



MATERNAL HEALTH Fact Sheet

Black Maternal Health in New Jersey

Black maternal health definition

Black Maternal Health refers to the well-being of Black women during the prenatal period, pregnancy, and the postnatal period.¹ Black women in the United States experience significantly disparate maternal health outcomes including disproportionately high rates of death related to pregnancy or childbirth compared to other racial and ethnic groups.²

What is the status of black maternal health in the U.S.?

1. Black women are three times more likely to die from a pregnancy-related cause than White women.³
2. The maternal mortality rate for Black women increased from 37 deaths per 100,000 live births to 55.3 deaths per 100,000 live births from 2018 to 2020. In contrast, the rate for White women was 19.1 deaths per 100,000 live births in 2020.⁴
3. Black women are more likely to be uninsured and face greater financial barriers to prenatal care than White women.⁵
4. Black women are more likely to experience complications throughout the course of their pregnancies than White women.⁶
5. Black women experience structural racism in health care delivery, which contributes to significantly higher rates of preventable death compared to other groups.⁷
6. Implicit bias contributes to disparities in maternal health, including how obstetricians and gynecologists counsel Black women regarding treatment options.⁸
7. Black women have a heightened risk of pregnancy-related death irrespective of their incomes and education levels.⁹
 - a. The CDC reports that a Black woman with a higher education degree is 1.6 times as likely to die from a pregnancy-related death as a White or Latina woman with less than a high school diploma.¹⁰
 - b. Despite socioeconomic status, the newborns of college-educated Black women still face a greater risk of being low birthweight when compared to White newborns.¹¹
 - c. A recent study found that the infants of Black parents in the top of the income distribution had a rate of low birthweight and preterm birth 1.5 times higher than the infants of White parents in the bottom of the income distribution; and further found that infant mortality for Black infants in the top decile of the income distribution was 23 percent higher than that of White infants in the bottom decile of the income distribution.¹²



8. Compared to White women, Black women more frequently reported: (1) unfair treatment and disrespect by providers because of their race, (2) no patient autonomy during labor and delivery, and (3) pressure to have a cesarean section.¹³
9. Black women are more likely to report having their pain minimized or ignored and have still births more frequently than White women.¹⁴
10. Black women are less likely to exclusively breastfeed at one week and six months with “rates of breastfeeding initiation, duration, and exclusivity . . . 10–20 percentage points lower among Black infants,” compared with White infants.¹⁵
 - a. Although breastfeeding lowers the risk for developing type 2 diabetes, hypertension, and breast and ovarian cancers, hospitals in Black communities are less likely to promote breastfeeding.¹⁶
 - b. The ongoing infant formula shortage is likely creating serious risk of undernutrition among Black infants, who are less likely to be breastfed.¹⁷
11. The national average of infant mortality is 5.67 per 1,000 live births, but that rate is nearly double for infants of Black women at 10.75 per 1,000 live births.¹⁸
12. In 2021, the rate of preterm birth among Black women was fifty percent (50%) higher than the rate of preterm birth among White and Hispanic women.¹⁹

Facts about black maternal health in New Jersey

1. New Jersey’s Black maternal and infant mortality rates are among the worst disparities in the United States.²⁰
2. New Jersey ranks 47th in the United States for its high maternal infant mortality rate, with 46.5 fatalities per 100,000 live births.²¹
3. A Black infant in New Jersey is more than three times more likely than a White infant to die before their first birthday.²²
4. Black women die from pregnancy-related causes at 7.6 times the rate of White women.²³
5. Black women in New Jersey experience preterm births at a rate of nearly 14% compared to White women whose preterm birth rates were closer to 8% in 2019.²⁴
6. As of 2019, Black infants (13%) were more than twice as likely to have a low birth weight compared to White infants (6%).²⁵
7. Approximately 61% of Black women in New Jersey receive early and consistent prenatal care compared to 83% of White women.²⁶
8. Black women in New Jersey reported that health care providers failed to listen to their pregnancy-related needs and concerns.²⁷

Opportunities for action in New Jersey

1. **Learn the issues.** It is critical to understand the risks that women face and address all relevant factors, including the availability of clinical care, access to treatment before and after birth, the effects of structural racism, and social determinants of health to achieve complete equity. The references in this fact sheet reveal just a few dynamics regarding Black maternal health in New Jersey. The Network for Public Health Law can assist with additional research on request.
2. **Advocate to declare that racism is a public health crisis.** Advocate that New Jersey and localities in the State declare that racism is a public health crisis to amplify Black voices and address the maternal health needs of Black women.²⁸ It is essential to develop equity-centered models of care to reduce maternal health disparities.²⁹ By following the examples set by the New Jersey boroughs of Leonia³⁰ and Montclair,³¹ declaring racism as a public health crisis statewide could help improve Black maternal health by encouraging officials to implement racial equity/implicit bias training for health care providers and reduce or eliminate discrimination and bias.³²
 - The New Jersey Legislature is considering a bill in the 2022-23 session that is a statewide resolution that declares racism is a public health crisis in the State.³³



3. **Advocate for improved racial equity training and education of health care professionals.** Implicit bias training and other racial equity training and education helps health care professionals recognize and understand patient differences related to race and inequality.³⁴ This enhances individualized treatment of health needs, reduces implicit bias, and improves health outcomes. Health care professionals should be trained on implicit bias, structural racism, and equitable care during their education and while in practice. Training and education improvements include:
- Training on the impact of social determinants of health to providers (through continuing education courses) and students in professional health care schools and training programs.
 - Implicit bias education that is integrated into training curricula for health care professionals and mandated for members of health care professional boards (who adjudicate complaints against health care professionals and regulate practice).
 - Continuing medical education credits in implicit bias, particularly for those working with pregnant women.

Advocate for and support efforts to improve health care access. Improving access to Black-led community-based providers such as doulas and midwives is an essential step toward improving maternal health outcomes for Black women.³⁵ Doula care improves health outcomes for pregnant Black women by providing emotional, physical, and educational support throughout the perinatal period. Doulas can assist with managing chronic medical conditions, developing a birthing plan, and advocating for the pregnant woman, particularly during childbirth.³⁶ It is crucial that legislation and certification requirements do not marginalize Black providers, particularly Black doulas and midwives. As of 2022, 12 states offer some coverage of doula care to Medicaid patients. Minnesota, Florida, and Oregon have offered such coverage for several years and newcomer states are in various phases of implementation of doula coverage for Medicaid patients: California, District of Columbia, Illinois, Indiana, Maryland, Nevada, New Jersey, Rhode Island, and Virginia.³⁷ In New Jersey, a doula or an agency providing doula services may enroll, as a Medicaid/NJ FamilyCare provider in fee-for-service (FFS) and managed care as of January 1, 2021. Comprehensive reform will ensure that private and public health care coverage extend for the length of time needed for gestation, delivery, and caring for an infant and for the well-being of the birthing parent. While Black women are generally more likely to be uninsured or face financial barriers to prenatal care, and although many policymakers tend to gravitate to Medicaid reform to improve outcomes for Black maternal health, Medicaid reform is not the only way to improve outcomes and can tend to perpetuate an exaggerated dynamic between Blackness and poverty when racial disparities in maternal health go beyond education and income level.


Key legislation that can help improve access includes:

Increase access to affordable health insurance.

- Consider Maryland's Healthy Babies Equity Act passed in 2022, expanding Medicaid to cover prenatal and postpartum medical services for all pregnant women regardless of immigration status.³⁸
- New Jersey Bill A2655 in the 2022-23 legislative session would establish requirements concerning the provision of postpartum care information and the development of individualized postpartum care plans.³⁹
- New Jersey Bill S1035 in the 2022-23 legislative session would extend the length of postpartum coverage for Medicaid services for eligible pregnant women to 180-day period.⁴⁰
- Advocate for more community funding and grants and implement accountability measures to ensure funds are appropriately allocated to maternal health issues.
- Spread awareness about **The New Jersey Family Leave Act**, which allows a pregnant woman or new mother to take an additional 12 weeks of leave to bond with and care for their infant after their doctor certifies that they are fit to return to work or they have exhausted their Federal Family Medical Leave Act (FMLA) (whichever comes first).⁴¹ [Learn more here](#).⁴²

Non-legislative opportunities to improve access include:

- Provide access to reliable transportation for pregnant women to attend their medical appointments.
 - Seek government or philanthropic funds to subsidize public transportation tokens that can be provided through clinics and hospitals.
 - Partner with taxi and ride share companies through programs for low-income pregnant women to utilize these services for free or reduced rates.

- 
- Camden and Newark are working to improve maternal health outcomes by partnering with local health coalitions to increase pregnant and postpartum women’s connection to services and care coordination, educate health care providers on best practices for maternity care, develop a public education campaign to increase people’s awareness of pregnancy and postnatal conditions, and share findings with maternal health stakeholders.⁴³
4. **Advocate for full adoption and accountable implementation of the *Nurture New Jersey* action plan.** First Lady Tammy Murphy proposed a nine-step action plan known as “[Nurture New Jersey](#)” to reduce health disparities for maternal health in the State. Read more about the action plan [here](#), and work with your local nonprofits and representatives to insist on credible, transparent, and accountable action and implementation.⁴⁴

This document was developed by law students Thuy Langrill-Miles, Alexis Lovings, and Hope Randolph, Class of 2023; and former students Ayesha Rajan, J.D., and Aisha Williams, J.D., Class of 2022, at the University of Maryland Carey School of Law, under the supervision of Kathleen Hoke, J.D., Law School Professor and Director of the Network’s Eastern Region Office. The Network for Public Health Law provides information and technical assistance on issues related to public health. The legal information and assistance provided in this document does not constitute legal advice or legal representation. For legal advice, please consult specific legal counsel.

Last Updated March 2023

SUPPORTERS

Support for the Network provided by the Robert Wood Johnson Foundation. The views expressed in this document do not necessarily reflect the views of the Foundation.



Robert Wood Johnson Foundation



References

- ¹ World Health Organization, *Maternal Health*, https://www.who.int/health-topics/maternal-health - tab=tab_1 (last visited Feb. 26, 2023).
- ² *Black Women’s Maternal Health: A Multifaceted Approach to Addressing Persistent and Dire Health Disparities*, NATIONAL PARTNERSHIP FOR WOMEN AND FAMILIES (Apr. 2018), <https://www.nationalpartnership.org/our-work/health/reports/black-womens-maternal-health.html>.
- ³ *Working Together to Reduce Black Maternal Mortality*, CDC (Apr. 6, 2022), <https://www.cdc.gov/healthequity/features/maternal-mortality/index.html>.
- ⁴ Donna L. Hoyert, *Maternal Mortality Rates in the United States, 2020*, CDC (2020), <https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2020/E-stat-Maternal-Mortality-Rates-2022.pdf>; Erica L. Green, ‘I Don’t Want to Die’: Fighting Maternal Mortality Among Black Women, N.Y. TIMES (Jan. 20, 2023) <https://www.nytimes.com/2023/01/18/us/doula-black-women.html>.
- ⁵ National Partnership for Women and Families, *supra* note 2.
- ⁶ *Id.*
- ⁷ Judith Solomon, *Closing the Coverage Gap Would Improve Black Maternal Health*, CTR. ON BUDGET & POLICY PRIORITIES (July 26, 2021), <https://www.cbpp.org/sites/default/files/7-26-21health.pdf>.
- ⁸ Bani Saluja & Zenobia Bryant, *How Implicit Bias Contributes to Racial Disparities in Maternal Morbidity and Mortality in the United States*, J WOMEN’S HEALTH (Feb. 30, 2021), <https://www.liebertpub.com/doi/epdf/10.1089/jwh.2020.8874>.
- ⁹ National Partnership for Women and Families, *supra* note 2, at 2. See also Eugene Declercq & Laurie Zephyrin, *Maternal Mortality in the United States: A Primer*, THE COMMONWEALTH FUND 7 (Dec. 16, 2020), <https://www.commonwealthfund.org/publications/issue-brief-report/2020/dec/maternal-mortality-united-states-primer#:~:text=The%20most%20recent%20U.S.%20maternal,after%20the%20day%20of%20birth>.
- ¹⁰ Emily E. Petersen, et al., *Racial/Ethnic Disparities in Pregnancy–Related Deaths–United States, 2007–2016*, 68 MORBIDITY & MORTALITY WKLY. REP. 762, (Sept. 6, 2019), <https://www.cdc.gov/mmwr/volumes/68/wr/mm6835a3.htm>.
- ¹¹ Cynthia G. Colen, et al., *Maternal Upward Socioeconomic Mobility and Black–White Disparities in Infant Birthweight*, AM. J. PUBLIC HEALTH (Nov. 2006), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1751798/#:~:text=Conclusions.,true%20for%20their%20Black%20counterparts.&text=Indeed%2C%20numerous%20research%20efforts%20find,maternal%20birthweight%20and%20infant%20health>.
- ¹² U.S. CENSUS BUREAU: CTR. FOR ECON. STUD., CES 22-55, MATERNAL AND INFANT HEALTH INEQUALITY: NEW EVIDENCE FROM LINKED ADMINISTRATIVE DATA 5 (2022).
- ¹³ Declercq & Zephyrin, *supra* note 9, at 11.
- ¹⁴ Lilo H. Stainton, *Road Map Details Steps to Improve Maternal Health*, N.J. SPOTLIGHT NEWS (July 13, 2022), <https://www.njspotlightnews.org/2022/07/nj-maternal-health-road-map-to-improvement-curbing-high-mortality-rates/>.
- ¹⁵ *Racial Disparities in Breastfeeding Initiation and Duration Among U.S. Infants Born in 2015*, CDC (Aug. 30, 2019), <https://www.cdc.gov/mmwr/volumes/68/wr/mm6834a3.htm>.
- ¹⁶ *The Challenges of Breastfeeding as a Black Person*, ACLU (Aug. 15, 2019), <https://www.aclu.org/news/womens-rights/challenges-breastfeeding-black-person#:~:text=Black%20women%20are%20also%20more,maternal%20and%20infant%20health%20outcomes>.
- ¹⁷ Mary Cunningham, *Because Black infants are less likely to be breastfed, the ongoing infant formula shortage is likely creating serious risk of undernutrition among Black babies*, GEORGE MASON UNIVERSITY (June 3, 2022), <https://www.gmu.edu/news/2022-06/how-baby-formula-shortage-disproportionally-affects-black-and-low-income-babies>.

18 Declercq & Zephyrin, *supra* note 9, at 11.

19 *Preterm Birth*, CDC (Nov. 1, 2022), <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pretermbirth.htm>.

20 *One State's Approach to Maternal Deaths: Free Nurse Visits After Birth*, N.Y. TIMES (Nov. 3, 2021), <https://www.nytimes.com/2021/07/29/nyregion/maternal-mortality-new-jersey.html>.

21 CDC, *supra* note 14.

22 *The Challenges of Breastfeeding as a Black Person*, ACLU (Aug. 15, 2019), <https://www.aclu.org/blog/womens-rights/pregnancy-and-parenting-discrimination/challenges-breastfeeding-black-person#:~:text=Black%20women%20are%20also%20more,maternal%20and%20infant%20health%20outcomes>.

23 *Maternal Mortality: New Jersey 2014-2016*, NEW JERSEY DEPARTMENT OF HEALTH, https://nj.gov/health/fhs/maternalchild/documents/NJ%20Maternal%20Mortality_2014-2016_12.14.21_Final.pdf (last visited Mar. 2, 2023).

24 *Preterm Birth*, MARCH OF DIMES (Jan. 2022), <https://www.marchofdimes.org/peristats/data?reg=99&top=3&stop=63&lev=1&slev=4&obj=1&sreg=34>.

25 Theresa Andrasfay & Noreen Goldman, *Intergenerational Change in Birthweight*, EPIDEMIOLOGY (Sept. 2020), https://journals.lww.com/epidem/fulltext/2020/09000/intergenerational_change_in_birthweight_effects.7.aspx.

26 *Health Indicator Report of First Trimester Prenatal Care*, Center for Health Statistics, New Jersey Department of Health, <https://www-doh.state.nj.us/doh-shad/indicator/view/PNC1.RETrend.html>.

27 Michelle LeBlanc, *Centering Women's Voices in Maternal and Infant Health*, NAT'L GOVERNOR'S ASSOC., (Nov. 16, 2022), <https://www.nga.org/news/commentary/centering-womens-voices-in-maternal-and-infant-health/>.

28 *Racism as a Public Health Crisis*, THE NETWORK FOR PUBLIC HEALTH LAW, <https://www.networkforphl.org/resources/topics/racism-as-a-public-health-crisis/> (last visited Mar. 7, 2023).

29 Michelle LeBlanc, *supra* note 26.

30 *Commitment to Racial Equality*, BOROUGH OF LEONIA, <https://www.leonianj.gov/home/showpublisheddocument/1512/637269716116270000> (last visited Mar. 7, 2023).

31 Eric Kiefer, *Montclair Mayor, Council: 'Racism Is A Public Health Crisis'*, PATCH (Feb. 17, 2021), <https://patch.com/new-jersey/montclair/montclair-mayor-council-racism-public-health-crisis>.

32 Janice A. Sabin, *Tackling Implicit Bias in Health Care*, THE NEW ENGLAND JOURNAL OF MEDICINE (July 14, 2022), <https://www.nejm.org/doi/full/10.1056/NEJMp2201180>.

33 Assembly Resolution No. 53, A.R. 53, 2022 Leg., 220th Sess. (NJ. 2022), https://pub.njleg.state.nj.us/Bills/2022/AR/53_I1.PDF.

34 William J. Hall, *Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review*, NATIONAL LIBRARY OF MEDICINE (Dec. 2015), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4638275/>.

35 Kenneth J. Gruber, et al., *Impact of Doula on Healthy Birth Outcomes*, NATIONAL LIBRARY OF MEDICINE (2013), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3647727/>.

36 *Id.*

37 Alexis Robles-Fradet, *Medicaid Coverage for Doula Care: State Implementation Efforts*, NATIONAL HEALTH LAW PROGRAM (Dec. 2021), <https://healthlaw.org/medicaid-coverage-for-doula-care-state-implementation-efforts/>.

38 *Healthy Babies Equity Act*, H.B. 1080, 2022 Leg., 444th Sess. (Md. 2022), <https://mgaleg.maryland.gov/mgaweb/Legislation/Details/hb1080?ys=2022RS>.

39 Bill A2655, 220th Sess. (NJ. 2022), <https://www.njleg.state.nj.us/bill-search/2022/A2655>.

⁴⁰ Bill S1035, 220th Sess. (NJ. 2022), <https://www.njleg.state.nj.us/bill-search/2022/S1035>.

⁴¹ *5 Things You Should Know About Job-Protected Family Leave*, NJ OFFICE OF THE ATTORNEY GENERAL (May 5, 2020), https://www.nj.gov/oag/dcr/downloads/fact-FLA.pdf?_gl=1*f68em*_ga*MTQyMjYyMjk1NS4xNjc2ODY4MDA5*_ga_N8RFJ4LE4D*MTY3Njg5OTE1OS4xLjAuMTY3Njg5OTE1OS4wLjAuMA..&_ga=2.31186743.985161458.1676899159-1422622955.1676868009.

⁴² *Id.*

⁴³ *Safer Childbirth Cities Initiatives*, THE BURKE FOUNDATION, <https://burkefoundation.org/burke-portfolio/initiatives/safer-childbirth-cities-initiative/> (last visited Mar. 7, 2023).

⁴⁴ V.K. Hogan, et al., *Nurture New Jersey 2021 Strategic Plan*, NURTURE NJ (Jan. 2021), <https://nurturenj.nj.gov/wp-content/uploads/2021/01/20210120-Nurture-NJ-Strategic-Plan.pdf>.