its own. Less than 1 in 10 Black respondents (9%) gave birth spontaneously without any medical interventions. Seven in 10 (70%) Black mothers reported receiving two or more common procedures out of five: medical induction, epidural analgesia, labor augmentation, forceps- or vacuum-assisted birth, and cesarean birth:

- **Planned cesareans and labor inductions:** Almost half of all Black mothers (48%) experienced either a planned cesarean or labor induction before labor began on its own.
- **Inductions:**
  - 38% of Black respondents had their labor induced.
  - Only 16% of Black women experienced the highest level of shared decision-making for elective inductions. A full 31% experienced little to no shared decision-making.
  - Among respondents whose care provider spoke with them about having an induction because it was near their due date, 66% of Black and Multiracial respondents had a provider recommend an elective induction, compared with AIAN-NHPI (49%), Asian (57%), Latina (57%), and White (57%) respondents, and AIAN-NHPI (49%).
- **Unplanned cesareans:**
  - Among respondents with a cesarean birth, 63% were unplanned cesareans, a significantly higher proportion than for White respondents (46%).
  - Black mothers with a cesarean birth were the most likely of any group to have regular labor contractions before their cesarean (75%), raising questions about the benefits and necessity of surgery, compared with AIAN-NHPI (50%), Latina (52%), Asian (54%), and White (59%) respondents.
- **Episiotomies:** 73% of Black mothers who had an episiotomy had no input in the decision, compared with 62% of White mothers.

Black respondents' high rates of interventions are counter to what they want. Black respondents (60%) strongly agreed that "birth is a process that should not be interfered with unless medically necessary," compared with just 35% of White respondents.



Views on trust, quality, and safety in the U.S. health care system

Feeling unsafe.

Three of four (76%) of Black mothers felt that they and their babies were always safe during their postpartum hospital stay, and the same proportion trusted all the members of their hospital health care team (75%). The top reasons stated for not trusting their health care team were: being unsure their decisions would be respected (40%), having heard about poor childbirth experiences and outcomes (36%), having poor experiences with their care team during their childbirth (34%), and poor health care experiences in the past (33%).

Concern about medical errors.

Black respondents also reported higher rates of concerns about medical errors. Black respondents (29%) were nearly five times more likely to be very concerned about a medical error during postpartum care than Latinas (6%), and more than three times more likely than White (8%) and Multiracial respondents (9%). The concern about a medical error was also high among Black respondents during prenatal care (31%) and their hospital stay (20%).

Black mothers shared complex views on trust, quality, and safety within the U.S. health care system.

Despite higher levels of concern about safety and medical errors, Black respondents were more likely than other groups to rate the quality of both general health (44%) and maternity care (45%) in the United States as excellent (Asian (10% and 18%), White (14% and 16%), Multiracial (15% and 24%), and AIAN-NHPI (34% and 26%) respondents, respectively).

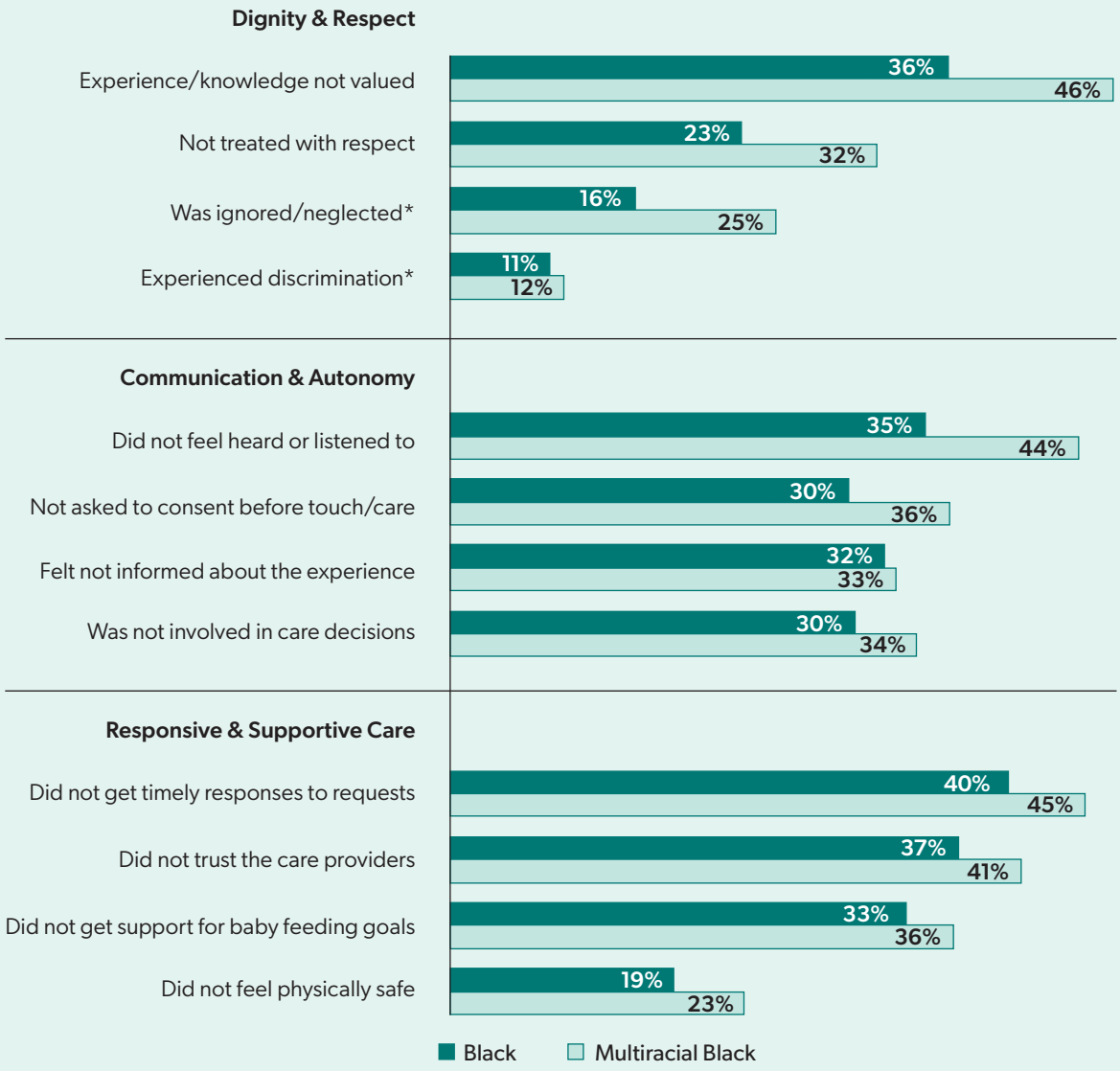
For Black respondents who felt safe at some point during their hospital stay, 70% attributed the feeling of safety to trusting the quality of the health care system (Multiracial (47%), AIAN-NHPI (54%), White (57%), Asian (58%), and Latina (67%)). Additionally, 75% of Black respondents trusted all members of their health care team during their hospital stay, compared with only 56% of Multiracial, 60% of White, and 61% of AIAN-NHPI respondents.



3 Too many Black women experience disrespect, mistreatment, and being ignored.

Many Black and Multiracial Black respondents told us they felt disrespected, disempowered, discriminated against, and mistreated during their care **(Figure 1)**. Multiracial Black respondents were slightly more likely to report disrespect, suggesting the need to examine how anti-Blackness and other forms of bias negatively impact Multiracial Black mothers' health and well-being specifically.

Figure 1: Black respondents who did not always receive person-centered maternity care, per PCMC-US scale



Base: all single-race (n=1,091) and Multiracial (n=304) Black respondents from Questionnaire 1 (n=1,395)

PCMC-US is the Person-Centered Maternity Care Scale.

For clarity, this figure reverses the way the questions were asked. Original phrasing was, "Were you treated with respect: never, a few times, most of the time, or always?"

* The questionnaire asked if respondents felt they had been ignored or neglected, and if they felt discriminated against. These questions were reverse-scored from all of the time=never to never=all of the time.

See Afulani, P., Altman, M., Castillo, E., Bernal, N., Jones, L., . . . Kuppermann, M. (2022, July). Adaptation of the Person-Centered Maternity Care Scale in the United States: Prioritizing the Experiences of Black Women and Birthing People. *Women's Health Issues*, 32(4), 352–361. Retrieved October 20, 2026, from https://doi.org/10.1016/j.whi.2022.01.006

Discrimination.

Black respondents who experienced discrimination cited: race (57%), ethnicity (24%), age (24%), marital status (11%), and income (10%).

Feeling judged.

Black respondents (47%) were more likely than White respondents (37%) to have felt judged negatively by a member of their care team, citing: their care choices (23%); race, ethnicity, or heritage (10%); marital status (7%); clothes or hair (6%); and language, accent, or how they spoke (4%).

Black respondents' responses to feeling judged included: held back information (32%), felt anxious or stressed when meeting with care providers (23%), losing trust in their health care team (21%), and worrying they would be treated poorly (20%).

Black mothers felt safer and believed they would receive higher-quality care when providers shared their identities.

Many Black respondents (27%) were not sure that people who did not look or speak like them would provide good, respectful care, and 21% felt unsafe during their hospital stays when cared for by providers of a different race, ethnicity, or language. For 84% of Black respondents, it was important to have maternity providers who shared their race, ethnicity, or heritage, compared with just 36% of White, 56% of Asian and Multiracial, 66% of Latina, and 75% of AIAN-NHPI respondents. However, only one in four Black respondents always had maternity providers who shared their race, ethnicity, or heritage.

"When I mentioned that I probably needed a new IV, she pushed through the old one and left the room. She caused me to have an IV extravasation."

"I had signs of preeclampsia. My feet were swelling, vision became blurry. I was repeatedly ignored and told I was overreacting."

"Because of my race and how I speak, people assume I'm uneducated or that I can easily be swayed. Also, they assume I can be mistreated and not properly cared for because they believe my skin color makes me less than."

"At the end, I had an amazing birth experience, and I solely believe it was because I had a care team that was of the same or similar background as me."

4 Black mothers experienced persistent, untreated mental health needs amid efforts to prioritize their well-being.

Perinatal mental health conditions are a primary driver of pregnancy-related mortality.[8] Black mothers reported high rates of symptoms of anxiety and depression before and during pregnancy and postpartum. Most did not receive treatment, whether counseling, medication, or a combination of both.

Mental health outcomes

Mental health during pregnancy: Black mothers were most likely to report symptoms of anxiety (46%) compared with other groups (Asian (28%), Latina (29%), and White mothers (33%)). A full 35% of Black mothers indicated symptoms of depression during pregnancy. They were also more likely to report severe psychological distress — anxiety and depression — (14%) compared with others: 3% of Asian, 6% of White, 7% of Latina, and 11% of Multiracial respondents.

Postpartum mental health: The highest rates of mental-health-related mortality and morbidity occur postpartum. Black mothers (30%) were significantly more likely to indicate symptoms of depression postpartum, as compared with Latina (19%) and White mothers (21%). Nearly 40% of Black mothers indicated symptoms of anxiety postpartum. They were also more likely to report severe postpartum psychological distress (16%) compared with others: 8% of Latina, 9% of Asian, 11% of White, and 14% of AIAN-NHPI respondents.

Treatment and Support for Emotional and Mental Well-Being

Receiving mental health care and support.

Among Black respondents with symptoms of anxiety and/or depression, 58% received no treatment (counseling or medication) during pregnancy, and 53% received no treatment postpartum. Overall, Black mothers were more likely to seek counseling only, compared with medication only or a combination of medication and counseling for treatment. Black respondents were also more likely to receive counseling or therapy for mental health conditions during pregnancy, as compared with respondents across all other racial and ethnic groups.

Taking care of themselves.

Self-care has a particular history and meaning in Black women's circles, resulting in strong, long-standing community-based self-care practices as an essential form of survival, self-preservation, and resistance through reclaiming rest and joy.[9,10]

- **Prioritizing self-care.** Following their recent birth, 57% of Black mothers used self-care for emotional or mental well-being. Popular self-care activities among Black mothers included staying active (51%), eating healthy food (41%), staying connected with family and friends (40%), managing stress (37%), getting enough rest and sleep (37%), and having time to themselves (34%).
- **Leveraging personal networks for mental health and well-being support.** Most Black mothers reported getting emotional or mental well-being support from family or friends (69%). Many Black respondents found that their family members (56%) and friends (41%) were a completely trustworthy source of information about pregnancy and childbirth, as compared with White respondents (23% and 15%, respectively).

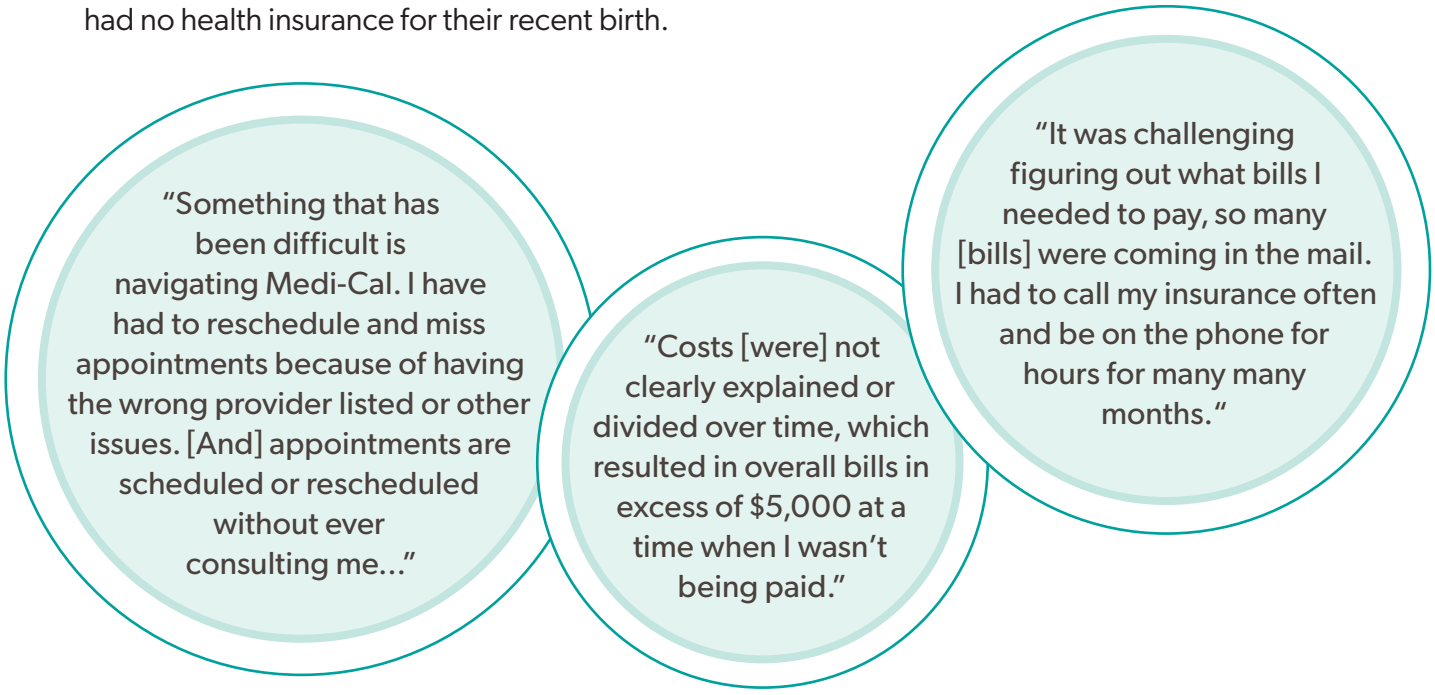


5 Insurance gaps, lapses in coverage, and unaffordable costs delay care for Black mothers.

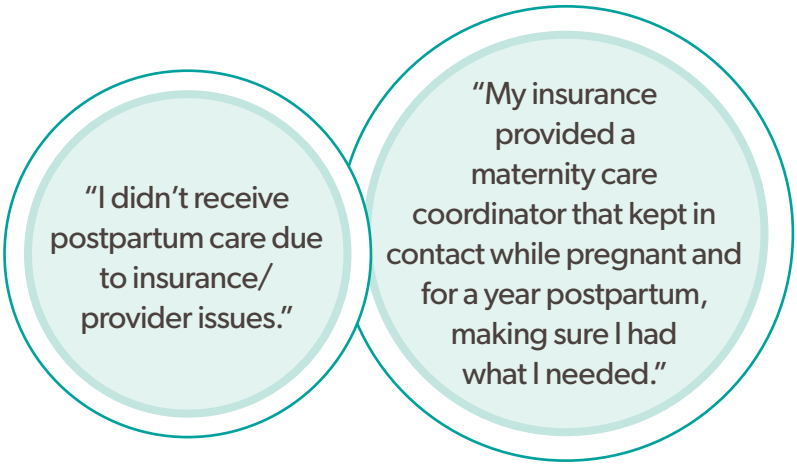
Adequate health insurance coverage is essential to accessing health care in the United States, especially as health care costs continue to rise sharply. Most Black respondents reported being insured by Medicaid,[viii] underinsured, or uninsured at the time of their recent birth. Black mothers reported that having insurance did not guarantee they could actually get the care and support they needed from their preferred providers without delay or financial strain. The gap between having coverage and receiving needed care was widest for those covered by Medicaid, citing providers who would not accept their insurance, services their plans would not cover, and billing problems.

Maternal health insurance coverage before and during pregnancy.

Medicaid was the primary payer for the prenatal care of 57% of Black respondents. By the time of childbirth, 62% of Black respondents reported that Medicaid paid for their childbirth.[ix,11] Over one-fourth of Black respondents (28%) reported their health insurance coverage began during their pregnancy, meaning that many mothers were uninsured before their pregnancy. For Black mothers whose health insurance coverage began during pregnancy, 10% received coverage one month into pregnancy, 42% between two and three months, 20% between four and five months, and 18% six or more months into pregnancy. Also, just under one-fourth of Black respondents (22%) reported a gap in their health insurance coverage at some point during their pregnancy. Four percent of Black mothers had no health insurance for their recent birth.



viii Medicaid includes the Children's Health Insurance Program (CHIP).
ix This percentage mirrors the national average proportion (64%) of births by Black mothers financed by Medicaid.



6 Structural racism and social inequities harm Black women's health.

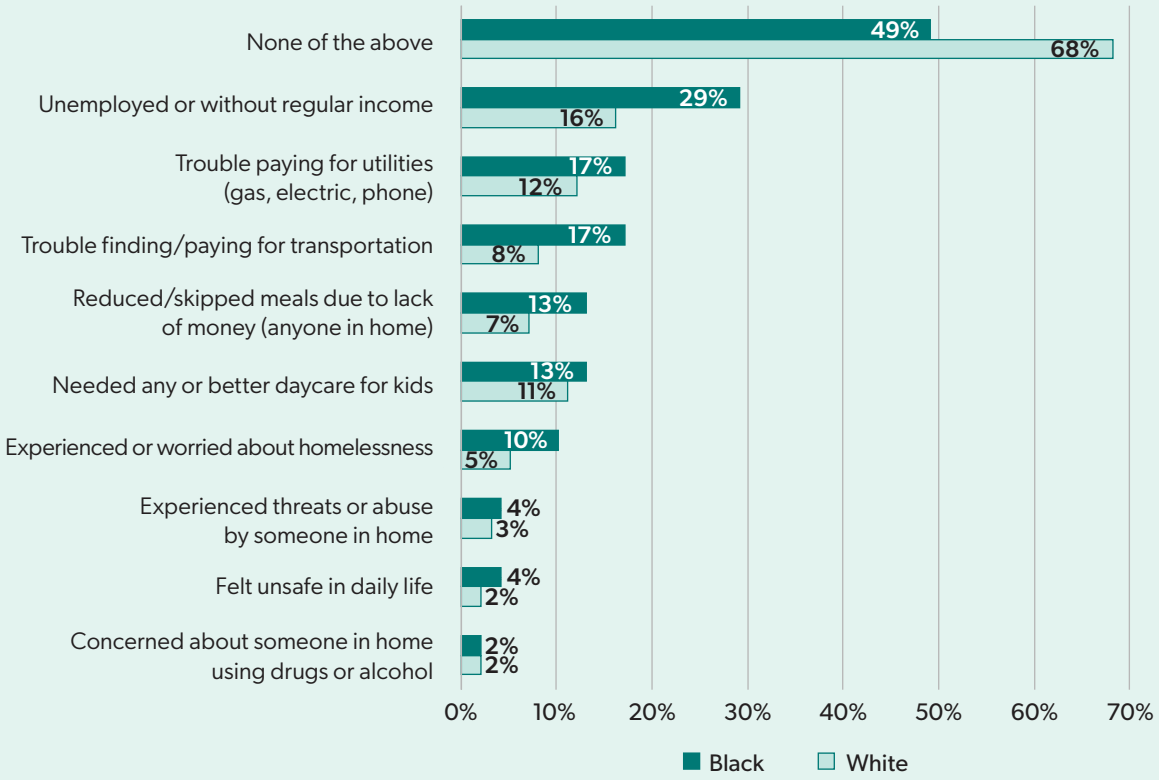
Non-medical social needs that shape the conditions in which people live, work, and age (i.e., safe housing, transportation, and income) directly affect a person's and a community's health. For some communities that are particularly affected by oversurveillance and policing, unmet social needs can be even more problematic, as they can trigger punitive involvement by authorities that can lead to unnecessary and traumatic family separations.[12]

Social needs during pregnancy.

More than half of Black respondents (51%) identified one or more unmet social needs among nine listed **(Figure 2)**. Black respondents (31%) most often reported that these issues remained unresolved postpartum, compared with Asian (12%), White (17%), Latina (24%), AIAN-NHPI (27%), and Multiracial respondents (28%).



Figure 2: Black respondents' unmet social needs during pregnancy compared with White respondents



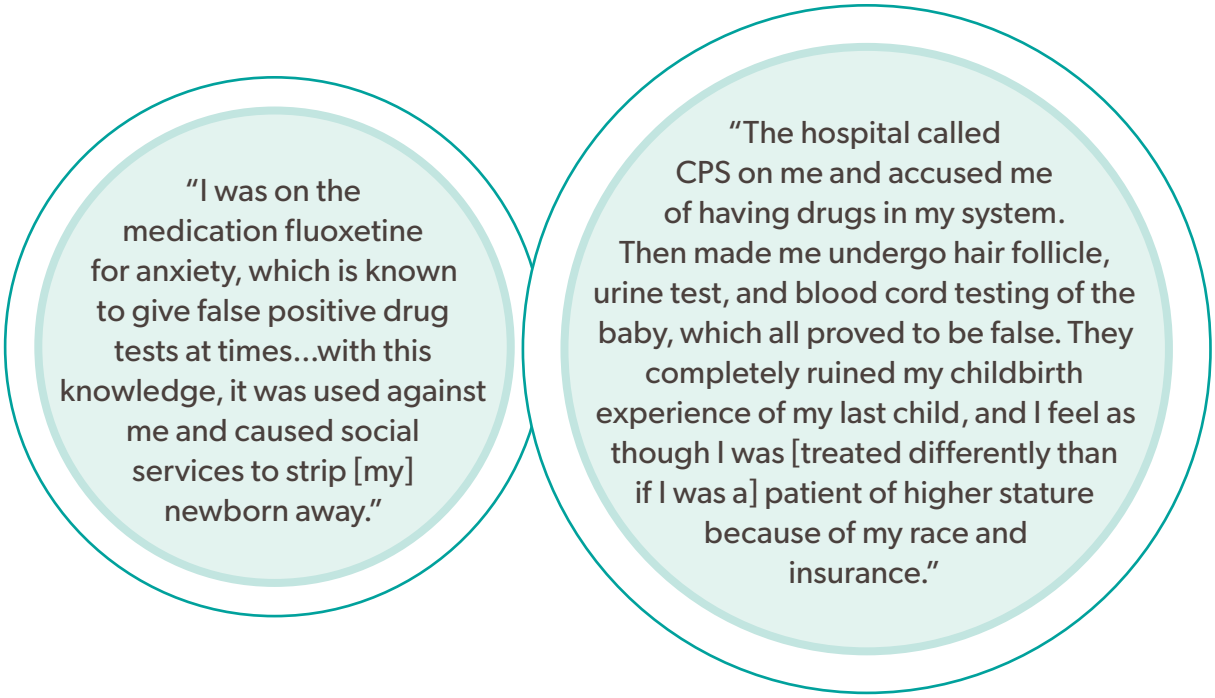
Base: All Black (n=1,091) and White respondents (n=1,156) from Questionnaire 1

Respondents selected all that applied.

Family surveillance and policing.

Black respondents (5%) were more likely to report that someone on their health care team reported them or their families to Child Protective Services or other authorities than White respondents (2%). When authorities were notified, 79% of Black respondents resulted in an investigation, compared with 60% for White respondents.

"My OB/GYN contact[ed] child protective services based off of a drug test that was supposedly administered at my very first prenatal visit that I was unaware of."



Employment and Economic Security

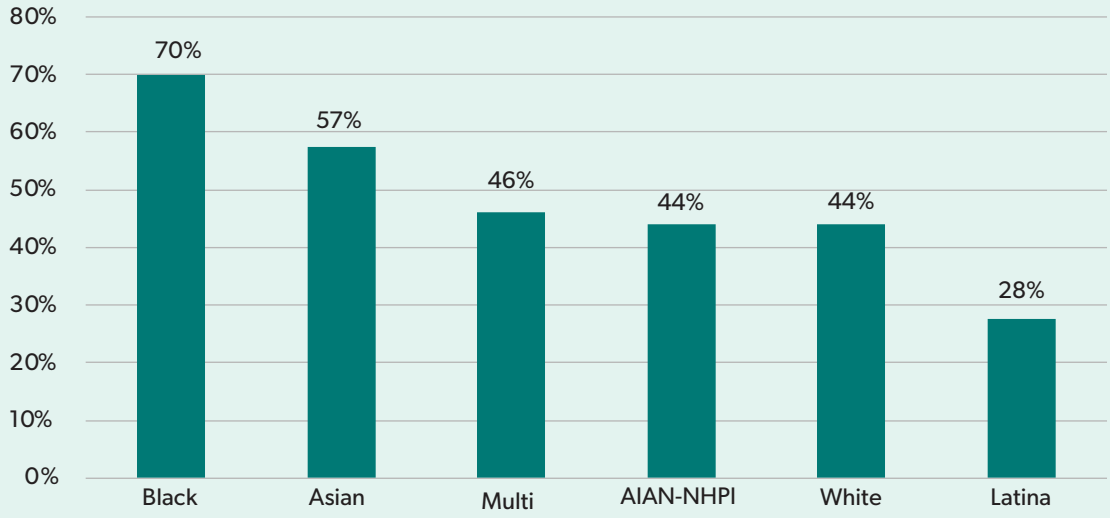
Employment.

Fully 37% of Black respondents were unemployed during their pregnancy, compared with only 28% of White respondents. Employed Black respondents were less likely to work full-time (67%) than employed White respondents (79%).

Leave policies and use.

Among Black respondents who were employed, 42% had no paid sick time or other workplace benefits that would have enabled them to take paid time off for prenatal visits, compared with 29% of White respondents. Interestingly, Black respondents (70%) were more likely to report having remaining days of paid time off (i.e., vacation, sick, flex, or personal days) when they returned to their job after taking time off with their baby, compared with White (44%) and Latina respondents (28%) **(Figure 3)**. The top reasons Black respondents returned to work early from maternity leave included not being able to afford taking more time off (55%), concern that staying on leave could affect their job security (22%), using up all their available benefits (21%), and their spouse or partner being home with the baby (19%).

Figure 3: Respondents with remaining days of paid time off when they returned to work postpartum



Base: all respondents from Questionnaire 2 who were currently employed by the same employer they worked for during their recent pregnancy at the time of the survey (n=539)

$p < 0.05$ comparing Black with White and Latina

Pregnancy accommodations.

Black respondents (57%) were more likely to need pregnancy-related workplace accommodations or temporary changes to workplace conditions (e.g., bathroom breaks, or sitting down), as compared with White respondents (41%). When Black mothers requested these accommodations, only 52% said their employer fully adjusted their job conditions. Twice as many Black mothers (14%) as White mothers (7%) said their employers failed to make any adjustment to their working conditions.

"I was not given paid leave by my employer, and I couldn't receive accommodations after giving birth, which caused me to lose my job."

"I also liked the part you asked about paid leave. I think women are always on the disadvantaged side because there's no time to properly recover. I think nationally something has to be done to address this, as it will reduce the effects of postpartum depression."

New Perspectives on the Black Maternal Health Crisis

Black Maternal Health Is Resistance, Resilience, and Joy

The *LTM* results illustrate Black mothers' complex, even contradictory views on trust, quality, and safety within the U.S. health care system. This nuance may reflect their trust in the health care system's *capacity* — advanced technology, highly trained providers, and wealth — but question the system's *commitment to protect* Black women and childbearing people. This is supported by the many responses expressing Black mothers' grave concern about whether they and their baby would survive childbirth.



History and experience have taught Black communities that they must stay vigilant and advocate for themselves, because the health system too often makes mistakes, ignores their concerns, and reflects entrenched biases. Black mothers have learned, from personal, familial, and vicarious trauma, that the health care system often fails to meet their needs, is not always equitable, and that its safeguards do not protect them equally.

Thus, Black communities have rallied and long resisted systems designed to harm Black bodies, while remaining resilient and joyful in the fight for autonomy and liberation.[13] Historically, Black communities have relied on internal support systems and mutual aid to bridge gaps left by public and private sectors. *LTM* reveals these throughlines by showing how Black women and communities are cultivating care networks that close inequities in maternal health care. Mothers highlighted the impact of community-based doula support and midwifery care, overcoming barriers and stigma to access mental health support, engaging in family and peer support, and practicing self-care.

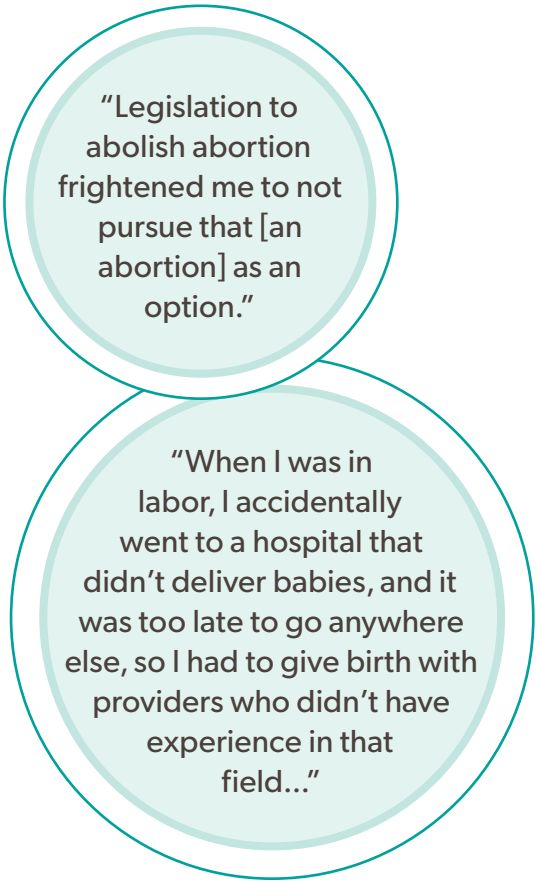
Community-based maternal health organizations and birth justice movements led by Black women and childbearing people have pioneered systemic reform to elevate community-centered, culturally congruent approaches. These models of clinical care and peer and professional support combat structural racism and institutional harm. **This is resilience in action.** However, what is often left out of the conversation is how this resilience is unaccounted for, invisible, and underpaid or unpaid labor, with Black women shouldering the brunt of this load, physically and psychologically, within their communities. Often, Black women balance the tension between joy as a means of surviving persistent trauma and joy as an inherent, unburdened human right.



Black birth joy — the act by Black childbearing people of finding a positive nourishment of self and others that is safe, healing, and rests mind, body, and spirit throughout the perinatal period, in response to the racialized and traumatic experiences they continue to encounter — is at the center of Black maternal health community solutions and must be a valued, prioritized, and adequately resourced component of maternal health strategies.[14]

A Confluence of Enduring Crises

The *Listening to Black Mothers* findings illustrate how longstanding structural inequities and current threats to maternal health, reproductive freedom, and economic security coincide in Black women's everyday experiences. **Addressing the Black maternal health crisis requires recognizing how these systems intersect and ensuring that progress in one area is not undermined by failures in another.** For example, Black mothers should not have to choose between their jobs and their health. Further, the states that have made the least progress on policies vital for maternal health, reproductive health, and families' economic well-being — such as states that have yet to expand Medicaid and states with severely low access to maternity care — are home to a disproportionate number of Black women.[15] Addressing and redressing the social and economic drivers of the Black maternal health crisis requires alignment and shared commitment to mothers, babies, and families across birth, reproductive, and economic justice movements.



New Directions of Inquiry for Black Maternal Health

Climate change and environmental impact.

Climate change, widely recognized as an environmental emergency threatening human health, is exacerbating the already large racial gap in maternal health outcomes.[16] Over one-third of Black mothers (34%) reported experiencing a weather-related disaster (e.g., extreme heat, severe storms, flooding) during pregnancy. Black women and communities of color face a disproportionate exposure and vulnerability to natural disasters, extreme weather events, and environmental pollutants due to historical redlining. Combating climate change, improving the built environment, and more comprehensive disaster management planning are overlooked ways to address the maternal health crisis, and more must be done.[17,18]



Multiracial Black birth experiences.

As the nation becomes more diverse, a larger share of the population identifies with more than one racial and/or ethnic group, raising questions about the experiences of Multiracial people in health care. Understanding the experiences of multiracial people can shed light on systemic and interpersonal discrimination within and outside the health care system, and the impact of being perceived as belonging, or not belonging, to a particular group, which can negatively impact health and well-being. For example, Pregnancy Mortality Surveillance System data from 2024 found that the pregnancy-related mortality ratio was nearly two times greater for non-Hispanic multiracial women compared with non-Hispanic white women.[19] We asked whether people felt discriminated against because of how others perceive their race, but we did not collect information on respondents' skin color to assess the impact of colorism within the maternity care system.

The Multiracial data were complex and inconsistent. Even so, we identified meaningful trends in respectful care, as noted above, and mental health, warranting further investigation. In alignment with prior studies,[20] multiracial Black respondents reported a higher prevalence of symptoms of depression and anxiety before pregnancy, during pregnancy, and postpartum, compared with both monoracial Black and monoracial White respondents. Despite reporting mental health conditions more often than Black participants, Multiracial Black respondents were less likely to have received mental health treatment (either counseling or medication).

Moving forward, maternal health research has much to learn by disaggregating Multiracial data to conduct more robust and valuable analysis of the growing Multiracial population.

Moving from Black Women's Experiences to Action

The *LTM* findings underscore that Black childbearing families are struggling in a health care system that was not built for them and that can be actively harmful. The challenges Black mothers describe are not individual failures — they are indicators of structural barriers that demand structural solutions.

Black women clearly told us not just what they need and what must be fixed, but which positive experiences are worth scaling and building on. We know the solutions that will improve the maternity care system for all.

Listening to Black Mothers: Priority Action Areas

1. Center Black women's safety, autonomy, and experiences in efforts to transform maternity care
2. Shift power and resources toward Black-led, community-rooted maternity care and workforce models
3. Close gaps in access to high-quality physical, mental, and behavioral health care and support for Black women
4. Hold policymakers and decisionmakers accountable for eliminating structural inequities in Black maternal health



PRIORITY 1 | Center Black women's safety, autonomy, and experiences in efforts to transform maternity care.

Maternity care settings must implement anti-racist practices and policies that establish accountability by integrating transparent, measurable respectful care quality metrics across clinical practice, hospital governance, and institutional evaluations.

Targeted Actions:

Respectful person-centered care is a core patient safety and quality standard. Federal and state policymakers, accrediting organizations, and health systems must recognize respectful, person-centered care as an essential component of quality, not a secondary measure of patient experience. Mistreatment, discrimination, coercion, and failure to respond to patient concerns are — and must be treated as — preventable medical errors and should be integral components of quality improvement and patient safety initiatives.

- **Measure and publicly report respectful care indicators that accurately capture Black women's experiences of care.** Health care systems should measure respectful care, mistreatment, and shared decision-making using validated tools (e.g., MIST,[21] PCMC-U.S.,[22] MADM,[23] and PREM-OB[24] scales). Make results publicly available so patients can make informed choices and systems are held accountable. Link scores to pay-for-performance models for providers and hospitals on measures related to respectful care.
- **Create standardized definitions of disrespectful care and establish reporting systems within health systems to document disrespect and ensure accountability.** Thorough follow-up, inquiry, and review must be conducted after reports of disrespectful care, and obstetric racism or violence must result in meaningful consequences, including, as appropriate, professional accountability, formal warnings and reprimands, financial penalties, license restrictions, and loss of hospital privileges. Individuals and communities harmed should be provided meaningful redress.
    - **In-hospital:** Congress should fund respectful maternity care compliance programs within hospitals to establish mechanisms for pregnant and postpartum patients to report disrespect or evidence of racial, ethnic, or other types of bias.
    - **Out-of-hospital:** State governments should establish confidential reporting systems unaffiliated with hospitals where patients and employees can confidentially report mistreatment and abuse and receive an immediate response in urgent cases of active mistreatment and abuse.

- **Mandate anti-racism training.** Health care professionals must complete anti-racism and implicit bias training as a condition to renew their professional license or certificate. Training must be required for all staff in maternity care settings, ongoing, and connected to accountability.

CONGRESSIONAL RECOMMENDATION

Pass the **Kira Johnson Act**, which provides funding to establish racism and discrimination trainings for maternity care setting staff and Respectful Maternity Care Compliance Programs within hospitals to provide mechanisms for pregnant and postpartum patients to report instances of disrespect.

Ensure maternity care providers meet the medical, legal, and ethical standards of informed consent. Meaningful informed consent requires that childbearing people have sufficient information about their healthcare options, in a form that is understandable to them, the chance to ask questions, and the opportunity to decide between options without pressure or coercion. Informed consent respects each childbearing person's right to self-determination, free from coercion, discrimination, criminalization, or unnecessary government interference. Childbearing people have the right to full bodily autonomy, to the best available information, and to protect themselves and their children from harm.[25] The post-*Dobbs* environment makes these protections even more essential to ensuring safe and ethical maternity care.

- **Ensure patients can exercise their right to informed refusal and eliminate the use of court-ordered processes to override patients, forcing them to undergo unconsented medical procedures.** The failure to explain the risks and benefits of an intervention or procedure, the use of opaque medical jargon, failing to present alternative options, paternalistic framing, and rushed decision-making timelines make it difficult for childbearing people to make informed decisions, including informed refusal.
- **Guarantee informed consent for medical students and trainees to engage in or observe care is met in practice, and respect patient preferences if the childbearing person refuses care or examination by a resident.**

STATE POLICY EXAMPLES

The **Colorado Momnibus**, signed into law in 2021, sets human rights standards in perinatal care, including for those who are incarcerated, and removes exclusion of pregnant people from advance directives.[26]

The **Michigan Momnibus**, if passed and signed into law, would require transparent reporting of obstetric violence, the collection of information on medical malpractice insurers' policies for perinatal care services, the protection of childbearing people in life-threatening situations, and would bolster civil protections.[27]

Apply anti-discrimination laws to protect childbearing people. Ensure anti-discrimination laws explicitly apply during pregnancy and childbirth, and that obstetric violence,[x,28] which can have elements of obstetric racism, sexism, and other forms of rights violations, is recognized as a form of discrimination.

Repeal and reverse fetal personhood laws at the state and federal levels. Fetal personhood laws override and ignore the constitutional rights of pregnant people. In practice, these laws are disproportionately enforced on Black communities, using surveillance and the threat of criminalization to impose criminal liability on pregnant people's health decisions and the essential care clinicians provide.[29]

PRIORITY 2 | Shift power and resources toward Black-led, community-rooted maternity care and workforce models.

Black mothers are expressing clear preferences for maternity care that offers greater choice, continuity, and cultural connection. They also reinforce the importance of Black-led and -centered organizations and birth centers that have pioneered culturally congruent, community-rooted approaches.

Targeted Actions:

Invest in community organizations as essential partners in maternal health.

- **Increase funding for and scale Black-led holistic care[30] initiatives with demonstrated success in improving Black birth outcomes.**
- **Remove administrative barriers for community-based organizations working to improve Black maternal health to access federal and state maternal health funding.** This includes eliminating costly financial audit requirements, burdensome data-tracking processes, and the lack of resources for administrative support.[31]

CONGRESSIONAL RECOMMENDATION

Maintain and increase funding for the Healthy Start Program, a community initiative funded by the Health Resources and Services Administration to reduce infant mortality in acute areas.

x Obstetric violence and obstetric racism are distinct yet interconnected forms of discrimination, systemic harm, and violence. "Obstetric violence" refers to the abuse, coercion (e.g., manipulation of consent), and mistreatment that perinatal people experience as perpetrated by health providers. "Obstetric racism" describes the mechanisms and practices Black people's reproduction is subordinated to that align with histories of anti-Black racism.

Invest directly in growing and sustaining the Black, evidence-based maternity care workforce. This includes midwifery care, continuity models, doula integration, collaborative practice, peer support, behavioral health integration, and other community-rooted services that improve maternal outcomes, patient experience, and health equity, particularly in areas affected by historical disinvestment and maternity care closures.

- **Expand the pipeline to train more Black midwives, doulas, perinatal community health workers, and other support providers through state and federal workforce programs.**
- **Address burnout and fatigue among Black doulas working in high-stress health care settings.** Black community-based doulas working within predominantly white-led medical institutions face institutional barriers and racialized experiences, emotional labor (e.g., vicarious trauma), occupational hazards, and the hidden emotional costs and fatigue of maternal health advocacy. Culturally specific retention strategies, including collaborating with community-based doula organizations, need to be explored and invested in by health systems to sustain the Black doula workforce.
- **Remove health coverage and payment barriers that prevent people from switching providers** (e.g., late-pregnancy cut-off policies, network restrictions, standards that discourage provider coordination, and delays in transferring medical records).

CONGRESSIONAL RECOMMENDATION

Support growing, strengthening, and diversifying the maternal health workforce by passing the following bills:

- **Mamas First Act** requires state Medicaid programs to cover doula and midwifery services.
- **Midwives for Maximizing Optimal Maternity Services Act** establishes new funding streams for midwifery education and increases diversity in the midwifery workforce.
- **Better Availability of Birth Centers Improves Outcomes and Expands Savings Act** requires Medicaid to establish a demonstration program to improve access to freestanding birth center services and would provide grants to cover start-up or expansion costs to expand birth centers in underserved areas.

Strengthen maternity care infrastructure in Black communities. Federal and state investments must address maternal health redlining,[xi] hospital and maternity unit closures, and geographic workforce shortages. This includes strengthening rural maternity services, community-based care, telehealth, and other innovative delivery models that improve access while preserving local capacity.

- **Require health facilities to submit equity impact assessments and enforceable mitigation plans to state governments before maternity unit closures.**
- **Invest in programs to improve the health care workforce diversity through low-interest grants, loan repayment programs, scholarships, and fellowships.**
- **Strengthen coordination of maternity care delivery between community-based perinatal providers and hospital settings (e.g., freestanding birth center-to-hospital transfer policies), at the state level, to facilitate Black mothers accessing culturally congruent and risk-appropriate care.**
- **Address fragmented care and eliminate gaps in continuity of perinatal care by investing in integrated care models, co-locating maternal and mental health care and strengthening referral networks between providers.**
- **Establish state recognition of all midwives** (Certified Nurse Midwife (CNM), Certified Midwife (CM), Certified Professional Midwife (CPM), and traditional midwives).
- **Ensure the survival and sustainability of Black-owned birth centers and community-based organizations (e.g., support reparative birth economy and capital) through state, federal, and philanthropic funding.**[xii,32] A reparative birth economy is one that intentionally directs financial resources and investments to heal historical and ongoing systemic harms — such as maternal health redlining, extraction, and exclusion — in Black communities.

CONGRESSIONAL RECOMMENDATION

Pass the **Perinatal Workforce Act**, which would require Health and Human Services to award grants to education and training programs to grow and diversify the perinatal workforce and would require the National Institutes of Health to study best practices for culturally and linguistically congruent maternity care.

xi Maternal health redlining is the intentional act of financially undermining and under resourcing maternal health care options in neighborhoods and communities (e.g., failing to expand Medicaid coverage through the Affordable Care Act, profit-driven relocation of health systems to serve wealthier, privately insured patients, provider shortages in low-income neighborhoods, and unreliable transportation to and from health facilities). This often disproportionately impacts the health outcomes of poor, minoritized, and/or marginalized communities.

xii Reparative Capital is a transformative approach to financing that seeks to rectify systemic inequities faced by marginalized communities. Combined with power building and narrative shifts, reparative capital challenges extractive financial systems.

STATE POLICY EXAMPLE

In **New York State**, the Health Equity Impact Assessment requirement compels health facilities to demonstrate the health equity impacts of a proposed project, including service closures (e.g., closing an obstetric unit); identify how the project affects access to and delivery of health care services; enhance health equity and contribute to mitigating health disparities in the facility's service area; and consider stakeholder input and health equity impacts.[33]

PRIORITY 3 | Close gaps in access to high-quality physical, mental, and behavioral health care and support for Black women.

LTM findings reveal important gaps between health care needs, obtaining coverage, and receiving timely, appropriate services. When Black mothers do receive care, too often their maternity care is shaped by institutional routines, instead of evidence or women's informed choices and preferences for labor, birth, and newborn care. These findings underscore the need for a system that provides comprehensive, culturally responsive care before pregnancy, during childbirth, and well beyond birth.

Targeted Actions:

Transform payment to sustain Black-led community-rooted care and support workforce sustainability. The payment, policy, and regulatory systems that undervalue and exclude Black and community-rooted providers and birth workers must change to ensure that the workforce reflects the communities it serves, and to provide culturally responsive, respectful care. Payment policies must fairly compensate the full maternity care team, including non-clinical providers like doulas and community health workers, and should reward and incentivize collaboration, continuity, prevention, and whole-person care.

- **State policymakers should ensure that Medicaid and private insurance cover doula support, all licensed midwifery care, community birth, and community health workers.**
- **Federal and state policymakers should mandate public and private insurance to reimburse midwives at 100% of the physician rate for identical services, including preconception, pregnancy, childbirth, and postpartum care.**
- **Federal and state policymakers should ensure that payment rates for Medicaid- and private-insurance-covered maternity care are sufficient to support high-quality care.**

Invest in payment reform that rewards quality over procedures. Payment models should incentivize prevention, continuity, shared decision-making, spontaneous birth when appropriate, interdisciplinary care, and improved maternal and infant outcomes rather than procedure volume. States should continue to innovate around different approaches to adopt value-based payment models for maternity care in Medicaid.[xiii,34]

Reduce unnecessary interventions through evidence-based guardrails. Health systems should strengthen clinical review processes, require documentation of medical necessity for commonly overused and/or low-value interventions, and promote informed decision-making to reduce unnecessary inductions, cesareans, and other interventions.

- **Establish payment incentives to avoid the unnecessary, non-beneficial use of procedures (e.g., cesarean sections, labor inductions, and episiotomies), and establish clear standards to ensure their use is supported by best evidence and prioritizes informed, shared decision-making and patient self-determination.**

Expand access to culturally responsive, community-based care. Payers and policies must support the full range of support and treatment options, including psychotherapy, psychiatric care, substance use treatment, peer support, community health workers, doulas, telebehavioral health, and care navigation.

- **Increase availability of community-based and peer support as the first line of support and prevention.**
- **Increase the number of Black mental health providers participating in Medicaid and other public and private insurance programs.**
- **Public and private health insurers should consider covering alternative behavioral health therapies, such as meditation or art therapy, which promote good mental health and patient choice in treatment options.**[35]

Address trauma and promote healing. Maternity care systems should recognize the effects of anti-Black racism (e.g., weathering[36]), birth trauma, and adverse experiences while expanding trauma-informed care, early relational health, dyadic models of care, and family-centered recovery services. This should also recognize the effects of historical and ongoing harms and support culturally grounded pathways to healing, resilience, and family well-being.

xiii The elimination of traditional "global" maternity billing codes and adoption of fee-for-service codes for pregnancy and postpartum services, effective January 1, 2027, will likely have implications for maternity-specific value-based care models.

- **Increase access to group prenatal care programs.** Specifically, health care providers and payers in collaboration with community health networks should scale group prenatal care programs led by midwives that are intentionally created by, for, and with Black people, and incorporate health, reproductive, and birth justice lenses. Ideally providing Black childbearing people access to a Black, midwifery-led care team, a built-in village of peer support, and wraparound social support.

- **Fund and expand the reach of Black perinatal peer support programs.**

Expand access to the providers and settings families choose. Payment and coverage policies should support hospitals, community health centers, freestanding birth centers, home birth when appropriate, telehealth, home visiting programs, and community-based providers, including doulas and community health workers.

Protect, restore, and expand Medicaid as the foundation of maternal health coverage.

- **Mitigate harm caused by the Republican budget reconciliation bill that guts Medicaid.** H.R. 1 will worsen maternal health care access concerns for all, and this is acute for Black women living in maternal health redlined areas. To mitigate harm and improve maternal outcomes, states must preserve optional Medicaid maternal health benefits (e.g., reimbursement for care provided by doulas and CPMs); allow midwives to practice at the top of their license; expand pathways to strengthen the peer support workforce; cross-train diverse care and support providers in maternal mental health, implementing a "no wrong door" approach; and improve obstetric emergency readiness across inpatient, outpatient, and non-obstetric settings.[37]

- **Remove Medicaid barriers that limit meaningful access to care, especially specialized care for pregnant people with comorbidities and/or complex health conditions.** Health plans should strengthen provider networks, reduce unnecessary administrative burdens, improve provider directory accuracy, minimize inappropriate prior authorization use, and ensure women can get timely appointments with qualified providers.

CONGRESSIONAL RECOMMENDATION

Build on the gains made under the Affordable Care Act by passing the **Health Equity and Accountability Act**, which aims to eliminate racial and ethnic health inequities by expanding access to culturally appropriate care; diversifying the health care workforce; removing cost and administrative barriers to coverage and care; increasing federal support for Medicaid and public health systems; addressing the social determinants; and more.

Ensure comprehensive coverage of the full spectrum of reproductive health services.

- **Remove barriers to obtaining health insurance coverage during pregnancy.** State policymakers should allow pregnant individuals to enroll in a marketplace health plan at any time.
- **Remove out-of-pocket costs for preconception care, including contraceptives and infertility treatment; labor-, childbirth-, and pregnancy-related labs; mental health; and postpartum visits.**

PRIORITY 4 | Hold policymakers and decisionmakers accountable for eliminating structural inequities in Black maternal health.

Black maternal health inequities extend far beyond clinical care. Historical disinvestment in Black communities has resulted in economic and social conditions that prevent Black childbearing people from achieving optimal health outcomes.

Targeted Actions:

Strengthen the economic and environmental conditions that allow families to thrive.

- **Establish paid family and medical leave as an essential part of the nation's maternal health infrastructure, alongside health coverage and clinical care.** Every family should have access to comprehensive, paid family and medical leave that supports healthy pregnancies, childbirth, postpartum recovery, caregiving, breastfeeding, parent-infant bonding, and maternal mental health without sacrificing economic security.
- **Close the wage gap.** Nearly 70% of Black mothers are key breadwinners for their families, which means their households rely heavily on their wages to make ends meet and get ahead. However, today, Black women in the United States are typically paid just 63 cents for every dollar paid to white, non-Hispanic men.[38]
- **State and local governments should investigate avenues to implement monthly financial supplements or universal incomes for low-income pregnant people through 12 months postpartum.**[39,40]

STATE POLICY EXAMPLE

Michigan secured funding in its final 2027 state budget to expand its Rx Kids program across Genesee County. The program provides qualified mothers with $1,500 during pregnancy, and an additional $500 a month for 12 months after their babies are born.[41]

CONGRESSIONAL RECOMMENDATION

Address America's paid family and medical leave crisis by passing the **FAMILY Act**. The act would create a comprehensive national program that meets the needs of working pregnant people and new parents through a shared fund that makes paid leave affordable for employers of all sizes and for workers and their families.

Pass the **Paycheck Fairness Act**, which would address wage discrimination on the basis of sex, which is defined to include pregnancy, sexual orientation, gender identity, and sex characteristics.

Pass the **Momnibus Act**, which addresses the drivers of maternal mortality, morbidity, and disparity across the country, including investments in social drivers of health that influence maternal health outcomes.

Decouple health care and policing to replace criminalization and family separation with compassionate care. People must be able to seek mental health and substance use treatment without fear of judgment, negative stereotyping, criminalization, or family separation.[42]

- **Replace punitive mandated reporting laws in health care settings with mandated supporting frameworks to connect patients with non-carceral resources and community-based services.**
- **End coercive, non-consensual drug testing and criminalization of substance use.** Prohibit routine, mandatory, or universal biologic urine drug testing without specific clinical indication or informed consent. These practices can produce false positives, do not determine substance use disorder, deter pregnant people from seeking care, and lead to disparate reporting of Black mothers to carceral systems.
- **State lawmakers should prohibit hospitals and state agencies from utilizing court-ordered interventions, child welfare threats, or emergency custody processes to override the informed refusal of pregnant patients.**
- **State and federal policymakers should ban unnecessary sharing of medical records and electronic data with carceral systems to investigate and prosecute people for their reproductive health care and pregnancy outcomes.**[43]

LOCAL POLICY EXAMPLE

The **Los Angeles County Mandated Supporting Initiative** aims to prevent children from experiencing harm from unnecessary involvement with the child welfare system; promotes holistic family well-being; and eliminates mandated reporting as a driver of racial disproportionality and disparity within the child welfare system.[44]

- **Mandatory inclusion of perinatal needs in all environmental health and emergency preparedness plans.**
- **Pass legislation that specifically addresses the risks Black women and childbearing people face from climate change.**
- **State and federal lawmakers should fund programs that address environmental determinants of maternal and reproductive health, including clean water infrastructure, air pollutant reduction, and restrictions on constructing hazardous facilities in Black communities.**
- **States should create public awareness campaigns for perinatal preparedness to inform and equip families.**
- **State and local governments, academic institutions, and national, state and local organizations should raise awareness about vital climate resilience among birth workers, and develop and distribute resources for them to share with families.**[45]

CONGRESSIONAL RECOMMENDATION

Pass the **Protecting Moms and Babies Against Climate Change Act**, which makes investments to reduce exposure to climate-change related risks to childbearing people and families, and the **Maternal Health Pandemic Response Act**, which would establish a federal task force to develop recommendations for safe, respectful, responsive, and empowering maternity care during public health emergencies.

Acknowledge the disproportionate burden communities of color, Tribal and Indigenous, and low-income communities bear from environmental injustices and climate change by passing the **Environmental Justice for All Act**. The act is rooted in the belief that all people have the right to pure air, clean water, and an environment that enriches life.

From Listening to Action

For decades, Black maternal health care and support providers, scholars, advocates, mothers, and childbearing people have pioneered the frameworks and care models needed to navigate, transform, and rectify a health care system built on a pervasive history of gendered racism. *Listening to Black Mothers* highlights that our maternal health care system continues to fail Black childbearing people and their families, who frequently lack access to essential, respectful care, support, and services they want and need. At the same time, Black women carry the responsibility of being primary breadwinners and caregivers in a country that has historically and actively bypassed and divested resources from their communities, creating persistent barriers that affect their health and well-being before, during, and after pregnancy.

The problems are clear and so are the solutions. Across *Listening to Black Mothers*, respondents shared the resilient solutions they have turned to in response: solutions that require urgent investment, collective action, accountability, and political engagement to scale and build upon. **What is missing is not evidence; it is the collective commitment to act.**

To liberate Black births means moving beyond crisis-oriented narratives to dismantle oppressive systems and actualize the cross-sector goals of birth and reproductive justice movements so **Black women and childbearing people have the ability to thrive, not just survive**. To truly transform Black maternal health experiences and improve the Black childbearing experience, our institutions must prove that we are all listening to Black mothers.

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