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Research Article

Scoping Review of Black Maternal Morbidity and Mortality in the United States: The Role of Social Determinants of Health, Systemic Racism, and Implicit Bias

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Abstract

Background

Evidence suggests that social determinants of health (SDoH), systemic racism, implicit biases in healthcare, and environmental factors are major contributors to the disproportionately high rates of maternal morbidity and mortality among Black women in the United States. In order to find themes, forms of evidence, and gaps in the research, this scoping review maps the literature.

Methods

Following PRISMA-ScR criteria and Arksey and O'Malley's methodology, we searched EBSCOhost, ProQuest, Google Scholar, and CDC databases for papers published between 2017 and 2024. The inclusion criteria were based on quantitative (e.g., vital statistics, cross-sectional) and qualitative (e.g., focus groups) evidence of Black maternal health inequalities in the US. The data were organized into themes such as SDoH, racism, segregation, and intersectionality, with narrative synthesis.

Results

Fifteen sources were included out of 150 initial records. Primary concerns include the intersectional effects of race and gender, systematic racism through redlining and segregation, implicit biases resulting in unequal care, and SDoH links to health issues including preeclampsia (59% of discrepancies). Longitudinal research on the long-term impacts of treatments has gaps. The results highlight the necessity of racial policies in order to correct injustices and enhance results. Bias training, legislative changes, and community-based interventions are among the recommendations and areas for future research. Potential publishing bias and restricted regional variety are among the limitations.

Keywords: Black Maternal Mortality, Implicit Bias, Systemic Racism, Morbidity, Social Determinants of Health (SDoH), and Scoping Review

Introduction

For many families, becoming mothers and expanding their families rank among their greatest achievements in the United State (U.S). Even though society expects this natural process, it can be a difficult milestone for individuals of race, particularly Black American women. Black women in the United States have a maternal mortality rate that is three times higher than that of other racial groups, particularly White women, according to the Centers for Disease Control and Prevention [1]. This is due to both societal and healthcare-related factors that fall under the broad category of Social Determinants of Health (SDoH). Additionally, eclampsia, preeclampsia, postpartum cardiomyopathy, embolism, and hemorrhage account for 59% of the discrepancy in these fatality rates [2].

Furthermore, the Black maternal mortality rate (BMMR) is rising in the United States, which cannot be attributed entirely to socioeconomic circumstances or limited healthcare access.

McDorman et al. (2021) found that non-Hispanic Black women have a 3.55 times higher maternal death rate than non-Hispanic White women [2]. These results are linked to SDoH—non-medical factors that influence health, such as economic stability, local environment, and social context—which impede fair access to resources for racial and ethnic minorities [1]. Despite research showing a link between SDoH and Black women's reproductive health, this does not adequately account for the significant disparities between Black women who give birth and other underprivileged women. Black maternal morbidity and mortality studies highlight a public health crisis by highlighting the disproportionate number of pregnancy-related deaths among Black women relative to other racial groups, exposing racism and systemic healthcare biases, and calling for immediate action to address racial disparities in order to close these gaps, enhance Black women's reproductive health, and lessen the burden on society and the healthcare system [3]. Addressing Black maternal mortality is critical in combating a significant public health epidemic that demonstrates systemic healthcare disparities. Studies have shown that minimizing unnecessary deaths and enhancing treatment for Black women is critical to benefit not only individuals but also their families and communities.

This scoping review investigates the literature on Black maternal morbidity and death rates, with an emphasis on how SDoH affects Black women's health and lives, implicit bias, systemic racism, and their intersections. In contrast to systematic reviews, scoping studies provide a wide perspective to uncover evidence, gaps, and themes [4]. The goal is to identify essential themes, compare included papers, and provide recommendations for publication in a public health journal.

Methods

We followed the Arksey and O'Malley (2005) approach to ensure transparency and repeatability. The Arksey and O'Malley approach (2005), was expanded by Levac et al. (2010), and included five stages: establishing the research topic, locating relevant studies, study selection, charting data, and compiling results [4,5]. A scoping review enhances detailed and extensive exploration and mapping of the available literature on the study phenomena. In particular, the aim of our scoping review was to identify the types and nature of evidence available, explore the key prevailing characteristics about Maternal mortality and morbidity, and to identify gaps in the available literature. We followed an iterative process that included identification of the review question, identification of relevant literature, selection of relevant studies, charting and collating data, and summarizing and reporting findings. We followed the Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) checklist to ensure a coherent and transparent reporting of literature. The starting point was the following: "What does the literature reveal about the roles of SDoH, systemic racism, and implicit bias in Black maternal morbidity and mortality in the U.S.?

Search Strategy

We conducted searches on EBSCOhost, ProQuest (via Monroe University Online Library), Google Scholar, and the CDC websites. We also searched for grey literature from government and university databases. These included the following keywords: "Black maternal mortality," "Black maternal morbidity," "social determinants of health," "systemic racism," "implicit bias," "racial disparities in maternal health," plus "intersectionality in maternal outcomes" "segregation," as well as "U.S." Boolean operators (AND/OR) were utilized, with searches restricted to English-language publications published between 2017 and 2024 to focus on current evidence. Initially, no date limitations were employed, however older studies were removed throughout the relevance selection process.

Eligibility Criteria

Sources were included if they are peer-reviewed publications, reports, or reviews. (1) addressed Black maternal morbidity and mortality in the United States; (2) were published between 2017 and 2024; (3) included quantitative data (e.g., from the National Vital Statistics System, cross-sectional studies) or qualitative insights (e.g., focus groups) or mixed-methods designs; full-text availability; and (4) focused on SDoH, racism, biases, or environmental factors. Non-peer-reviewed articles, international research, non-US-focused studies, data-free editorials, duplicates, and those unrelated to maternal outcomes were excluded. We focused on primary sources and varied designs (e.g., reviews, cross-sectional, qualitative).

Study Selection and Data Charting

Two reviewers (PEN, AB) reviewed titles/abstracts separately before doing a full-text review to establish eligibility for inclusion. Disagreements were resolved through discussions. All the recognized articles were saved in the reference management program Zotero. Full-text publications from studies that met the inclusion criteria were collected, and their eligibility was assessed separately by two reviewers. We began by conducting basic database searches, identifying 145 articles across all databases and 5 papers from grey literature sources. After removing duplicates (n=30) and screening titles/abstracts using the Zotero reference manager, 120 titles/abstracts remained for further screening. Following abstract and title screening, as well as full text screening, 15 records met our inclusion criteria and were included in the study. Full texts were then evaluated. 105 articles did not fulfill our inclusion criteria, so they were excluded (n=105), leaving 14 studies.

We checked the reference lists of the included studies and found 1 other article that fulfilled the inclusion criteria. We consequently did include one (1) paper from the reference lists. In our screening approach, we included any published and grey literature that investigated or discussed black maternal mortality and morbidity in the United States between the years we selected. In all, a total of 15 articles were selected and included in our studies. See Figure 1.0 (PRISMA flow diagram) for the study selection process.

Data extraction and charting was performed by the two reviewers using a standardized form developed and pre-approved by all the authors: the template was used to chart the data, which included author/year, study design, population/sample, important findings, and themes. Thematic analysis and narrative comparison were used in the synthesis (for example, SDoH affects and racism in healthcare). The extracted data was stored and included, see (Table 1.0)

Results

After deduplication and screening, fifteen (15) studies met the requirements and were therefore included. These included four critical reviews, three qualitative investigations, five quantitative analyses, and three mixed-methods or case studies. The majority of the focus was on national statistics from the United States, with some regional instances (e.g., Ohio and California). Table 1.0 highlights the qualities.

No.	Author(s) (Year)	Study Design	Key Focus	Sample/Population	Main Findings
1	Barnett et al. (2024)	Historical case study	Discriminatory policies, housing, maternal/child/ infant health	Linden, Ohio community (historical data)	Redlining and segregation caused high infant mortality; race-neutral interventions were insufficient.
2	Brailey & Slatton (2024)	Qualitative (focus groups)	Systemic racism in maternal care	27 Black women, Harris County, TX	Themes include institutional hurdles, unequal care, and daily racism, with calls for Black-centered solutions.
3	CDC (2024)	Report	Reducing Black maternal mortality	National U.S. data	Black women are three times more likely to die; the SDoH encourages teamwork.
4	Dagher & Linares (2022)	Critical review	SDoH interplay with mortality	Literature on U.S. minorities	Racism and segregation are examples of multilevel SDoH that hasten aging and have intergenerational repercussions.

5	Gao et al. (2023)	Quantitative (cohort)	Redlining and severe maternal morbidity	California birth cohort	Higher Severe Maternal Morbidity (SMM) in minorities is associated with lower Home Owners' Loan Corporation (HOLC) redlining grades.
6	Howell (2018)	Review	Reducing disparities	U.S. national data	Key factors include provider bias and unequal access; intervention mechanisms have been identified.
7	Josiah et al. (2023)	Review	Implicit bias, neuroscience	Black birthing women	Bias impacts empathy and treatment, and has been connected to a 243% higher mortality rate.
8	Katon et al. (2021)	Evidence review	Policies for equity	U.S. policy literature	Racism is a key motivator, along with systemic issues including poor income and educational disparities.
9	Lee et al. (2019)	Quantitative (trends)	Preeclampsia trends	Hawaii/U.S. hospitalizations	Higher hazards for minorities; rising

					expenses and mortality.
10	Lister et al. (2019)	Systematic Review	Black maternal mortality overview	U.S. Black women	Maternal mortality rate among blacks are are four times higher; Socioeconomic Status (SES) cannot explain this alone.
11	MacDorman et al. (2021)	Quantitative (vital records)	Racial disparities	2016-2017 U.S. data	Non-Hispanic Black women had a 3.55-fold higher maternal death rate than non-Hispanic White women. Eclampsia/preeclampsia and postpartum cardiomyopathy lead causes of death in Black women, with 5x those of White women; Obstetric embolism and hemorrhage rates were 2.3-2.6 times higher.
12	Njoku et al. (2023)	Review	Addressing morbidity/mortality	U.S. Black women	Focus on structural racism; listen for early warning signs to prevent it.

13	Ohrnberger et al. (2017)	Quantitative (mediation)	Physical-mental health links	U.K. data (adapted to U.S. context)	Stress from SDoH has reciprocal impacts on health.
14	Patterson et al. (2022)	Intersectional analysis	Gendered racism	U.S. maternal data 1990-2019	shows U.S. Black women face double maternal mortality rates compared to white women (2015-2019), linked to gendered racism and accelerated aging Black rates 2 times that of White in 2019.
15	Snyder et al. (2020)	Quantitative (regional)	Workforce availability	U.S. regions	Subnational variations; lower providers linked to higher mortality. U.S. maternal mortality rose 2009-2017, highest in South, lowest in Northeast. Linked to lower health workforce availability in South.

Table 1.0: Summary of Included Studies

Figure 1 - Identification of studies via databases and registers

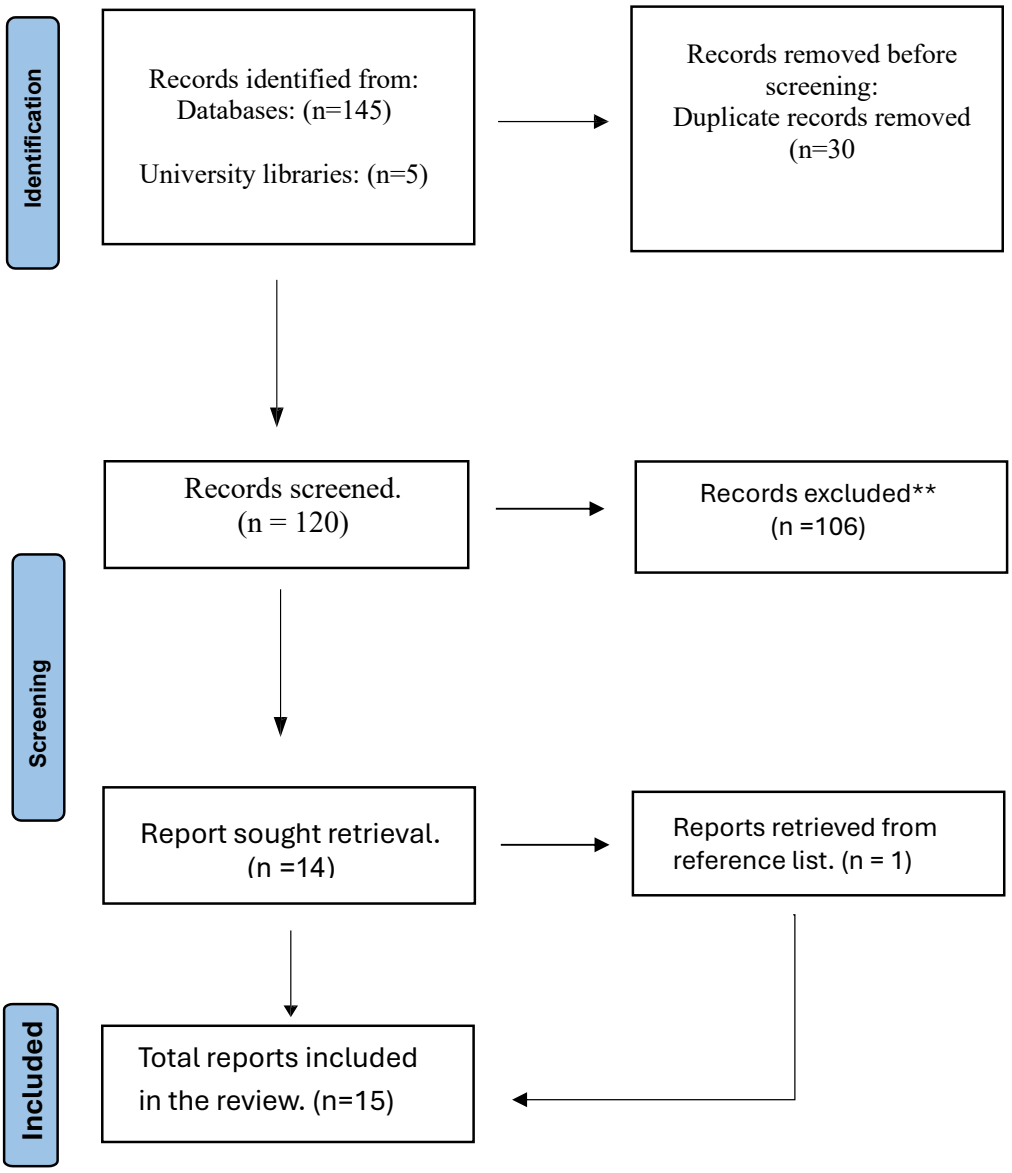

Figure 1.0: PRISMA flow diagram for study selection process

Thematic Synthesis and Results

Themes emerged: (1) SDoH Impacts: Research has linked SDoH to disorders such as gestational diabetes and preterm birth [6,7]. (2) Segregation and Environment: Redlining maintains dangerous neighborhoods and heightens hazards [8,9]. (3) Healthcare Access and Racism: Implicit bias leads to ignoring pain [10,11]. (4) Intersectionality: Race and gender exacerbate stress [12].

Social Determinants of Health (SDoH) Impacting Black Women

Black women are disproportionately impacted by social determinants of health (SDoH), such as food hardship, economic insecurity, and environmental risks, all of which are exacerbated by systematic racism [6]. Stress brought on by unfavorable SDoH deteriorates mental and physical health and raises the risk of preterm delivery, small for gestational age births, preeclampsia, and gestational diabetes, all of which are associated with subsequent cardiovascular disease [6,13]. Because early and ongoing exposure to prejudice can hasten biological aging and pass on health hazards to future generations, these stressors also function throughout the life span [7]. As a result, Black maternal mortality is intimately linked to greater morbidity loads that are not biologically innate but rather socially created in the context of systemic racism in the United States.

Structural racism is a primary cause of SDoH by influencing social systems, institutions, and beliefs that perpetuate racial imbalances. Practices such as residential segregation and redlining have limited homeownership and wealth accumulation for people of color through discriminatory lending, resulting in long-term economic

and local disadvantages. These diseases have a direct and indirect impact on pregnancy-related problems such as gestational diabetes mellitus, preeclampsia, small for gestational age outcomes, and preterm birth, which contribute to increased mortality and morbidity in Black women [6]. While prejudice affects other communities of color, Black women are disproportionately affected, which emphasizes the need for targeted public health interventions.

Racism also shows up as unconscious bias and discrimination, especially in healthcare settings, which exacerbates stress and lowers the standard of care. Therefore, rather than being solely the result of individual behaviors, maternal and infant health disparities reflect cumulative exposure to SDoH, including segregation, poor healthcare, and restricted support. While low socioeconomic position, inadequate education, and limited healthcare access all contribute to disparities, they do not fully account for poor birth outcomes for Black women [10]. Racism continues to be a major driver, manifesting itself through economic insecurity, limited educational and career possibilities, and an increase in the incidence of avoidable illnesses. Access to protective resources, such as strong social networks, high-quality healthcare, and supportive public policies, can significantly reduce these harms and improve intergenerational mother and newborn health outcomes [7].

Segregation: Built-in Environment and Safe Neighborhood

Historical policies such as redlining have resulted in segregated communities with inadequate housing, pollution, and crime, which are associated with increased maternal risks [8,9]. Despite being illegal, historical racism and redlining in the United States have greatly contributed to the wealth gap by limiting access to financial and economic opportunities, resulting in extremely segregated neighborhoods. While poverty is associated with higher morbidity and mortality risks, racial differences in maternal health exist at all income and education levels. It's found that Black pregnant people had maternal mortality rates that were almost four times higher than those of their non-Black counterparts, even in wealthy communities, according to a study conducted in New York City. This underscores the need for policies to address systemic racism and SDoH, including bias in healthcare. The built environment and community have an impact on Black women's well-being. Segregation is reinforced by past and present discriminatory housing and lending policies that impact housing conditions and neighborhood quality. Health problems, environmental dangers, and poor housing conditions are common in communities of color. Housing insecurity and poor living circumstances have been connected to maternal mental health concerns, raising the risk of maternal morbidity and mortality.

Furthermore, emerging data suggests that environmental pollution may contribute to pregnancy issues such as pre-eclampsia and placental abruption, raising maternal health concerns. According to Barnett et al. (2024), decades of discriminatory laws and systemic segregation have resulted in shockingly high infant mortality rates in racial minority areas throughout the United States [8]. The Linden, Ohio case shows how disinvestment resulted in newborn death rates of 26/1,000 and decreased homeownership [8]. Housing has a substantial impact on health outcomes. Safe, stable, and affordable housing in well-served areas is critical for mother and infant health. However, racial segregation, exacerbated by discriminatory housing rules, has resulted in substantial disparities in living conditions, crime rates, and poverty—factors associated with poor birth outcomes, particularly among Black mothers. According to research, living in segregated communities increases the risk of preterm birth and other negative effects for both mother and child. Black women's health results may also be influenced by the social and community circumstances. Living in dangerous neighborhoods has a detrimental effect on the health of persons of color who are pregnant or giving birth, particularly those impacted by redlining and persistent segregation. Vulnerable people are compelled to reside in hazardous areas, and discrimination through segregation exacerbates already-existing disparities.

Higher rates of crime and overpolicing are common in these neighborhoods, which raises maternal morbidity and death. Preterm delivery, maternal homicide, suicide, and problems with mental and physical health are all made more likely by exposure to dangerous circumstances and places, such as mass incarceration and police violence.

While there have been several studies on the effects of neighborhood deprivation, crime, and violence on birth outcomes, there has been less attention paid to the influence on chronic health issues and severe maternal morbidity (Barnett et al., 2024). While community development and housing efforts seek to address social and health disparities, they frequently fail to consider the impact of structural racism. While community development efforts aim to alleviate neighborhood imbalances, many use a race-neutral strategy, failing to resolve racial health disparities. Race-neutral programs (such as the One Linden Plan) demonstrate limits in resolving inequities. A more effective method calls for race-conscious reinvestment that acknowledges past injustices, focuses resources toward genuine change, and assures financial commitments to address disparities.

Healthcare Access and Racism Impact on Maternal and Infant Mortality Rate

According to Dagher and Linares (2022), Dr. Camara Phyllis Jones characterized racism as a system that provides opportunities and assigns value based on physical appearance, disadvantages certain groups while benefiting others, and eventually weakens society by wasting human potential [7]. Racism can occur on a personal (interpersonal), community, or systemic level. Interpersonal racism includes both explicit and implicit prejudices, in which unconscious feelings impact conduct toward specific ethnic groups (implicit form). As a result, black women frequently visit lower-quality hospitals, where prejudices lead to complaints being disregarded and inadequate pain care [14]. Obstetric shortages in rural locations increase the risk by 9% [14]. Qualitative data from 27 Black women in Texas reveal institutional constraints (e.g., insurance limitations), uneven interactions, and everyday racism that contribute to "weathering" [11]. Implicit biases based on preconceptions reinforce falsehoods about pain tolerance.

Barnett et al. (2024) use Linden, Ohio, as an example of past racist incidents that have affected Black and baby health [8]. Decades of policies encouraging White flight and disinvestment caused significant demographic and economic changes in this community. Originally founded as Linden Heights Village in 1908 and incorporated into Columbus in 1921, Linden was primarily white until 2020, when it was 63% Black, had a high incidence of unoccupied homes, inadequate infrastructure, and one of the highest infant mortality rates in Franklin County. Black inhabitants were prohibited by racial covenants in almost all new

home developments, which furthered segregation until 1948, when legally binding restrictions were lifted. Long-term disinvestment resulted from redlining in the 1930s, which classified a large portion of Linden as high-risk and restricted loans and homeownership for Black inhabitants. Brailey & Slatton (2024) found racism in this system and a lack of access to healthcare; their findings illuminated the ways in which systemic racism and unjust policies impede access to high-quality maternal care [11]. Its origins can be traced back to a lengthy history of oppression, including forced sterilizations during the eugenics era and medical experiments on enslaved Black women. Maternal care inequities have persisted as a result of these practices.

Key obstacles to receiving high-quality maternity care were identified during focus groups with twenty-seven Black women. These themes shed light on how Black women's prenatal and postpartum experiences are specifically impacted by systemic influences. The study uncovered three major themes: (1) institutional hurdles to equitable maternity care, (2) unequal clinical treatment and provider-patient relationships, and (3) dealing with everyday racism. The women's stories emphasize how systemic factors, such as racism and discriminatory legislation, impede access to appropriate maternal care. By concentrating on their experiences, we can develop solutions that address the real-world difficulties that this community faces.

First, health insurance restrictions limited Black women's access and care options, causing stress and negative results. Participants reported staffing shortages and insufficient diversity among healthcare personnel, preferring Black doctors and nurses for greater understanding. These constraints demand governmental changes to provide equitable access and a diverse workforce.

Second, experiences included ineffective pain treatment, disregard for autonomy, and poor provider communication. Women reported being denied preferences, such as unneeded cesarean sections, emphasizing the need for culturally competent care and increased discussion to develop respect. Third, frequent racist encounters increased stress, undermined trust, and resulted in "weathering," or worsening health. Such racism, through dismissive treatment and unequal care, exacerbates maternal inequities, necessitating anti-racist healthcare initiatives. Between the 1950s and 1960s, White flight increased as realtors took advantage of integration anxieties, forcing White homeowners to sell cheaply and reselling to Black families at exorbitant prices. By the 1970s, Linden's school desegregation had diminished due to continuous White exodus and policy consequences. Job losses due to deindustrialization destabilized the town, increasing unemployment and poverty.

Harsh drug regulations disproportionately affected Black people, increasing incarceration and worsening conditions. By the late 1990s, Linden's Black infant mortality rate had reached 26 fatalities per 1,000 live births. The 2000s subprime crisis hit hard, with over 50% of loans being predatory, foreclosures skyrocketing, vacancies doubling, and homeownership falling from 56% in 2000 to 36% in 2016 [11]. The median household income declined from $37,265 in 2000 to $25,040 in 2016 [11]. In general, better maternal care, communication, and representation depend on tackling institutional and interpersonal racism, elevating the voices of Black women, and implementing systemic changes [11].

Intersectionality - Complex Interplay Between Sex, Gender, and Race

Black women and Hispanics experience particular discrimination as a result of the intersection of race, gender, and socioeconomic characteristics [12]. U.S. maternal death rates increased to 24.7/100,000 between 1990 and 2015, primarily due to Black inequalities (37.3 vs. 14.9 in 2019). The majority of these deaths are significantly higher among Black women. Restrictive regulations make problems worse. According to Patterson et al. (2022), the number of high-income countries decreased from 25.4 to 15 per 100,000 births. Black women saw more than twice as many pregnancy-related deaths in 2019 as White women, a disparity that researchers attribute to institutional racism [12]. The reasons for increased maternal mortality and racial inequities are still discussed. Research also reveals greater racial health inequities, with Black Americans having poorer health outcomes and higher mortality rates than White Americans across a variety of metrics.

It has been discovered that structural inequalities, including racism and sexism, determine maternal health outcomes, which are influenced by the chronic stress of discrimination and hastened aging, resulting in lower health for Black women. The intersectionality paradigm emphasizes how race, gender, and societal injustices intersect, resulting in disproportionately high maternal death rates.

Furthermore, these inequities are made worse by restricted reproductive policy. Additionally, research has demonstrated a connection between higher maternal mortality and restricted access to abortion, especially in jurisdictions with tight legislation. In order to provide reproductive healthcare, particularly for low-income and marginalized women, Planned Parenthood and comparable clinics are essential. To improve outcomes for all women, especially those who are at risk, understanding maternal mortality necessitates tackling these intersecting determinants [12]. Gaps include assessments of race-conscious therapies and a lack of attention to the long-term effects of chronic diseases.

Discussion

This scoping review examines research on Black maternal morbidity and death, focusing on SDoH, racism, and segregation as linked factors. It has been revealed that institutional racism and past discriminatory policies worsen these disparities, limiting access to excellent healthcare, education, food security, housing, and work. While SDoH interconnects and influences pregnancy through complicated pathways, such as hypertension caused by poor exercise or diet, financial pressures from food insecurity exacerbate physical and mental health problems. Racism-induced stress worsens well-being, highlighting the bidirectional relationship between mental and physical health, while the processes are unclear [13].

The studies give complimentary views and differ in scope and approach. In contrast to empirical quantitative works that employ data to quantify disparities (e.g., 3.55x rate ratios), critical reviews offer wide overviews of SDoH and policy [2,3,7,9,14,15]. Unlike historical cases that trace policy legacies like redlining, qualitative studies focus on lived experiences. Josiah et al. (2023) incorporate neuroscience on bias in a novel way, whereas Lister et al. (2019) and Howell (2018) highlight unexplained gaps beyond SES [6,10,11,16]. Mental-physical connections are added by

Ohrnberger et al. (2017), but its U.K. foundation contrasts with U.S.-focused efforts [13]. Research relating SDoH to health outcomes reveals disproportionate effects on persons of color, but Black birthing mothers face much greater disparities than White and other minority groups. Overall, reviews emphasize systemic factors.

Key SDoH include many forms of discrimination that impede access to healthcare, education, safe settings, and healthy lives. Patterson et al. (2022) stands out for intersectionality, exposing gaps in non-intersectional approaches, while specifics (e.g., Lee et al., 2019 on preeclampsia) demonstrate regional tendencies [12,17]. The results also support earlier research demonstrating that inequalities continue to exist across socioeconomic levels, requiring a variety of strategies. Black women are more vulnerable to the combined effects of racism and SDoH, which are present at all income levels [3,16]. Thematic breadth is one of its strengths; reliance on U.S.-centric sources, possible bias in database selection, and the absence of a quality assessment are its drawbacks. Consequences: To lower rates by 2030, give community-based prevention, education, and advocacy a priority. Longitudinal interventions and underrepresented areas should be investigated in future studies.

Recommendations

In order to lower maternal mortality and infant death rates by 2030: (1) Put community-based prevention into practice (doula programs, education, etc.); (2) Promote policies that address bias training and redlining legacies [15]. (3) Improve workforce diversity and access in underserved areas [14]. (4) Center Black voices in research [11].

Conclusion

Systemic injustices are the root cause of Black maternal health issues, necessitating immediate, equity-focused intervention. In order to promote healthier outcomes and societal well-being, integrated methods are necessary, as this scoping review highlights through examining of various research/articles.

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