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Black Mamas Matter: State Maternal Mortality Review Committees and the Reproduction of Race

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Abstract

The maternal mortality ratio (MMR) in the United States has doubled over the past three decades, representing a crisis in maternal health. The overall death rate obscures the reality that Black mothers are significantly more likely than white mothers to experience severe morbidity and death while pregnant, birthing, and during the postpartum period. Research demonstrates that obstetric racism operates as a core contributing factor to high and racially disparate MMRs in the United States. In response, states have legislated the creation of maternal mortality review committees to review mortality cases, determine causal factors, and make recommendations to reduce the rate of maternal deaths. This research examines the extent to which these committees acknowledge and address obstetric racism in their annual reports and recommendations. The analysis reveals that only three of 51 review committees comprehensively address obstetric racism, and the remaining committees vary in their commitment to birth equity. By reducing high mortality rates to patient-level factors, these state actors absolve health care providers and delivery systems of their role in the deaths of Black mothers while also reproducing controlling stereotypes of Black mothers.

Keywords: birth justice, reproductive justice, motherhood, maternal mortality, racism

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> There is a crisis in [B]lack women's maternal health care … we don't want to think that these things have anything to do with professional or institutional failings. We'd rather think of the doctors and hospitals as knights on white horses, riding in to save women and infants from enemies with mysterious names like preeclampsia or venous thromboembolism. But if lives are to be saved, we must listen to and face hard truths. (Oseguera et al., 2018, p. 12)

Birth Justice, Obstetric Racism, and the Maternal Mortality Crisis

The maternal mortality ratio in the United States exceeds that of every other high resource nation; it is one of only three nations across the globe in which the maternal mortality ratio is increasing, nearly doubling over the past three decades (Centers for Disease Control, 2019). While the United States reports 19 deaths per 100,000 live births, European ratios fall below 10, with many nations reporting under five deaths, and countries like Norway and Italy reporting only two maternal deaths per 100,000 live births (World Health Organization, 2019). In the United States, the overall maternal mortality rate obscures that Black women are significantly more likely to die from pregnancy-related causes. According to the Centers for Disease Control and Prevention (2020), Black (37.1 deaths per 100,000) and American Indian/Alaskan Native (AI/AN) women are three times more likely to die of pregnancy-related causes than are white (14.7 per 100,000) women, a disparity that grows even wider with age. In some cities, the disparity further widens, with Black maternal death rates up to 12 times higher than white women (Howell, 2018). Racial-ethnic inequities also vary across states; for example, Arizona reports 70.8 AI/AN maternal deaths per 100,000 live births compared to 22.4 for Hispanics and 17.4 for white women (Cabasag et al., 2019). The CDC (2020) acknowledges that at least two-thirds of the 700 maternal deaths each year in the United States are preventable.

Responding to this public health crisis, numerous states have implemented maternal mortality review committees (MMRCs), most commonly housed in state health departments, seeking to identify the factors contributing to maternal death and promoting recommendations and interventions. Established and well-known organizations such as Sister Song, Black Women Birthing Justice, and the Black Mamas Matter Alliance have already researched, identified causal factors of racial disparities, and proposed recommendations to reduce maternal mortality. Yet, instead of looking to these experts, federal and state governments are turning to MMRCs, comprised largely of health care providers, to craft implementable recommendations that generate impactful outcomes.

Because maternal mortality rates in the United States are racialized, and the rise in maternal death in many states is largely explained by an increase in Black mothers dying, MMRCs must consider the impact of obstetric racism as a central part of their work. *Obstetric racism*, defined by Davis (2019) as the racism experienced during maternal healthcare processes, comes in many forms, including "critical lapses in diagnosis, being neglectful, dismissive, or disrespectful; causing pain; and engaging in medical abuse through coercion to perform procedures or performing procedures without consent" (Davis, 2019, p. 562).

This research utilizes a birth justice framework to examine the extent to which MMRCs consider and examine obstetric

racism as a central contributing factor of maternal death for women of Color. Highlighting obstetric racism as a driver of maternal morbidity and mortality, the *birth justice framework* extends the reproductive justice model and focuses specifically on the birthing process, arguing that pregnant individuals have the right to safe and dignified birth (Oparah, 2016). More broadly, *reproductive justice* (R. J.) is an intersectional, theoretical, and methodological framework first mapped out by an alliance of Black women, including the widely influential scholar and activist Loretta Ross, in 1994. Three core values guide reproductive justice—the right to have a child, the right not to have a child, and the right to safe and dignified parenting (Ross & Solinger, 2017, p. 65). The birth justice framework advances the notion that "Black Mamas Matter" and provides key theoretical concepts and analytic tools for exploring the extent to which reports and recommendations of MMRCs comprehensively acknowledge, address, and intervene in obstetric racism.

Explaining Racial Inequality in Maternal Mortality

The fact that United States maternal death is disproportionately distributed across the population has been discussed by the lay press and medical and social science literature. In 2019 and 2020 alone, *New York Magazine*, *Glamour Magazine*, National Public Radio, and *Good Morning America*, amongst a host of other news media, covered racial disparities in maternal death rates. Alongside these lay presses, biomedical and social science scholarship investigate racial disparities in maternal death, searching for causal factors from preconception to postpartum. This body of scholarship attributes racial disparities in maternal illness and death to multiple factors, ranging from patient-level to systems-level explanatory factors and mechanisms.

Patient-Level Factors

It is customary practice to attribute racial disparities in maternal mortality to Black mothers' deficient bodies and behaviors. This fallacious view is inseparable from the historical legacy of obstetric racism in the United States (for an overview, see Ross & Solinger, 2017, and Solinger, 2005). From J. Marion Sims' early obstetric experiments conducted on enslaved women to the 2020 allegations of coerced sterilization of Black, Latinx, and Indigenous women under carceral control, dark bodies have systematically been deemed unfit for motherhood (see Bekiempis, 2020, and Ross & Solinger, 2017). Within this dominant narrative, Black women's higher rates of preconception chronic illness and their higher rates of certain types of hemorrhage, preeclampsia and eclampsia, gestational diabetes, and hypertension are all identified as primary medical causes of maternal mortality. Patient-level factors such as advanced maternal age, drug abuse, poor nutrition, lack of knowledge, and failure to seek early and regular prenatal care are attributed to be causes of mortality.

Societal-Level Factors

Social scientists have critiqued the "mother blame" discourse in which MMR explanations are entrenched, revealing how environmental factors, including racism, can lead to chronic illnesses that heighten the risk of maternal morbidity and mortality. Social and anthropological perspectives highlight that the chronic stress of living in racialized environments and interacting in racist institutions maps onto the bodies of women of Color, regardless of class and

level of education. This work often builds upon Geronimus' (1991) well-known *weathering hypothesis*, in which cumulative social and economic disadvantages are shown to lead to accelerated aging and an early deterioration of health in Black women. Evidence of weathering due to social inequality has also been shown to impact Mexican-origin women, especially those U.S.-born (Fishman, 2020; Wildsmith, 2002) and AI/AN women (Fishman, 2020). The low socioeconomic status of women of Color, which causes toxic stress, is argued to play a large role in the weathering process. However, studies demonstrate that disparities in the MMR persist even for high-status women of Color and for Black women with advanced degrees (Petersen et al., 2019). Thus, while health care delivery systems are often conceptualized as lifesaving in studies on maternal mortality, birth justice studies reveal that health care provider (HCP) factors are part of the system of power that shapes Black women's birth trauma, survival, and death.

Obstetric Racism

Provider racism in health care has been well-documented. In a literature review (Maina et al., 2018) on implicit bias amongst health care practitioners, 31 of 37 studies found racial bias. Paradies et al. (2014) also found evidence of HCP across 26 of 37 studies examined in their review of provider racism. *Obstetric racism* involves the racism that emerges specifically during medical encounters relating to women of Color's reproductive health (Davis, 2019). Davis explains, "Obstetric racism lies at the intersection of obstetric violence and medical racism" (2019, p. 561). In light of the history of race-based obstetric violence against women of Color, scholarship must consider the significance of HCP racism in obstetric care. Along these lines, Valdez and Deomampo (2019) have urged scholars to center race and racism in reproduction scholarship. Neither patient-level nor societal-level models explain why Black and AI/AN women are more likely than white women to die of pregnancy disorders (Petersen et al., 2019). They also do not explain why racial disparities in maternal outcomes persist even when controlling for education and income. Centering race and racism opens the research on MMR to considering how obstetric racism produces birthing inequities.

To understand the persistence of racial inequality in MMR, a growing body of scholarship examines how, within the biomedical model of maternal care, health care provider racism during prenatal, birth, and postnatal care operate as an additional social determinant (Bridges, 2011; Morton et al., 2018; Oparah & Bonaparte, 2016; Oparah, 2016). Given that many pregnant individuals gestate in chronically stressful environments, prenatal care providers must provide supportive environments for their patients. Contrarily, research demonstrates that pregnant individuals of Color enter into what Colen (1995) terms a *system of stratified reproduction* in which they are condescended, assumed deviant, and provided with culturally inappropriate, substandard care. Systems of stratified reproduction exacerbate stressors that impact women's reproduction (Valdez & Deomampo, 2019; Oparah et al., 2018).

Davis (2019) analyzes the birth stories of U.S. Black women and finds that obstetric racism is woven throughout prenatal and postnatal medical encounters and that these racialized experiences link to stratified maternal outcomes. Obstetric racism increases women's stress and discourages early and regular prenatal care. Bridges' (2011) fieldwork in a public hospital in New

York highlights how social workers and medical experts socially construct the behaviors that they expect to see in Black mothers who are Medicaid recipients. For example, bureaucratic streamlining of services for mothers on public insurance, social workers often purposely misrecorded mothers' eating behaviors as deficient to receive the supplemental nutrition benefits (i.e., food stamps). Beyond this tracking of constructed maternal "bad" behavior, heightened surveillance of Medicaid recipients also means that prenatal behaviors are surveilled and scrutinized in ways that their affluent, white counterparts are not (Bridges, 2011).

In the third wave of the *Listening to Mothers* survey, one in five Black and Hispanic women reported racial-ethnic discrimination in their maternal care encounters (Declercq et al., 2013). Interviews with Black women similarly identify four practices commonly deployed by medical staff that contribute to strained and stressful relationships (Oparah et al., 2018). The themes identified were: (a) the refusal of HCP's to listen to women's concerns and knowledge about their own bodies, (b) the lack of respect for women's boundaries, (c) stereotyping, and (d) the suppression of self-advocacy.

Racial and ethnic inequalities in severe maternal morbidity (SMM) further highlight the role of provider racism. Leonard et al. (2019) find that SMM is higher amongst Black women and lowest in white women, and these inequalities persist even after controlling for patient-level factors. Authors suggest that institutionalized racism, including within health care delivery systems, is likely implicated and that there is a "need for initiatives that specifically target maternal health inequalities" (p. 7). While some initiatives have curbed maternal mortality rates overall, race disparities remain substantial (Leonard et al., 2019, p. 35). Obstetric racism explains this remaining disparity, explaining why Black women die of pregnancy-related disorders that white women do not. In her foreword to *Battling Over Birth* (2018), sociologist Christine Morton shifts the discussion away from the pathological Black mother and toward the health care industry. She writes, "We need to know more about the training and attitudes of clinicians who care for [B]lack women during their pregnancies, how they interact with [B]lack women and their families, and how these factors affect outcomes" (2018, p. 5). This paper explores the extent to which maternal mortality review committees consider the health care industry.

Study Design & Background: The Rise of Review Committees to Address MMR

In 2020, The Centers for Disease Control and Prevention launched the *Hear Her* Campaign, urging individuals, families, and health care providers to listen when pregnant and postpartum women report symptoms of pregnancy-related complications. While the campaign takes a colorblind approach, they, along with The American College of Obstetricians and Gynecologists (ACOG), have encouraged all states to implement MMRCs and examine system failures as they impact maternal health. At both federal and state levels, several review committees have been formed to study maternal mortality and design initiatives to reverse trends in maternal mortality. MMRCs are tasked with investigating state-level maternal mortality rates, their causes, preventions, and developing implementable recommendations for averting future death. Many of these committees' partner with ACOG through the broader national collaboration of

organizations, the Alliance for Innovation on Maternal Health (AIM). AIM works through MMRCs to implement initiatives that intend to curb maternal death.

This is true regarding Black maternal mortality, with many committees dedicated to improving birth outcomes for Black mothers. While Metz (2018) shows that such committees can effectively collect data, assess the preventability of maternal death, and create recommendations for curbing maternal death, the extent to which these committees' efforts translate into impactful practices that reduce maternal death is unclear—it is not apparent that the formation of such committees and initiatives has been effective. For example, in an early study of maternal mortality state-level committees (1938–1978), states with committees showed smaller declines in maternal mortality rates (Grimes & Cates, 1977). Further, in some states such as California, initiatives appear to reduce overall maternal death, yet racial disparities persist (Oparah et al., 2018).

Because obstetric racism produces negative outcomes for obstetric patients, initiatives must interrupt stratified reproduction directly and address how health care providers and hospital policies operate as core drivers of maternal morbidity and mortality disparities. As birth justice research highlights, there is a significant need for initiatives that address deep-rooted maternal health inequalities. If maternal mortality committees and initiatives do not address racial inequality, their ability to curb maternal mortality inequality between white and Black pregnant and birthing individuals is limited. This research inquires whether MMRCs: (a) acknowledge or address racial inequality in their states, (b) acknowledge or address obstetric racism, and (c) advance recommendations specifically intervene in practices of obstetric racism.

The output of MMRCs constitutes a discursive formation surrounding Black maternal death that influences health care delivery systems and the practices of obstetric providers within these systems. This research involved creating a large database of MMRCs and their work in all 50 states and Washington, DC. The data were discursive—including legal documents, full committee reports, websites, and info sheets. I coded these documents in two waves, using the research questions as a framework of analysis. I examined each committee in-depth, noting its year of formation, whether or not it was formed by statute, the number of seats it included, and the stakeholders included in each committee. I examined and coded the reports and recommendations of MMRCs in every state and explored the extent to which they directly and comprehensively addressed racial inequality in maternal mortality. I specifically focused on obstetric racism and looked for recommendations that directly addressed how race shaped the missed opportunities for diagnosis and treatment of maternal morbidity.

All 50 U.S. states and Washington, DC have a maternal mortality review committee or are in the process of implementing a committee at the time of this research. Beyond this, states varied widely in noticeable ways—whether or not their committees were appointed by legislation, the amount of funding they receive, how often they meet and publish reports, their access to medical information, and their ability to oversee and implement actionable initiatives—were all points of differentiation. In the following section, I highlight findings germane to the research questions, specifically addressing the extent

to which committees acknowledge obstetric racism as a driver of racial inequality in maternal mortality and how states generated initiatives and recommendations that specifically address obstetric racism. As opposed to addressing the findings of each state MMRC, I highlight themes that emerged throughout the process of coding and offer examples from different state MMRCs as relevant.

Findings

State MMRCs and the Reproduction of Race

Coding and analysis of reports, related legislation, and informational materials of 51 MMRCs, revealed that only two states—California and New York—and Washington DC directly addressed obstetric racism in their stated goals, reports, and recommendations. These MMRCs stand as models of commitment to reducing racial disparities in maternal mortality and highlight three strategies for reducing maternal mortality.

Obstetric Racism as a Driver of Maternal Mortality

First, these three committees acknowledge that it is necessary to center Black women as the leading experts on Black women's prenatal, birthing, and postpartum experiences. As Collins (2005) argues in regard to the mainstream feminist critique of motherhood, knowledge produced without the critical standpoint of Black mothers is likely to be limited in its impact and usefulness in the lives of Black mothers. Each of these committees includes Black doulas and midwives, as well as community organizations that advocate for and work with Black pregnant individuals. In New York, Dana Ain-Davis, a trained doula and the anthropologist who coined the term "obstetric racism," serves the MMRC. The Washington, DC MMRC, still in its early phases of organization, opens its meetings to the public and includes a diverse array of stakeholders on its committee. Along these same lines, the New York MMRC recommends equitable reimbursement for midwives, and if implemented by New York Medicaid, this would enable Black women to seek out Black midwives for their care. The California MMRC regularly hosts webinars and information sessions led by community and non-profit organizations that serve Black and Latinx individuals and families.

Second, both New York and Washington, DC have integrated implicit-bias training for health care providers into their recommendations (in DC, it is mentioned in the legislative statute). While the effectiveness of these trainings is debated, for this research, it is important because it demonstrates a shifting of MMRCs' focus from patients to providers. New York MMRC recommends comprehensive implicit bias training for providers and hospital staff that is attached to incentives. These trainings are coupled with numerous other strategies that directly address the differential treatment received by Black women in medicalized birthing settings. New York also suggests loan forgiveness for HCPs from underrepresented groups who work in maternal health for three years, ideally, to reduce the biases experienced by Black pregnant and birthing individuals.

Third, these states recommend evidence-based strategies that remove biases from the process of treating women with symptoms of pregnancy-related disorders. In California, which stands as a model in quality prenatal care and the only state to

radically reduce maternal mortality rates, the focus is on provider and hospital training, not on patient control and surveillance. By combining checklists, protocol, and the integration of safety bundles into hospital care, California has taken actionable steps to ensure hospitals address life-threatening pregnancy disorders such as hemorrhage. Referred to as the CMQCC model, California has pioneered free and easy-to-access evidence-based toolkits as resources for providers. Each toolkit contains resources on specific disorders of pregnancy and specific information on racial and ethnic disparities. CMQCC has facilitated the implementation of "safety bundles" in hospitals to ensure that providers have life-saving medical supplies needed for obstetric hemorrhage and preeclampsia. Hosting webinars on birth equity and quality care for all women, they also supply public-facing materials for pregnant individuals with information on "How to avoid a C-section if I don't need one" and tips on avoiding hospitals with high rates of cesarean surgeries (CMQCC, 2020)—these surgeries are known to increase the risk of maternal death. While the racial disparity in birthing outcomes has not been entirely eliminated, California has seen a 55% decline in maternal mortality (CMQCC, 2020). The New York MMRC recommends using the same model to providers across the state.

In both states and DC, reducing racial disparities in maternal mortality is central to the initiative. Each recognizes racial disparity and recognizes that obstetric racism is an explanatory factor. While it is true that many state MMRCs recognize racial disparity, their reports and recommendations do not include provider racism as an underlying factor. In sharp contrast to the MMRCs just discussed, the Arizona MMRC, where the death rate for AI/AN mothers is 70.8 per 100,000 births, invests publicly funded dollars in seatbelt awareness campaigns and admonishes mothers for their supposed resistance to medical advice. What are MMRCs similar to Arizona's reporting and recommending regarding maternal mortality?

The Other 48 MMRCs

The most recent report issued by the MMRC of Maryland revealed a rate of 44 deaths per 100,000 births for Black women during the 2013–2017 review period. More than three times greater than the rate of white maternal death (11.8), it is astounding that their report did not discuss the underlying causes of this inequity. Comprised entirely of medical doctors, who failed to reflect upon their own practices, the panel did not report that it considered or attributed maternal death to any provider-related causes. The Maryland MMRC exemplifies the overall findings of this research: through their work, state MMRCs build a discursive formation surrounding maternal mortality that reproduces racist ideologies about Black women. This formation is not evidence-based but instead relies upon dominant ideologies that demean and blame Black women as the cause of their own suffering. While it is outside the scope of this research to examine the history of controlling images of Black women, it is important to note that at the center of these images is the stereotype that Black mothers are unconcerned with the wellbeing of their children—they are simultaneously (and contradictorily) viewed as welfare-reliant, scheming but also stupid, promiscuous, and belligerent (see Bridges, 2011; Collins, 1990, 2005). In this way, most state MMRC reports perpetuate controlling images of Black women, dangerously couching their reports in medicalized terms, tables, and recommendations cloaked in objectivity. This section highlights two findings

regarding the other 48 state-level MMRCs. First, the analysis of MMRC reports and other relevant documents revealed that maternal mortality continues to be understood as a patient-driven phenomenon. Second, in states that do explore systems-level factors, including provider-level factors, racism enacted by providers is not considered.

Patient-Level Factors

Many states, exemplified by Arizona's seatbelt-wearing campaign, continue to blame mothers for their deaths. Like Arizona, many states mention structural-level barriers to care (such as lack of access in rural areas) in their reports but rely on patient-level solutions when making recommendations. In the case of Arizona, two of the top three recommendations are mother-blaming (see Cabasag et al., 2019). When recommendations are framed through a patient-level lens, the recommendations that result often suggest extending the disciplinary apparatus of the state further into the lives of marginalized women, typically by intensifying the scope of social control into the homes and private lives of women. Arizona, for example, is one of many states that recommend considering home visitations. While a home visitation can be incredibly valuable to a healing new mother, their value is experienced differently based on access to racial and class privilege, particularly when the home visitation becomes a requirement. In these situations, home visitations can coerce women into a regulatory position in exchange for prenatal care. Adding requirements and visitations for Black women who are already receiving low-quality or culturally inappropriate prenatal care only further subjects them to objectification under a racialized and medicalized gaze—a gaze that is given access to mothers in the most private and intimate spaces of their everyday lives.

As Clarke et al. (2010) explain, "risk and surveillance are aspects of the medical gaze that is disciplining bodies" (p. 64). Being "at-risk" demands and justifies the coercive surveillance of the imagined population. Health is assumed to be achieved largely through surveillance and avoidance of risk through the technomedical gaze (Clarke et al., 2010); for pregnant individuals, this achievement involves ongoing prenatal surveillance even in the absence of symptoms that might suggest or indicate risk. In this way, Virginia's MMRC, who also advocates for additional home visitations for postpartum women who are publicly insured, might be interpreted as a state actor that is building additional mechanisms of state surveillance and discipline in which the state is permitted to enter the home of pathologized and criminalized mothers.

Clarke et al. (2010, p. 63) also explain that, under the biomedical era, health is framed as a social and moral responsibility. Along these lines, I found that maternal mortality review committees demonstrate high commitment to prenatal care as a moral responsibility, without acknowledging how providers routinely discourage regular and early care through disrespectful or dismissive care. States commonly recommend that women seek prenatal care as early and consistently as possible throughout the entire gestation period while failing to acknowledge why women do not (and that the majority of women die in the postpartum period). They fail to consider the many ways in which women of Color, particularly Black women, put themselves at risk just by entering into a biomedical model of birthing and delivery.

In this way, mothers are implicated in their own deaths, failing in their moral and social responsibility to nurture their children. MMRCs commonly define women who eschew prenatal care as negligent, irresponsible, and even abusive. MMRCs should consider that a mother so readily labeled as abusive would likely not want the state in her home, assessing her body and behaviors.

MMRCs systematically did not indicate the percentage of maternal death attributed to failure to seek out prenatal care or discontinued prenatal care. This leaves one to question the percentage of deaths that were related to sporadic or dispensed prenatal care. This may be because there is no evidence that women of Color do not seek prenatal and postnatal care when they become symptomatic of complications. In contrast, an abundance of research, including research gathered by MMRCs, demonstrates that women of Color are overlooked when reporting problematic symptoms, including extremely dangerous symptoms such as high blood pressure and bleeding. Despite this, MMRC reports overwhelmingly relied upon a narrative of a neglectful or unintelligent mother who ignores prenatal care and postnatal warning signs.

If MMRCs looked to expert organizations such as Black Women Birthing Justice, Black Mamas Matter Alliance, and other groups leading Black women's health, they would likely conclude differently. Yet, MMRCs were highly unlikely to involve patient advocates, Black midwives and doulas, or stakeholders representing Black mothers. Their committees tended to be small (under 20 seats) and comprised entirely of obstetricians and medical practitioners. Reproductive justice for women of Color requires recognizing Black women as leaders of the birth justice movement (Ross, 2017, p. 79) and bringing them to the table to chart the way forward. These organizations shift the lens from patient to provider-level factors; MMRCs, comprised almost entirely of medical providers and representatives of the biomedical industry, produce a patient-level discourse that absolves them of any responsibility. To end reproductive injustices in the lives of Black women necessarily involves the dismantling of state barriers to Black women's agency and power in identifying and ending the injustices that shape their birth experiences.

Systems-Level Factors

MMRCs occasionally recognized systemic racism as an explanatory factor. Most often utilizing some variation of the weathering hypothesis, these MMRCs acknowledged how a lifetime of toxic stress maps onto the pregnant body. These MMRCs, such as New Mexico, Illinois, Indiana, Connecticut, Colorado, Florida, Georgia, South Dakota, and Washington, discussed MMR disparities in their states. While acknowledging a racialized problem, these states often proposed colorblind solutions or patient-level solutions. Further, they commonly neglected to include health care institutions as a racialized environment, furthering the assumption that health care, and the providers that practice within them, are colorblind.

Absolving physicians, medical delivery services, and the state of their role in perpetuating racial inequality, these states sometimes discussed provider-level deficiencies. In reviewing the deaths of pregnant and postpartum individuals, many MMRCs acknowledge that providers routinely miss opportunities for diagnosis and treatment, commonly referred to as

system failure. In this model, state MMRCs such as Ohio, Iowa, and Indiana acknowledge that provider care is often inadequate. Ohio, for example, highlights in their reports that poor quality care and failure to screen and diagnose women have resulted in many preventable deaths. In fact, most states acknowledge that at least over half of the maternal deaths are preventable. These states do not investigate further, seeking to understand how obstetric racism shapes which women are screened, diagnosed, and listened to and those who are not. Data tell us that the system fails many more Black mothers than it does white mothers, a fact MMRCs systematically disregard. Why are MMRCs conceptualizing healthcare delivery systems as racially neutral actors situated outside of systems of power? In-depth interviews with members of MMRCs would be a useful avenue for future research.

Conclusion

Kimberlé Crenshaw (2016) noted the urgency of understanding the intersection of race and gender in Black women's lives. This urgency cannot be overstated when examining maternal mortality in the United States. This analysis shows that of 51 MMRCs, only three address obstetric racism in their reports and recommendations. That 48 MMRCs do not comprehensively center race and racism in their work is puzzling given that they are charged with resolving a race-based public health crisis. Consequently, these state actors reproduce racist and controlling images of Black mothers as pathological, lacking in knowledge, defiant, and deficient. Far from offering solutions, MMRCs largely absolve health care providers and health care delivery systems of their role in constructing high rates of maternal mortality in the United States. Their recommendations largely ignore the profound forms of provider racism and obstetric violence endured by women of Color within biomedical systems of maternal care. In so doing, these initiatives comprise a discursive formation that socially constructs an imagined population of "at-risk" Black and Indigenous mothers, reproduces biological notions of race, and fails to address racial inequalities in maternal care.

Black Mamas Matter. My research suggests that state-level maternal mortality committees and their initiatives have not yet integrated the ethos and spirit of this movement. State MMRCs may be comprised of experts, but they are not necessarily experts on Black maternal health; to be impactful, MMRCs must acknowledge and intervene in the everyday practices of obstetric racism that kills Black mothers.

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