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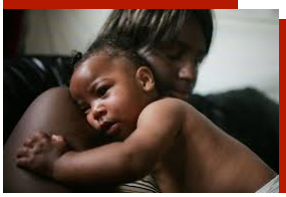
RESEARCH BRIEF

Addressing Black Maternal Health Disparities, Suicidal Ideation, and Solutions



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Introduction

The United States has an unfavorable reputation for quality maternal care (Slomski, 2019). "In fact, the United States has the highest maternal mortality rate in the developed world, making it the most dangerous industrialized country in which pregnant women can live and deliver" (Villavicencio, McHugh, & Edmonds, 2020, p.408). Although childbirth is natural, it is one of the deadliest experiences a pregnant woman can endure in the United States. According to Slomski (2019), there are approximately 800 deaths yearly from pregnancy and postpartum complications up to one year after pregnancy. What is more alarming is that of these hundreds of women, Black women are at the highest risk. "Black women are three times more likely to die from childbirth or pregnancy complications than white women" (Abboud, 2020, p. 413).

Literature implies that the reasoning for disproportionate rates in maternal care in the United States is multifaceted and complex; yet, an estimated $27 billion is spent annually for maternity-related hospitalization (Kozhimanniel, et al., 2017). Interestingly, the United States has the highest prenatal cost in the world and is the most expensive country for childbirth, yet there are negative health outcomes (Adam & Thomas, 2017). There are several risk factors that have led to these "longstanding and unacceptable [statistics] in maternal care" (Small, Pettiford, Shuler, & Jones-Vessey, 2020, p.55). Some of them include reproductive racial disparities, suicidal ideation, and Medicaid limitations. Although these issues have been made public in some capacity, there is still a deficiency in awareness, action, and prevention.

Disparities in Maternal Care

Reproductive racial disparities and biases in the health care system is placing a strain on quality maternal care. Since slavery, hundreds of years ago, Black women have been at the mercy of an unjust system. Black women's bodies were discriminated against, degraded, and devalued by slave owners and doctors (Goode & Rothman, 2017). Most recently, nearly one in five black women disclosed maltreatment from hospital staff due to "race, ethnicity, cultural background, and/or language" (Adams & Thomas, 2017, p. 3). Literature emphasizes the reality of discrimination by exposing that "physicians are less likely to recommend adequate pain relief or particular procedures to black [women] than to white [women]" (Nouri, Saluja, & Richey, 2020, para. 15). It is a biased belief that "black women are somehow more primitive and feel less pain" which is defined as "obstetrical hardness" (Goode & Katz Rothman, 2017, p. 66).

Suicidality and Black Maternal Women

Suicide ideation amongst pregnant and postpartum women in the United States is a serious yet insufficiently researched issue. "Suicide is the leading cause of death amongst pregnant and postpartum women in the United States" (Gavin, Tabb, Melville, Guo, & Katon, 2011, p. 239). Suicide has gone undetected because historically it is an assumption that pregnancy and childbirth equate to emotional well-being and becoming a mother negates suicide and suicide behaviors (Zhong et al., 2016). "In the postpartum period, the most common cause of maternal death is suicide, often associated with postpartum depression" (Doucet & Letourneau, 2009). Although the majority of maternal suicide cases are due to postpartum depression, "more than 30% of hospitalization were for suicidal behavior without depression diagnoses" (Zhong et al., 2016, p. 463). Researchers report that 3.9% of women report experiencing suicidal thoughts which is distressingly associated with higher risks of death by suicide (Bodnar-Deren, Klipstein, Fersh, Shemesh, & Howell, 2016). Of this portion of women, Black women within the age range of 12-18 have higher rates of suicide ideation than White women (Zhong, 2016). Unfortunately, some researchers attempt to credit this to Black teens having unplanned and unwanted pregnancies (Zhong, 2016).

Prenatal Health Coverage and Limitations

Medicaid is a federal and state health coverage program that was created to help people, including pregnant women, that fall within 138% of the federal poverty level (Noursi et. al., 2020). According to the law, it is a requirement for all states to offer Medicaid to all pregnant women that are eligible based on income and the lack of other financial resources. Although providing a sense of security for pregnant women, there are limitations. Medicaid coverage lasts for 60 days postpartum which is beneficial, but a vast proportion of pregnancy-related deaths occur after delivery up to one year (Villavicenio, 2020). Addressing this loophole, under the Affordable Care Act (ACA) passed in 2010, all 50 states were given the option to expand maternal coverage for the full 365 days. As of January, of last year, 14 states, including North Carolina, have not expanded their Medicaid pregnancy plan. Literature pinpoints the disparities in race by proclaiming the profound statement that "Black women are more likely than white women to be affected negatively by these policies, as greater proportion [of them] die during the late-postpartum period" (Noursi, 2020, para. 21).

Solutions

In 2018, Congresswoman Robin Kelly, made the call to action to address reproductive racial disparities and biases by introducing the Mothers and Offspring Mortality and Morbidity Awareness Act (MOMMA Act). Of the many dimensions this act has, the MOMMA Act would hold practitioners accountable for maintaining high levels of quality care. Medical professionals would complete culturally competent training and establish national emergency obstetric guidelines (Kelly, 2018).

Promoting equality and wellness, health care professional institutes would address implicit and explicit biases through the curriculum to "increase awareness of potential differential treatment of patients" (Noursi et al., 2020, para. 26). Promoting longevity, the act would ensure that all physicians and medical staff are abreast of the best procedures and share them across demographics.

An efficient way to address suicide ideation which could lead to death by suicide is to conduct health screenings on all pregnant and postpartum women despite the history of depression. Pregnancy and postpartum can be a very difficult time for women. There are various factors to consider in suicide ideation "including the stress of delivering, caring for a newborn, and changes in hormonal levels" (Pope, Xie, Sharma, & Campbell, 2013, p. 483). Of the different assessments, the Patient Health Questionnaire (PHQ) and Hamilton Depression Rating Scale (HDRS) have direct questions regarding suicidal ideations that professionals can hub in on. "Item number 9 of the PHQ asks over the last 2 weeks how often have you been bothered by…thoughts that you would be better off dead or of hurting yourself in some way" (Gavin et al., 2011, p. 239). The answer choices are not at all, several days, more than half, and nearly every day. The HDRS measures suicidal ideation at item number 3. Professionals rate women based the scale of: "0 = absent, 1 = feeling life is not worth living, 2 = wishes [she] were dead or any thoughts of possible death to self, 3 = suicidal ideas or gestures, 4 = attempts at suicide" (Pope et al., 2013, p. 485).

In simplest context, Medicaid needs to be expanded beyond two months of postpartum for all 50 states. Congresswoman Robin Kelly, addressed this issue in her proposed MOMMA Act and the ACA supported it. The act should help to eliminate racial disparities in maternal health leading to catastrophic events. Expanding Medicaid would allow for all eligible postpartum women to receive holistic care 365 days after delivery. "A review released by Georgetown University demonstrated that expanded access to Medicaid under the ACA was associated with several important indicators of perinatal health: better health coverage for reproductive-aged women, improved adequacy of prenatal care, and perhaps most importantly, 1.6 fewer maternal deaths per 100,000 women" (Villavicencio et al., 2020, p. 408).

In conclusion, to combat disproportionate rates in maternal care that consist of reproductive racial disparities, suicidal ideation, and Medicaid restrictions, additional research must be conducted and there needs to be an abundance of culturally informed preventions. For example, little is understood and documented about suicide ideation in pregnant and postpartum women. Researchers are aware that "suicide is one of the leading causes of maternal mortality in many countries" and they admit "little is known about the epidemiology of suicide and suicide behavior among pregnant women in the USA" (Zhong et al., 2016, p. 463). As information becomes available, more people, other than scholars and professionals, need to be made aware. There should be diverse community wide knowledge of these issues and cultural practices set in place leading to substantial change, such as eliminating high rates of black teen mothers contemplating suicide.

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