# Being Black and pregnant in the Deep South can be a dangerous combination

December 13 2023, by Lauren Sausser, KFF Health News

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O'laysha Davis was a few weeks shy of her due date when in mid-August she decided it was time to switch doctors.

Davis had planned to give birth at a small community hospital about 20 minutes from her home in North Charleston, South Carolina. But that changed when her medical team started repeatedly calling her cellphone and pressuring her to come to the hospital and deliver the baby.

Davis said she'd told her doctor on more than one occasion that she was opposed to inducing labor early. Eventually, she reached her wits' end.

"It was ridiculous," said Davis, 33. "I don't feel heard most of the time. I feel like it's their way or no way, you know? Like you don't have a choice."

Davis had given birth twice before and knew from experience that Black women, like herself, and their infants face higher health risks during pregnancy and childbirth. In 2021, Davis lost a baby in the womb after a dangerous pregnancy complication in her first trimester.

"I was very fearful that the same thing would happen," Davis said when she found out in late 2022 that she was pregnant again.

Her fears weren't unfounded. Across South Carolina, Black infant and maternal deaths are troubling. About an hour and a half northwest of Charleston in Orangeburg County, the infant death rate was the highest in the state in 2021. Higher, in fact, than it was 50 years earlier in 1971, according to data KFF Health News obtained via a Freedom of Information Act request from the state health department. All but one of the 17 infants who died in 2021 in Orangeburg was Black.

Statistics like this scared Davis. But it was a horror story out of Georgia that really caught her attention: In July, a Black infant was decapitated during delivery by an obstetrician who allegedly used excessive force. Davis was eight months pregnant when the news broke.

"Something's terribly wrong," she recalled thinking.

## 'Moving in the wrong direction'

Being Black has always been dangerous for pregnant women and infants in the South. The origin story of modern reproductive medicine can be traced to experiments conducted on Black enslaved women in Alabama during the 1840s by physician J. Marion Sims, the so-called Father of Gynecology, who subjected his patients to painful pelvic surgeries without anesthesia and drugged them with opium.

Sims, a native South Carolinian who is memorialized on the Statehouse grounds in Columbia, is credited with inventing an early version of the vaginal speculum, which he designed after probing an enslaved woman named Betsey with the bent handle of a spoon.

Fast-forward nearly 200 years, following a legacy of systemic discrimination that has prevented some Black families from getting health care: Poor outcomes for Black women and babies across the United States are alarmingly high compared with white patients.

These problems aren't unique to the South. In places such as Kansas, Arizona, and Wisconsin, for example, Black infants die at more than double the rate of white babies. In Flint, Michigan, where more than half of residents are Black, the infant mortality rate for all babies in 2021 exceeded the rate in any Southern state.

But in Deep South states like South Carolina, Louisiana, and Mississippi, infant mortality rates in rural counties, especially for Black babies, often resemble those in much poorer parts of the world.

Things are poised to get worse. More than one year after the U.S. Supreme Court issued its decision in Dobbs v. Jackson Women's Health

Organization, allowing state legislatures to outlaw abortion, most states in the South have passed either full or partial bans. Both research and preliminary data suggest this will further jeopardize Black women and babies.

In 2021, 42% of all reported abortions in the United States were obtained by Black women, accounting for a larger share than any other race, according to KFF data. And more than half of all Black Americans live in the South, where many of the country's strictest abortion policies were enacted this year and last.

Already, birth rates in states that banned or restricted access to abortion have increased since the Dobbs ruling. State-level abortion bans will undoubtedly prove fatal for some people, particularly Black women and children, who are more likely to die before, during, and after childbirth than white women and children.

"There is so much anger," said Kelli Parker, director of communications and marketing for the nonprofit Women's Rights and Empowerment Network. "This type of legislation uniquely impacts women of color and other historically marginalized groups."

In Texas, for example, infant mortality data from the Department of State Health Services shows the number of babies who died during their first year of life significantly increased after lawmakers passed a six-week abortion ban in 2021, according to data obtained by CNN through a public records request.

In Texas, Black babies die before their 1st birthday at a rate more than twice that of white infants. That's because the health of the mother often translates to the health of the infant, and Black women face much higher pregnancy risks, such as high blood pressure, stroke, and hemorrhage.

In South Carolina, where the state Supreme Court upheld a ban that outlaws abortion if fetal cardiac activity can be detected, non-Hispanic Black infants are also more than twice as likely to die during their first year than non-Hispanic white infants. And the state's Black infant mortality rate increased by nearly 40% from 2017 to 2021.

Meanwhile, non-Hispanic Black women in South Carolina experienced a 67% higher pregnancy-related mortality ratio compared with their white counterparts in 2018 and 2019, according to the latest data from the state's Maternal Morbidity and Mortality Review Committee.

"We have a lot of work to do," said Sarah Knox, senior director of policy and advocacy at the nonprofit Children's Trust of South Carolina. "Unfortunately, our latest data shows we are moving in the wrong direction."

Most states haven't released infant and maternal death data that reflects the impact of the Dobbs decision. But maternal health experts aren't optimistic.

A KFF survey conducted this year of 569 OB-GYNs found that most doctors reported the Dobbs decision has worsened pregnancy-related mortality and exacerbated racial and ethnic inequities in maternal health.

But Dobbs isn't the only factor. Across the South, public health experts point to a confluence of things: the closure of rural hospitals, the scarcity of doctors and midwives, the pervasiveness of obesity and chronic disease, and many states' refusal to expand Medicaid under the Affordable Care Act.

In many cases, though, the intersection of poverty and structural racism in medicine is to blame for the deaths of Black women and their infants.

A KFF survey released this month found Black patients regularly said their health care provider assumed something about them without asking; suggested they were personally at fault for a health problem; ignored a direct request or question; or refused to prescribe them pain medication they thought they needed. More than half of all Black respondents also said they prepare to visit their health care provider by expecting insults or by being very careful about their appearance—or both.

"People are tired of being bullied by their providers," said Tiffany Townsend, a midwife and the owner of De la Flor Midwifery in Columbia, South Carolina.

In the KFF survey, Black women reported the highest rates of unfair treatment, with 1 in 5 saying a health care provider treated them differently because of their racial or ethnic background. And about twice as many Black adults who were pregnant or gave birth in the past decade said they were refused pain medicine they thought they needed compared with white adults.

The nation's Black maternal mortality rate is almost three times as high as the rate for white women. Townsend, one of the few Black midwives practicing in South Carolina, said that's because doctors often ignore their patients' complaints until it's too late.

## 'Using their voice'

In March 2012, Kim Smith was about 22 weeks pregnant when she felt an "unbelievable pain" in the upper-right side of her abdomen. She was immediately admitted to a hospital in Lexington, South Carolina, where she was diagnosed with HELLP syndrome, a severe case of a pregnancy condition called preeclampsia, which is marked by high blood pressure. She'd been tested for preeclampsia a few weeks earlier and the results were negative.

While the preeclampsia rate is much higher among Black women than white women, the diagnosis still came as a shock to Smith, who liked to run, taught aerobics classes in college, and thought of herself as a healthy person. She hadn't considered the possibility of a high-risk pregnancy.

"I was placed in a wheelchair and rushed to get an ultrasound," she remembered after arriving at the emergency room. The first ultrasound showed a faint heartbeat, but within a few minutes, it had stopped. Smith was prepped for labor and delivery, but it was too late. The baby she had named Lauren Kelly didn't survive.

More than half of all 516 fetal deaths reported that year in South Carolina were linked to Black mothers.

The loss of her daughter devastated Smith. She has since given birth to three boys and channeled the pain of her first pregnancy into the development of a patient navigation app called "Lauren," which she hopes will be used to spare other women from a similar loss.

The app is designed to allow pregnant and postpartum women to track their stress levels and vital signs, including their blood pressure, and to automatically relay those readings to their physicians. While not a diagnostic tool, Smith intends for the app to empower patients with real-time information so they can identify potential problems early and use it to advocate for themselves.

"You have to use your voice. You have to speak up," said Smith, who wants the Lauren app to be made available free to pregnant women enrolled in Medicaid. "I'm still finding that people are not using their voice when they go into the doctor's."

## New research

Across the South, researchers are trying to identify solutions to improve health outcomes for mothers and babies. "Nothing seems to be moving the needle," said Joseph Biggio, a maternal-fetal specialist at Ochsner Health in New Orleans.

The National Institutes of Health recently awarded Ochsner Health and its partners a $16.5 million grant to establish the Southern Center for Maternal Health Equity to address Louisiana's high maternal mortality rate. Part of that research will involve finding ways to deliver care in rural parts of the state where hospitals have closed, high-risk specialists don't exist, and pregnant women are disproportionately Black.

Biggio said the new research center will also compare birth outcomes in Louisiana to those in neighboring Mississippi, where infant and maternal mortality rates are the highest in the country, according to the Centers for Disease Control and Prevention.

A key difference between these two Deep South states: Lawmakers in Louisiana have expanded access to the Medicaid program under the Affordable Care Act, while lawmakers in Mississippi haven't.

Women in most states who qualify for Medicaid during pregnancy are also covered for 12 months after they give birth. But every year, many childless women in Southern states are not eligible for the low-income health insurance program until they become pregnant. Medicaid expansion, as it was designed under the Affordable Care Act, would fill this gap by loosening eligibility restrictions, but most states in the South haven't adopted the expansion.

Some health care policy experts believe that covering women before they become pregnant and between pregnancies would reduce the burden of obesity, diabetes, and hypertension, and the risks those conditions pose to women and infants.

Tracking long-term improvement is crucial because success won't be achieved overnight, said John Simpkins, president of the North Carolina-based MDC, a nonprofit focused on improving racial equity and economic mobility in the South.

"If we're talking about population health improvements, then really the intervention should be beginning with kids who are being born right now, and following them through adulthood, and then probably their kids," Simpkins said. Medicaid expansion, for example, could raise families out of poverty, but those benefits might not be realized for another generation, he said.

"I've found that the things that work the most are sustained investment over time," he said.

But this work isn't relegated to the South. In the majority-Black city of Flint, Michigan, for example, researchers are poised to launch in 2024 a multiyear project called Rx Kids to determine if direct, unrestricted cash payments to pregnant women and new moms improve birth outcomes.

"This is standard in other countries. This is common, basic sense," said Mona Hanna-Attisha, a pediatrician and the associate dean of public health at the Michigan State University College of Human Medicine, who is leading the Flint research.

Poverty tends to peak just before a woman gives birth, she said, and the project in Flint will attempt to offset that hardship by offering every woman in the city who becomes pregnant, regardless of race, a payment of $1,500 at the halfway point of her pregnancy and then an additional $500 a month during the first year of her infant's life, for a total of $7,500.

"This is designed to address this critical window, both economically and

neurodevelopmentally," Hanna-Attisha said. "It's fundamentally how we are supposed to take care of each other. And it is not revolutionary."

## 'Extra bad for black women'

Back in Charleston, the first seeds of concern had been planted during the first half of O'laysha Davis' pregnancy when, she said, an OB-GYN prescribed a drug to control high blood pressure. She'd declined to take it—against her doctor's guidance—because her blood pressure is normally "up and down," she said. It wasn't unusual for her reading to be high at the doctor's office and normal at home, a common phenomenon known as "white coat hypertension."

But high blood pressure during pregnancy, if left untreated, can be fatal for moms and babies. Along with medication, Davis' doctor recommended delivering the infant a few weeks before her due date to avoid complications.

It wasn't necessarily bad medical advice, but Davis feared the risks associated with inducing labor early, knowing that babies born after 39 weeks of gestation are generally healthier.

"I'm not getting an induction. Don't schedule me," she told the doctor.

Her OB-GYN scheduled one anyway. But on the morning of the scheduled induction, Davis received mixed messages from the hospital. First, there wasn't a hospital bed available, so they told her not to come in. Later that day, though, in phone calls to Davis and her emergency contact, they advised that she come in immediately.

Finally, Davis said, she lost trust in her medical team. Compelled to find someone who would listen, she Googled the names of midwives in Charleston.

Davis reached midwife Nicole Lavallee by phone.

"I have the same conversation multiple times a week," Lavallee said, with women who feel their medical team has stopped listening to them. "It's extra bad for Black women."

Lavallee connected Davis with a doula, then helped her make an appointment at another birthing hospital in Charleston.

Davis avoided an induction. She felt the first pains of labor at home and then delivered her baby—a girl named Journee Divine—on Aug. 31, a few days shy of her due date, at the Medical University of South Carolina.